WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

FINAL DECISION AND ORDER WITH VARIANCE
Case No. LS0608022MED

THOMAS E. GOODRICH, M.D.,
RESPONDENT.

[Division of Enforcement Case No. 03MED391]

PARTIES

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Thomas E. Goodrich, M.D.
1244 Wisconsin Avenue, Suite 105
Racine, WI 53403

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

This proceeding was commenced by the filing of a Notice of Hearing and Complaint. The hearing held in this matter concluded with the filing of the closing arguments in July, 2007. Attorney John R. Zwieg appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Kevin F. Milliken, Law Offices of Relles, Long and Milliken, appeared on behalf of Dr. Goodrich. The Administrative Law Judge Ruby Jefferson-Moore (hereinafter "ALJ") filed the *Proposed Decision in the Matter of Disciplinary Proceedings Against Thomas F. Goodrich, M.D,* LS 0608022 MED, on June 18, 2008. The Complainant and the Respondent filed simultaneous *Objections to the Proposed Decision* on July 14, 2008. Oral arguments were held before the Medical Examining Board on August 20, 2008.

Based upon the entire record herein, the Medical Examining Board (hereinafter "Board') adopts, in part, and rejects, in part, the recommendations of the ALJ in the Proposed Decision and hereby adopts as a variance decision the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Thomas E. Goodrich (d.o.b., 08/12/59), is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license #28720, which was first granted on July 1, 1987.

2. Dr. Goodrich's last address on file with the Department of Regulation and Licensing is 1244 Wisconsin Avenue, Suite 105, Racine, WI 53403

3. Dr. Goodrich's practice specialty is family practice.

Count I

4. On November 18, 1996, Ms. A, a 26-year-old married woman, began working in Dr. Goodrich's medical office, Thomas E. Goodrich, M.D., S.C., in Racine, Wisconsin. Ms. A is licensed as a Registered Nurse. She operated the lab in Dr. Goodrich's office and sometimes functioned as a nurse when the regular nurse was absent. Ms. A was employed by Dr. Goodrich from November 18, 1996 until March 31, 2003.

5. On July 19, 1997, Ms. A was having right quadrant pain. She asked Dr. Goodrich to see her for that pain. Sometime after that visit, Ms. A asked Dr. Goodrich if he would take her as a new patient. Dr. Goodrich agreed to do so. Ms. A arranged to have her medical records transferred from her previous doctor to Dr. Goodrich. Ms. A considered Dr. Goodrich to be her primary care provider. Dr. Goodrich continued to provide medical care to Ms. A until March 2003. During that time period, Ms. A also received professional services from Dr. Lenora Brockman, an obstetrician/gynecologist.

6. In May 2001, Dr. Goodrich diagnosed Ms. A with depression and premenstrual dysphoric disorder (PMDD). He treated Ms. A for those conditions from May 2001 through December 2002.

a. On May 8, 2001, Dr. Goodrich performed a physical examination of Ms. A and noted that he would consider providing her with medication for depression if her symptoms persisted or worsened.

b. At some point in time, towards the end of May 2001, Ms. A asked Dr. Goodrich for medication for her depression. Dr. Goodrich initially provided her with samples of Sarafem and Prozac, which are antidepressants. Later Dr. Goodrich wrote prescriptions for Ms. A for Prozac (fluoxetine), 20 m.g., to be taken one at night. The provision of the samples was not entered in Ms. A's medical records. The prescription for Prozac was noted in the patient's medical record.

c. On July 1, 2001, Dr. Goodrich noted in Ms A's medical record that her depression was improved.

d. On August 18, 2001, Ms. A saw Dr. Goodrich for another purpose and he noted that she was taking Prozac 20 m.g., one at bedtime.

e. On December 4, 2001, Dr. Goodrich noted in Ms. A's medical record that she reported continued and somewhat increased periods of depression.

f. Dr. Goodrich continued to prescribe anti-depressants to Ms. A. The medication and dose was changed on occasion as Ms. A reported changes in symptoms.

7. On February 17, 2002, Ms. A saw Dr. Goodrich for a recheck appointment for her depression. The visit took place on a Sunday when Dr. Goodrich was on call, and he and Ms. A were the only people working in the office. At that time, Dr. Goodrich was on call every fifth Sunday. While on call, Dr. Goodrich saw patients with the assistance of a nurse. Typically, Dr. Goodrich and the nurse would be the only staff working in the office on those days. At some point in time, during or immediately following Ms. A's re-check appointment, Ms. A told Dr. Goodrich that she felt attracted to him. Dr. Goodrich responded by telling Ms. A that he had those same feelings for her. Dr. Goodrich and Ms. A then hugged and kissed.

