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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
GREGORY ESTLUND, M.D.	:	LS0709192MED
RESPONDENT.	:	

[Division of Enforcement Case # 06 MED 367]

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

Gregory Estlund, M.D.
730 10th Avenue
P.O. Box 300
Baldwin WI 54002

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. Gregory J. Estlund, M.D., ("Respondent") was born on October 28, 1949, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 28346. This license was first granted on June 19, 1987.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 730 10th Avenue, P.O. Box 300, Baldwin, Wisconsin 54002.

3. At all times relevant to this proceeding, Respondent was working as a physician at the Baldwin Clinic, Baldwin, Wisconsin. Respondent is a family practice physician.

4. Patient E. H. was a male born on May 29, 1938.

5. On March 12, 1999, Respondent treated Patient E.H. in the emergency room at Baldwin Hospital for difficulty breathing with nasal congestion, and for marked swelling of the interior neck and sublingual tissues.

6. On March 15, 1999, Patient E.H. presented to Respondent for follow up from the emergency room visit on March 12, 1999. Respondent performed a complete physical examination, including prostate examination and blood work including prostate specific antigen (PSA).

7. On physical examination, Respondent found the prostate to be within normal limits, but the PSA test result was high, at 5.1, on a reference range of 0 to 4.0.

8. The PSA test result was sent to Patient E.H. at his home sometime in April 1999, but without an explanation of the possible significance of the test result.

9. Respondent received a copy of the PSA result, and requested Patient E.H.'s chart for follow up. Respondent did not receive the chart, and he forgot about the request and the PSA test result, and he did not follow up with Patient E.H. about the PSA test result.

10. Patient E.H. did not return to the Baldwin Clinic until March 2001, when he was seen by the physician's assistant for a different physician, for evaluation of a skin ulcer on his right foot, following surgery in Minneapolis to insert a pin in his fifth metatarsal, which was broken by a steel plate falling on his foot. The problem focused contact did not lead to the discovery of the missed follow up of the 1999 PSA test result.

11. On March 27, 2003, Patient E.H. was seen at the Veteran's Administration hospital in Minneapolis with complaints of back pain and blood in his urine.

12. A PSA test result of 506.8 was reported on April 3, 2003, and a PSA test result of 520.9 was reported on April 4, 2003. On April 4, 2003, a 2 cm. mass was found in Patient E.H.'s prostate. On April 11, 2003, earlier suspicions of extensive metastatic bone disease were confirmed.

13. Patient E.H. died of prostate cancer on April 1, 2004.

14. Respondent has voluntarily restricted his patient load, and has implemented routine scheduled conferences with his assistants to reduce the probability of any similar lack of patient communication. In addition, the clinic and hospital at which Respondent practices has implemented stricter controls on medical records filing, and has begun to make more records immediately available to practitioners through electronic access in the practitioners' offices.

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 6 through 9, above, constitutes a violation of Wisconsin Administrative Code § 10.02(2)(h).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Gregory J. Estlund, M.D., is hereby REPRIMANDED.

IT IS FURTHER ORDERED that:

2. The license of Gregory J. Estlund, M.D., to practice medicine and surgery in the state of Wisconsin is hereby LIMITED by the condition that, within six months of the date of this Order, he shall complete eight hours of continuing medical education in the topic of risk management for medical practice.

   a. Respondent shall be responsible for all costs associated with obtaining the continuing medical education under this Order, and it shall be Respondent's obligation to find a course or courses acceptable to the Board. Respondent shall obtain approval from the Board or the Board's designee for any course he intends to take in compliance with this Order.

   b. Any requests, petitions, reports and other information required by this Order shall be mailed, e-mailed, faxed or delivered to:

Department Monitor
Wisconsin Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax: (608) 266-2264
Telephone: (608) 267-3817
department.monitor@drl.state.wi.us

   c. The Board recognizes the changes in practice implemented by Respondent and the clinic and hospital at which he practices, together with the continuing move to electronic records access, as obviating the need for the Board to order additional limitations on Respondent's license.

IT IS FURTHER ORDERED that:

3. Respondent shall, within ninety (90) days from the date of this Order, pay costs of this proceeding in the amount of One Thousand Seven Hundred Sixty-Four ($1764.00) 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 or fails to comply with the ordered continuing education the Respondent's license(#28346) 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: Gene Musser MD 9/19/07

A Member of the Board Date