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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
KENNETH J. KURT, D.O. RESPONDENT.	:	LS0701242MED

Division of Enforcement Case #06 MED 17

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

Kenneth J. Kurt, D.O.
2405 Northwestern Ave. #141
Racine, WI 53404

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

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 Kenneth J. Kurt (dob 5/26/37) is and was at all times relevant to the facts set forth herein an osteopathic physician licensed in the State of Wisconsin pursuant to license #14968, first granted on 7/1/64. Respondent is a general practitioner.

2. On 2/10/06, Respondent's patient health care record of patient J.W., a male born in 1980, was requested by the Department. The request was:

> I hereby formally request […] Copies of any and all medical records, including but not limited to: physical examinations and histories, nurses' notes, progress notes, diagnostic test records, physician's notes and orders, medication orders, operative reports, laboratory reports, prescription and dispensing records, radiology reports, pathology reports, outpatient treatment records, emergency room records, consultation reports and discharge summaries regarding the patient(s) named below: [J.W.]

In response to this request, Respondent's staff sent 11 pages which consisted of Respondent's own progress notes, a laboratory test result showing that the patient had hepatitis C, a privacy policy notice, a work excuse, and a document entitled "Narcotics Agreement."

3. On 12/13/06, Respondent appeared before Departmental personnel with the actual original patient health care record. Respondent provided to the Department, for the first time, progress notes made by another physician who practiced in the clinic part-time, which predated the progress notes furnished earlier, and which notes were available to and considered by Respondent in making his own decisions about the care and treatment of the patient.

4. Between 2/10/06 and 12/13/06, Department staff spent several hours reviewing the incomplete chart, and evaluating it as if it was the complete chart. This time was largely wasted, as the evaluation would have been substantively

different had staff known that the chart contained additional physician notes which Respondent had read and incorporated into his own thought process; staff would also have read these notes and incorporated the knowledge into the evaluation.

5. On 8/18/03, a part time associate of Respondent, a Dr. G., first saw patient J.W. at Respondent's clinic. The note reads, in its entirety: "S. MVA 8/8/03 when hit car into tree after running off road to avoid a deer in the road. Seen by me on 8/8/03—day of accident. Given pain meds Endocet and asked to follow up. Wants to FU here with me to get further evaluation and treatment for sore right shoulder. Patient was wearing seat belt. Right should hit steering wheel. No other significant injuries. PH: neg. F.H: neg. Soc: rare ETOH, # cig. O: pleasant and NAD. Wearing right should sling. Right shoulder: ROM limited to <20º. Abdomen tender on palpation entire on[?] shoulder especially at long head of biceps and lesser extent over A and C joint. No clavicular pain except [??] A-C joint. Strength of SS muscles difficult to determine due to limited ability to abduct right arm. A: Rotator cuff injury (suspect ten) @ anterior right shoulder. P: check MRI of right shoulder. Refill Endocet 10/650 #253 and [??] another referral to MRI obtained." A staff noted then reads: "Scheduled MRI of right shoulder at MDI for 8/18/03."

6. On 9/15/03, the patient returned to care with Dr. G., whose note reads, in its entirety: "Stopped in for script for Anx/Per from interferon which he's taking for Hep. C per Dr. Catalino. Dr. C rec'd Paxil and occ'l Ativan and Xanax. He did have a rotator cuff tear but chose to rehab it here at IHF on his own to avoid surgery or he'd like to get into Marikes and this would facilitate that. P: Xanax 0.25mg #30 with three refills, take 1 up to TID. Paxil 20mg, take one qHS, #30 with three refills."

7. The chart contains no entries until a note that the patient cancelled a 3/10/04 appointment. On 3/11/04, the patient returned to care with Dr. G, whose note reads, in its entirety: "Back Pain. S: Moving couch last evening with brother slipped and felt increased pain in right mid-low back with some radiation to right posterior thigh (about half way down). Difficulty sleeping in spite of taking ibuprofen. PH positive for herniated disc. Recent DWI and now on electronic surveillance. Plans on [??] Army and hopes to play football and make it a career. O: usual pleasant, polite self. Back: ROM limited in all directions, especially flexion and leaning to left. Palp: palpable tenderness and spasm in right paraspinal muscles at upper lumbar area. SLR negative for radicular pain. A: Right midline back pain. P: Percocet 10/600 #20 take one every 406 hours PRN pain. Diazepam 2mg #20 take one every 304 hours PRN pain. [??] in heat packs [??] ibuprofen 600-800 QID ASAP. Note for police: he was here for 1 hr (203 PM)."