8. On February 21, 2002, Ms. A and Dr. Goodrich had a prearranged meeting at the office in the evening. They talked, kissed and engaged in sexual touching.

9. In early March 2002, Dr. Goodrich and Ms. A met at a building owned by Dr. Goodrich and they engaged in sexual intercourse for the first time. Dr. Goodrich and Ms. A maintained a personal and sexual relationship until March 2003. At some point in time during the relationship, they expressed their love for each other and discussed their plans for the future.

10. In October 2002, Ms. A referred herself to Dr. Robert Henkel, a Psychologist in the Employee Assistance Program at her husband's place of employment. Ms. A saw Dr. Henkel on October 29, 2002, November 14, 2002 and January 16, 2003, for treatment of her anxiety and stress relating to her relationship with Dr. Goodrich. Sometime prior to December 2002, Dr. Henkel referred Ms. A to Dr. Barry Altenberg, a Psychiatrist, for treatment of her depression.

11. From December 2002 to July 2003, Ms. A saw Dr. Altenberg for treatment of her depression. Dr. Altenberg

diagnosed Ms. A's condition as Dysthymic Disorder and prescribed Effexor 150 m.g., twice a day for treatment of her depression. At some point in time, because of a scheduling conflict, Ms. A stopped seeing Dr. Altenberg and started seeing another Psychiatrist, Dr. Donald Jacobson.

12. In March of 2003, Dr. Goodrich told his wife that he was in love with Ms. A and that he was going to pursue that relationship. On March 31, 2003, Dr. Goodrich's wife, who had an office management position at Thomas E. Goodrich, M.D., S.C., called Ms. A and fired her from her employment at the clinic.

13. By the end of March of 2003, Ms. A's personal and sexual relationship with Dr. Goodrich had ended; she had been fired by Dr. Goodrich's wife from employment at Dr. Goodrich's office clinic; her husband had filed for divorce; her two sons had been placed principally with her husband, and she had moved back home with her dad. She also had lost weight; she had GI (gastrointestinal) upset and symptoms; she was constantly crying, and she had suicidal thoughts and ideation.

14. By having sexual contact with Ms. A. while she was his patient, Respondent created an unacceptable level of risk that could lead to less than optimal care of the patient, could obscure Respondent's judgment in providing care and be detrimental to Patient A.'s wellbeing.

Count II

15. Since December 1, 2002, Wis. Admin. Code § MED 10.02 (2) (zd) has defined unprofessional conduct to include:

> Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient. For the purposes of this subsection, an adult receiving treatment shall continue to be a patient for 2 years after the termination of professional services. …

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 (3) Wis. Stats.

2. Dr. Goodrich's conduct, as described in Findings of Fact 5-9 and 13 and 14 herein, constitutes a violation of Wis. Admin. Code § MED 10.02 (2) (h).

3. Dr. Goodrich's conduct, as described in Findings of Fact 5-9 and 13 herein, constitutes a violation of Wis. Admin. Code § MED 10.02 (2) (zd).

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (#28720) of Thomas E. Goodrich to practice medicine and surgery in the State of Wisconsin be, and hereby is, suspended for a period of not less than twelve (12) months.

IT IS FURTHER ORDERED that:

1. The suspension of the license of Thomas E. Goodrich to practice medicine and surgery in the State of Wisconsin be, and hereby is, stayed for a period of three (3) months. Dr. Goodrich may petition for additional three month stays of suspension, which shall be granted upon Dr. Goodrich's compliance with the following terms and limitations in the preceeding three months.

(A) As recommended by Dr. Gary Schoener on page 6-7 of his Psychological Evaluation Report, dated January 6, 2006, Respondent shall:

> (1) Continue to work with his physician in terms of periodically reviewing his medications for treatment of his depression and anxiety.

(2) Continue counseling as needed to help with any adjustment problems. Such counseling would include either personal or marital counseling.

(3) Refrain from having a sexual relationship with his patients, as required under Wis. Admin. Code § MED 10.02 (2) (zd).

(B) Respondent shall arrange for submission of quarterly reports to the Board from the health care providers who provide treatment under paragraph A above evaluating his progress in therapy. If the health care providers recommend work or practice restrictions, Respondent shall comply with all restrictions recommended. Respondent shall also provide the Board with current releases complying with state and federal laws, authorizing release and access to the records of the health care providers providing treatment to him under paragraph A above.

(C) Upon a showing by Respondent of complete, successful and continuous compliance for a period of not less than one (1) year with the conditions and limitations set forth in paragraph A above, and submission of documentation from the health care providers who provide treatment under paragraph A above stating that Respondent can continue to safely practice medicine and surgery, the Board may grant a petition by Respondent for return of full licensure if it determines that Respondent may safely and competently engage in the practice of medicine and surgery.

(D) The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving and coordinating all reports and petitions. The Department Monitor may be reached as follows:

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

2. Pursuant to s. 440.22 Wis. Stats., the full cost of this proceeding shall be assessed against Respondent, and shall be payable to the Department of Regulation and Licensing.

3. This order is effective on the date on which it is signed on behalf of the Medical Examining Board.

OPINION

The Division of Enforcement alleges in its Complaint that, by having a sexual relationship with a patient, Dr. Goodrich violated Wis. Admin. Code § MED 10.02 (2) (h) and 10.02 (2) (zd). The evidence does not establish that Dr. Goodrich violated Wis. Admin. Code § MED 10.02 (2) (h), but it does establish that Dr. Goodrich violated § MED 10.02 (2) (zd).

I. Applicable Law

448.02 Authority. (1) License. The board may grant licenses, including various classes of temporary licenses, to practice medicine and surgery, to practice perfusion, and to practice as a physician assistant. …..

(3) Investigation; Hearing; Action. (a) The board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license, certificate or limited permit granted by the board. …..

(b) After an investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct or negligence in treatment, the board shall hold a hearing on such conduct. …..

(c) Subject to par. (cm), after a disciplinary hearing, the board may, when it … finds a person guilty of unprofessional conduct or negligence in treatment, do one or more of the following: warn or reprimand that person, or limit, suspend or revoke any license, certificate or limited permit granted by the board to that person. …..

Med 10.02 Definitions. For the purposes of these rules:

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:
….
(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.
….
(zd) Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient. For the purposes of this subsection, an adult receiving treatment shall continue to be a patient for 2 years after the termination of professional services. If the person receiving treatment is a minor, the person shall continue to be a patient for the purposes of this subsection for 2 years after termination of services, or for 2 years after the patient reaches the age of majority, whichever is longer.

II. Evidence Presented

(A) Ms. A (Patient)

(1) Background

Ms. A testified at the request of the Division of Enforcement. Ms. A is licensed as a Registered Nurse. She received a Bachelor of Science degree in Nursing from the University of Wisconsin-Milwaukee in 1994. After graduation, she worked as a staff nurse on the orthopedic and neurology floor at St. Mary's Medical Center for about a year and a half. Thereafter, Ms. A worked as an RN with the Visiting Nurse's Association. While working with the Visiting Nurse's Association, Ms. A provided nursing care to Dr. Goodrich's mother. Ms. A started working at Dr. Goodrich's Clinic in November of 1996 and continued to work there until March of 2003. Her main duties at the Clinic were to run the lab. She also provided nursing services from time-to-time.

(2) Physician-Patient Relationship

When Ms. A started working for Dr. Goodrich, she was not his patient. She testified that on July 19, 1997, she was having some trouble with right quadrant pain. Ms. A asked Dr. Goodrich to see her for that pain. At some point in time after the July 19 visit, Ms. A asked Dr. Goodrich if he would take her as a new patient. He said yes. She said that her reasons for changing doctors was that she was not really happy with her previous doctor, and part of it was convenience. She signed a release for medical records, which was sent from Dr. Goodrich's office to her previous doctor. Ms. A continued to see her previous doctor for yearly gynecologic examinations. Exhibit 1, p. 33. Dr. Goodrich provided medical care to Ms. A at the Clinic on the dates noted below for the conditions noted:

July 19, 1997 – right quadrant pain

November 6, 1997 - lumps in her left inguinal area. [She had recently had a laparoscopy, and the lumps showed up after that. She asked him to check those out.]

February 18, 1998 – sore throat

March 18, 1998 - right upper quadrant discomfort

September 8, 1998 – Ms. A was pregnant. She felt very faint and light-headed, was short of breath and was having palpitations.

July 1, 1999 - right-sided flank pain and back pain

December 10, 1999 - increased pelvic pain, bloating, decreased appetite

January 13, 2000 - flank pain again
February 9, 2000 - sore throat, throat congestion, cough

March 3, 2000 - cough, upper respiratory infection

May 8, 2001- complete physical

July 1, 2001 – Note in patient record: "Patient reports stable breast exam, decreased pain, mild, no exam, not repeated at this time, patient okay with this management, depression improved."