8. On 3/17/04, the patient cancelled his appointment. On 2/24/04, the patient returned to care with Dr. G., whose note reads, in its entirety: "S: 23 year old white male whom I've seen in past [??] for right shoulder pain then for LBP and then phone call for K. stone. Today he's most concerned about feeling of increased restlessness, anxiety, disconcertedness, difficulty sleeping and early AM awakening, decreased energy, social isolation, decreased confidence and decreased FUN!! Recently found out from MCW where he's getting monthly interferon that his Hepatitis C may not go away. This could ruin his life plan of joining Marines as a career and he's not got much of a backup plan. He could go to ITT for computers while awaiting decision from Marines on Hep.C. Reminds me that I ;put him on Paxil Ativan last summer, he discontinued them within 3 months. Paxil made him yawn a lot. Ativan helped. O: Mildly anxious appearing, reasonable affect but slightly flat. A: Anxiety, dep. P: Fluoxetine (Prozac) 20 in the morning, Ativan 1mg twice a day, PRN; increase P.A. to ½ hr/d, bike or walk/run. Try to eat more consciously."

9. The chart reflects that the patient rescheduled an appointment from 4/17/04, and then failed to appear for an appointment on 4/21/04. On 6/18/04, the patient returned to care with Dr. G., whose note reads, in its entirety: "4-5 days with rhino and slight cough with phlegm [??], tired and decreased appetite. Increased cough in the evening. History of frequent OM's in past but rare cough. No cigarettes. Concerned about whooping cough in areas. Decreased h[??]. O: Pleasant and NAD. HEENT: WNL's. Lungs: clear. Heart: reg, rhythmic, without murmur. A: Bronchitis. P: doxicycline 1—mg BID x IV d (Delayed Rx 2-3). Phenergan with codeine 4 fl.oz. Add: asked for some lorazepam (Ativan) for anxiety, rec'd #12 @ 1mg strength."

10. The patient returned to care with Dr. G. on 7/9/04, whose note reads, in its entirety: "Wisdom tooth impacted and need root canal, saw Dr. Blocher DDS. Mon Mollack. Lower right gum. Increased pain. P: Endocet 7/5/325 #30. Charged $10.00"

11. The patient returned to care with Dr. G. on 7/16/04, whose not reads, in its entirety: "Had increased pain and

used Endocet already. Ran out yesterday and appointment Tuesday @ 4:15 PM. P: Percocet 10mg #20."

12. On 9/2/04, Respondent first saw patient J.W. Respondent represents to the Board that he reviewed Dr. G's notes regarding the patient, and had at least a brief conversation with Dr. G., at which time it was understood that Respondent would be taking over the care of this patient. Respondent's initial electronic chart note reads, in part: "Neck pain lasting for 2 weeks, MRI shows herniated disc C-6, pain 6/10. Left cervical spine has been very sore for last two weeks. Difficulty sleeping, constant pain. Needs meds for pain and sleep." Respondent charted that he performed osteopathic manipulations to 3-4 body regions (without any further description), and applied traction to the cervical spine. The patient's blood pressure was measured at 120/80, and his heart rate was recorded as 80. The physical examination portion of the chart reads, in its entirety: "Physical Exam: Musculoskeletal spine: Tenderness: cervical spine, thoracic spine; trigger points: cervical spine, thoracic spine.' Respondent diagnosed: "Neck Pain 723.1; Herniation, nucleus pulposus, cervical, 722.0." Respondent prescribed Percocet 10/325 q4-6h x 2 weeks #50; Zanaflex 2mg TID #90; and Mobic 7.5mg 1-2/day #30. Respondent also noted that these are the patient's current medications. Based on the dosage instructions, these medications constitute a 2 week supply. There is no MRI film or report in the patient's health care record.

13. On 9/7/04, the patient returned to care. The chart reflects that the patient signed a "narcotics agreement" providing, among other things, that the patient would receive opioids only from Respondent. The chart note reads, in part: "Neck slightly better, needs OMT. Reports pain is still a 6/10." No vital signs are recorded. Respondent charts that he performed: "Traction: cervical; OMT, 3-4 body regions" without any further description. Respondent diagnoses the patient as follows: "Neck Pain 723.1, Somatic dysfunction, cervical 739.1, somatic dysfunction, thoracic 739.2." Respondent prescribed: Zanaflex 2mg TID #90, Mobic 7.5mg 1-2/day #30, Norco 10/325 q4-6h PRN #100, Avinza 60mg QD #40. Respondent also noted that these are the patient's current medications. Based on the dosage instructions, the medications are a 30-40 day supply.