August 18, 2001 – new lumps in her inguinal area

November 28, 2001 - cough, body aches, nausea, congestion

December 4, 2001 – Note in patient record: "Patient reports continuous -- somewhat increased period of depression, lasts one to two days intermittent, also notably with increased pelvic pain apparently related to endometriosis. These episodes coincide with specific times in patient's menstrual cycle, recommend increasing Sarafem to 30 milligrams QHS, follow up with gyne Dr. Brockman and consider for psychotherapy. Follow up three weeks for recheck."

December 26, 2001 – a recheck on the depression

January 21, 2002 - sore throat, body aches, cough

February 5, 2002 - sore throat, swollen glands, cough, muscle aches

February 17, 2002 - follow-up of the recheck on the depression

March 26, 2002 - back pain

April 19, 2002 - cellulitis just below her knee

April 24, 2002 - cough, sore throat, congestion, shortness of breath

April 29, 2002 - rechecked on bronchitis

May 1, 2002 - cough

May 13, 2002 - follow-up of the asthma/bronchitis

June 7, 2002 - recheck of the asthma, cough

July 10, 2002 - Note in patient record: "Patient complains of increased fatigue with Prozac at 30 milligrams, will decrease to 20 milligrams QHS, if persists or decreased efficacy, then consider Effexor or other alternative."

July 19, 2002 - recheck of the depression as well as the asthma. Note in patient records states: "Fatigue, improved with

decreased Prozac, cough improved on Serevent, no back pain, no shortness of breath."

August 7, 2002 - shortness of breath, cough

September 17, 2002 - cough, sore throat, fatigue, nausea, shortness of breath

March 3, 2003 - urinary frequency pain, urinary tract infection symptoms

(3) Personal and Sexual Relationship with Dr. Goodrich

Ms. A testified that on February 17, 2002, Dr. Goodrich was on call at the Clinic and that she worked with him as a nurse that day. At some point in time during the day, Dr. Goodrich asked Ms. A how things were going. She said that the depression was better, but that she was still having a lot of problems with an issue that she could not really talk to anybody about. She said that the nature of the issue was that she had some feelings for him and the person who had been her confidante had moved from that area.

Ms. A further testified that she told Dr. Goodrich that she was stressed over something that she was not able to really talk to anybody about. He said that she could talk to him about it, and she said that she knew she could but she was not sure that she should. She did not say anything right away, but then she told him that she had inappropriate feelings for him and that she was considering quitting because of those feelings. She said that she was very attracted to him. She liked being around him, but he was her boss. He was her doctor. According to Ms. A, Dr. Goodrich said that he was glad that she said something because he had some of those same feelings. After he said that, she said that they hugged, and when they pulled back, he kissed her.

Ms. A further testified as follows [Transcript p. 50-55]:

Q A kiss on the lips?
A Yes.

Q After this discussion the two of you had on February 17, 2002, did you have any further discussions about your feelings?

A Yes.

Q And approximately when did the next discussion take place and what was it?

A It was on the following Thursday, and we met that evening at the office to talk about things, and Dr. Goodrich mentioned that he was interested in us getting to know each other better, and we talked about -- I said I was interested in that, too, but also very scared.

Q Did the two of you do anything other than talking?

A Hugged, kiss.
……

Q What kind of a kiss was it?

A It was on the lips, romantic-type kiss. It was not a peck.

Q And did either of your hands touch anywhere on the body of the other one?

A Yes.

Q Whose hands touched who?

A Both of ours touched each other.

Q After that discussion the Thursday following February 17, 2002 and that kissing and other behavior, did you and Dr. Goodrich commence a sexual relationship?

A Yes.

……

Q How long after that time, when you kissed and hugged and touched one another, was it that you started a sexual relationship?

A Few weeks. It was by early March.

Q And did that include sexual intercourse?

A Yes.

Q How long did you and Dr. Goodrich have this sexual relationship in which you continued to have sexual intercourse?

A Until the end of March 2003.

Q And about how frequently was it that you would have sexual contact with one another?

A Once, twice a week.

Q At any time following February 17, 2002, did you have a discussion with Dr. Goodrich about your changing to another doctor?

A Yes, the Thursday that we met after the 17th.

Q And who said what?