14. On 9/21/04, the patient returned to care. The chart note reads, in part: "Very upset today, needs to talk to Dr. about personal issues. Concerned about treatment for Hepatitis C." No vital signs are recorded. There are no comments regarding the patient's pain. The chart contains a note that Respondent performed OMT, 3-4 body regions, without further description. The physical exam note reads: "Musculoskeletal; spine: Abnormal: diffuse; swelling: cervical spine, thoracic spine, lumbar spine; Tenderness: cervical spine, thoracic spine, lumbar spine; Trigger Points: cervical spine, thoracic spine, lumbar spine." Respondent's diagnoses are: "Neck pain 723.1, hepatitis C 070.51 See copy of lab work, Somatic dysfunction, lumbar 739.3, Somatic dysfunction, sacral 739.4." Respondent prescribed: methadone 10mg, 2@12-14hrs #100; Roxicodone 10mg 2-3/day #100; and Valium 5mg BID PRN anxiety or spasms #50. These are also listed as the current medications. Based on the dosage instructions, these constitute a 25-30 day supply.

15. On 10/18/04, the patient returned to care. The chart note reads, in part: "Neck stiff, needs OMT and med refills. Pain rated at 6-7 today." No vital signs are recorded. Respondent notes: "OMT, 3-4 body regions" without any further description. Respondent's diagnoses are: "somatic dysfunction, cervical 739.1; somatic dysfunction, thoracic, 739.2." Respondent prescribed methadone 10mg #60; OxyIR 5mg q6h PRN #200; and Valium 5mg 2-3/day PRN anxiety or spasms #100. Given the dosage instructions, these constitute a 50-60 day supply.

16. On 10/27/04, the patient returned to care. The chart note reads, in part: "Med Refill, neck pain, worse 8/10." Respondent performed "traction: cervical. OMT, 3-4 body regions" without further description. The physical examination notes that the patient's eyes are "Normal. Pupils equal, round, reactive to light: Bilateral; good accommodation: Bilateral." The patient's skin is noted as normal. The musculoskeletal examination note is: "Spine: Tenderness: cervical spine, thoracic spine; Trigger points: cervical spine, thoracic spine." Respondent's diagnoses are: "Neck pain 723.1, Herniation, nucleus pulposus, cervical 722.0." Respondent prescribed: OxyContin 20mg q12h PRN pain #30; and methadone 40mg 2-3/day #60. These are also listed as the patient's current medications. Based on the dosage instructions, the medications constitute a 15-20 day supply.

17. On 12/23/04, the patient returned to care. The chart note reads, in part: "Med Refill minimal amount of meds while in jail. Back pain, incarcerated for alcohol related driving." The patient is recorded as having a blood pressure of 142/96, heart rate of 60, respirations 20, and a weight of 167. The chart notes that the patient received the following in-office treatment: "Stimulation – electric stim ATTENDED BY MD. Packs, hot or cold. OMT, 3-4 body regions" all without further description. The diagnoses are: "Back pain, lumbar 724.2, somatic dysfunction, lumbar 739.3, somatic dysfunction, sacral

739.4 herniated cervical disc. Respondent prescribed: methadone 10mg 2-3/day #100; and Endocet 10mg q3-4h #100. These are also listed as the patient's current medications. Based on the dosage instructions, the medications are a 25-33+ day supply.

18. On 1/18/05, the patient returned to care. The chart note reads, in part: "Needs OMT and med refill. Pain under poor control." The patient is noted as having a blood pressure of 130/90, heart rate of 72, respirations of 20, and weight of 164. The chart records that the patient received "OMT, 3-4 body regions" without further description. The diagnoses are as recorded in the 12/23/05 note. Respondent prescribed: Percocet 10/325 q4-6h #100; methadone 10mg 2-3/day #100; and Valium 5mg BID PRN anxiety or spasms #60. These are also listed as the current medications. Based on the dosage instructions, this is a 16-33+ day supply.

19. Respondent's conduct in the care and treatment of this patient fell below the minimum standard of conduct for the profession in the following respects:

a. At no time does the chart reflect that the patient receive a comprehensive history and physical examination, including an AODA history, before chronic opioid analgesic therapy was initiated.
b. At no time does the chart reflect that the patient referred for evaluation of alcohol or other drug abuse, dependence, or addiction.
c. At no time does the chart reflect that the patient asked about the effectiveness of the therapies provided.
d. At no time does the chart reflect that the patient referred for physical therapy, evaluation for surgery, or any other alternative therapy.
e. When the patient informs Respondent of likely substance abuse, in that he is in jail for alcohol related driving, there is no followup to this highly relevant information.
f. There is no description of what the osteopathic manipulations were, to what parts of the body were they performed, or the effectiveness of this treatment modality. There is no description of the length of time or the weight or tension level used for each cervical traction treatment, or the effectiveness of this treatment modality.
g. There is no explanation given for the changes in medications and dosages prescribed.
h. Respondent was given new prescriptions for additional opioids when his current supply was adequate to carry him, and there is no medication sheet or other tracking of the medication supplied to the patient to determine if early refills were being requested or provided.
i. There is no recorded consultation with the pharmacy selected by the patient, to determine if other practitioners were providing prescriptions for controlled substances to the patient.
j. At no time does the chart reflect that functional goals were established for the patient, nor does the chart reflect any progress noted towards achieving such goals.
k. At no time does the chart reflect that alternative modes of treatment are noted as being offered to, or discussed with, the patient.
l. Long-acting products like OxyContin® are never dosed "PRN" but are always taken on a scheduled basis.