A I brought it up. I said that I knew it was inappropriate for a relationship with -- if we were going to be involved for a patient-physician and asked him if he wanted me to get another doctor.

Q Why did you do that?

A Because I didn't want him to get in trouble.

Q Is it possible that you asked him whether you should

get another doctor without explaining to him why you were asking that?

A Yes.

Q What was his response to your asking?

A He said that he didn't think it was necessary at that time and then it -- he asked me what I wanted to do, and I said that I would prefer not to because he had already been my doctor for several years.

(B) Thomas E. Goodrich, M.D.

(1) Background

Dr. Goodrich has been licensed to practice medicine and surgery in Wisconsin since July 1, 1987. He practices family medicine in Racine, Wisconsin. He obtained his medical degree from the University of Illinois College of Medicine in Champaign, Illinois, in 1986 and completed his residency at the Medical College of Wisconsin, Family Practice Residency Program, in 1989. Dr. Goodrich has been an Assistant Clinical Professor in the Department of Family Medicine at the Medical College of Wisconsin since 1989. He is certified by the National Board of Medical Examiners, and has been certified by the American Board of Family Practitioners since 1989. Exhibit 4

(2) Physician – Patient Relationship With Ms. A

Dr. Goodrich admitted that Ms. A became his patient in July 1997, and that the physician-patient relationship ended in March 2003. Transcript p. 120.

(3) Personal and Sexual Relationship With Ms. A

Dr. Goodrich admitted that sometime in February or March of 2002, he and Ms. A began a sexual relationship, and that the relationship continued until March of 2003. He acknowledged that at the time he began having a sexual relationship with Ms. A, if he had been asked at that time whether having a sexual relationship with Ms. A was a violation of a Board standard, he would have said yes. In addition, Dr. Goodrich acknowledged that, during the residency that he completed in 1989, he was taught that it was wrong to have sexual contact with a patient; that there was an imbalance of power in physician-patient relationships, and that a sexual relationship with a patient could lead to less than optimal care, obscure the physician's objective judgment and be detrimental to the patient's well-being. Transcript p. 120-122.

When asked why he entered into a sexual relationship with Ms. A when he knew that a doctor should not be in a sexual relationship with a patient, Dr. Goodrich testified as follows [with omission of references to Ms. A's name]:

Q Doctor, since you completed your residency in 1989 and you began your sexual relationship in with ----- ------ 13 years later, why did you enter into that sexual relationship if you knew that a doctor should not be in a sexual relationship with a patient?

A My relationship with ------ was two or threefold. It was as an employee and a colleague as two professionals. We had become friends over the five years, six years that she'd been with us and towards

the end more of a confidante, someone to talk to, and the physician-patient relationship was not at the forefront of that whole process, and no one asked me if it was unethical or specifically about that, you know, I -- just the relationship began. It progressed. I fell in love, and when that's happening, I really didn't -- I didn't -- I didn't even think about whether or not she was a patient.

Q You were in the room here for all of ------- testimony today; correct?

A Uh-huh, yes.

Q Did you hear her say that, as your personal sexual relationship was starting, she asked you whether she should get another doctor. Did you hear her say that today?

A I heard her say that.

Q Do you recall that taking place back at that time?

A No.

Q Do you recall you and she ever having a discussion in which the issue was whether she should have another doctor?

A Yes. In October of 2002, for some reason, I was driving along to the emergency room, and I got this terrible feeling that went throughout my body and I realized that I was having sex with a patient, that my relationship with ----- constituted that and that night I wasn't able to sleep. I got in the office early the next morning, as did -----, and I spoke to her at length about the problems inherent in what I basically just realized and suggested that her care be transferred. I also suggested that we decrease our relationship contact.

Q Did you decrease your relationship contact?

A I think so.

Q And --

A About 50 percent I'd say.

Q When you're talking about relationship contact, you're talking about personal relationship?

A Right. Because we were seeing each other every day in the office.

Q And what did you suggest about the professional relationship?

A I suggested that she pursue obtaining a psychiatrist and that she should consider Dr. Brockman as her ongoing primary care physician for the variety of things that she would come to me for, like urinary tract infections and bronchitis and whatever.

Q Do you know if she did that at that time, either one?

A Well, she was already seeing Dr. Brockman and so I assumed that she shifted her care in that regard, although, she did manage to schedule a couple more visits with me, and I'm not sure as to the exact timing of the psychiatrist, but I don't think it was shortly -- it was too long after that discussion that she established with a psychiatrist.