20. Respondent's conduct created the following unjustifiable risks to the health, safety or welfare of the patient or the public:

a. The patient was provided with early refills on multiple occasions, creating the risk of diversion or overconsumption for non-medical reasons.
b. The patient may fail to improve because appropriate treatment is not provided, including neuromodulators, NSAIDS, physical therapy, blocks, surgery, or other modalities.
c. Dosing a long-acting pain medication on a PRN basis results in the patient's receiving inadequate relief in that the patient is "chasing" the pain rather than staying ahead of it, as such products are designed to do.

21. A minimally competent physician would have avoided these risks by taking the following steps:

a. A careful initial history and physical examination would be conducted and charted, to determine the cause(s) of the patient's pain and what treatments had failed, or were effective. An AODA assessment or evaluation would be conducted before initiating chronic opioid analgesic therapy, and upon disclosure of any information suggesting a history of such abuse (including, but not limited to, disclosure of being "incarcerated for alcohol related driving").
b. The alternatives available to the patient would be discussed with the patient, and the chart would record the choices made, with reasons for those choices.

c. A treatment plan with clear functional goals would be devised and charted, and progress towards achieving those goals would be charted on each return visit. Changes in therapy, such as in medications, would be clearly noted, together with the indication for the change.

d. Long-acting opioids would be dosed on a scheduled basis, so that the patient's pain was well controlled around the clock, with short-acting products being provided for limited use for flare up pain, PRN.

e. A medication sheet would be used to record the days supply of medication provided to the patient.

f. The pharmacy used by the patient would be consulted to determine if the patient was complying with the "narcotics agreement." Collateral sources, such as the patient's family and girlfriend, would be consulted if there was doubt on this issue.

g. On any occasion when the patient appeared to be using more medication than prescribed, the patient would be questioned about his use, and counseled appropriately. Repeated overuse would have led to appropriate action by the prescriber, including ruling out of pseudoaddiction, and consideration of other medications such as NSAIDS, neuromodulators, and SSRIs; and consideration of other modes of treatment.

h. When osteopathic manipulations or traction were performed, details would be charted such as the location of the treatment, the exact nature of the manipulation provided, and an indication of the efficacy of the treatment. When cervical traction was applied, the length of the treatment and the tension applied would be recorded, together with a statement about the efficacy of the treatment.

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 2-4, above, violated Wis. Adm. Code Med § 10.02(2)(zc). The conduct described in 12-20, above, violated Wis. Adm. Code §§ Med 10.02(2)(h) and 18.05. 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 Kenneth J. Kurt, D.O., is REPRIMANDED for his unprofessional conduct in this matter.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of Respondent is LIMITED as provided in Wis. Stat. § 448.02(3)(e), and as follows: Respondent shall not order, prescribe, or administer any opioid or opiate, including any product containing tramadol, for more than 30 days in any 12 month period, for any patient. Notwithstanding this limitation, Respondent may prescribe FDA approved buprenorphine products to patients for the purpose of office based opioid treatment (OBOT), within the labeling of Subutex® and Suboxone®.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of Respondent is LIMITED as provided in Wis. Stat. § 448.02(3)(e), and as follows: Respondent shall take and successfully complete the "Intensive Course in Medical Record Keeping with Individual Preceptorships," offered at the Case Western Reserve University, School of Medicine, Continuing Medical Education Program, on June 7-8, 2007. Respondent shall arrange for the course sponsor to transmit information concerning his performance directly to the Department Monitor, and shall authorize the Board or designee to confer with CWRU staff concerning his performance and behavior. Respondent may propose an alternative course which is substantially equivalent to this offering, which may be approved by the Board or its designee.

IT IS FURTHER ORDERED, that respondent shall pay the COSTS of investigating and prosecuting this matter of $2,100 within 120 days of this Order.

IT IS FURTHER ORDERED, that pursuant to Wis. Stats. §§ 227.51(3) and 448.02(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, following notice and an opportunity to be heard. In the event Respondent fails to timely submit any payment of the Costs as set forth above, Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has paid them in full.

Dated this January 24, 2007.

WISCONSIN MEDICAL EXAMINING BOARD

by: Gene Musser MD
a member of the Board