Q Doctor, do you know what triggered this realization for you in October?

A No. I mean it was totally out of the blue. It was awful. I mean, I don't know if anyone can understand how it felt, but I could see that what I had been doing over the past eight to ten months was wrong, was completely wrong and that not only was my personal life going to be changed forever but my professional life very well could be, and that's a lot to take in all at once.

Dr. Goodrich further testified as follows regarding his relationship with Ms. A and how the relationship ended [with omission of references to Ms. A's name; Transcript p. 159-162]:

Q Were you in love with -----?
A Yes, I was.

Q When did you come to that understanding about your emotional state?

A Probably June.

Q Of what year?
A Of '02.

Q Did you express that to Ms. --------?
A Yes.
Q Did she express love toward you?

A Yes.

Q Did you make plans for the future?

A We talked about what it would be like to have a relationship without all the baggage and how nice that would be.

Q Did you take any steps to separate from your wife?

A Yes, I did.

Q What did you do?

A I moved out of the house in the first part of March of '03 and spoke to her frankly about the relationship towards the end of March basically telling her that I loved ------ and that I was going to pursue that relationship.

Q You told that to -------?

A Uh-huh.

Q Yes?

A Yes, I did.

Q You said you moved out. Was that to a condominium?

A Yes.

Q Did you rent or own that condominium?

A I rented it.

Q When did you rent that condominium?

A January of '03.

Q What brought you to the personal understanding or belief that you no longer wanted to pursue the relationship with ---------?

A Well, it was a number of things, the first being, when her husband filed for divorce and we had talked significantly on the fact of what -- how I would deal with her kids and whether I liked her kids and whether I would be okay with them in the same house, and I was very supportive of that so it seemed like her kids were one of her main concerns. And then, when this divorce proceeding started, there was basically no discussion, certainly not with me …

……

A All right. So, anyway, ------- just came to me and said, you know, "I'm going to let the kids have" -- "let ------ have the kids," and I was really amazed. I

mean, it just didn't fit with the woman that I had fallen in love with. And I asked her why, and she said so that we could spend more time together, which again didn't fit with the kind of person that I thought she was. Then there were some little things between then and the end which, after my wife found out about the affair, the relationship, she immediately called ----- and fired her. And so, shortly thereafter, I called ----- kind of happy actually that I had gotten around to telling my wife exactly what the story was and allow for us to move forward with our relationship, and basically she didn't want to hear anything of that. She's just pissed off that she lost her job, despite the fact that we had talked about the inevitability of that given that my wife was the office manager. She -- the hospital has been trying to get ----- to work for them ever since she worked for us. So there was no issue as to whether she could be able to have another job.

(C) <u>Gary Richard Schoener (Licensed Clinical Psychologist)</u>

Dr. Schoener testified at the request of Dr. Goodrich. Dr. Schoener is a Licensed Clinical Psychologist in Minnesota. He is the Executive Director of the Walk-In Counseling Center in Minneapolis, and he has a private consultation group called Gary R. Schoener Consulting. He worked as a Clinical Psychologist at the Minneapolis Clinic of Psychiatry and Neurology during most of his career. He has been a staff member at the Walk-In Counseling Center since July of 1971, and its Executive Director since the middle of 1973. He also has done private consultation work since the early seventies. Exhibit 17. Sometime between August 31, 2005 and January 9, 2006, Dr. Schoener performed an evaluation of Dr. Goodrich. The Division of Enforcement and Dr. Goodrich agreed to the evaluation. Tr. p. 205, 236-244; Exhibits 7 and 16.

In his January 9, 2006 evaluation report, Dr. Schoener reached the following conclusions and gave the following recommendations [Exhibit 16]:

<u>Conclusions</u>

No psychological evaluation can rule out some underlying sexual impulse control disorder, but it is my professional opinion, to a reasonable degree of psychological certainty, that none is present here. It is my professional belief, to a reasonable degree of psychological certainty, that the behaviors which led to the complaint against Dr. Goodrich had their origins in the interaction of a variety of factors which are common in this type of case involving a general or family practitioner:

(1) Difficulties in intimacy in Dr. Goodrich's marital relationship which despite some attempts to find a remedy were not healed, together with a desire for greater intimacy;

(2) The fact that Dr. Goodrich viewed the complainant as predominantly a colleague, which in fact she was, and a failure to grasp the fact that when she became a patient, the more conservative stance on boundaries due to patients was operative;

(3) As a consequence of (2) above, and the fact that Dr. Goodrich's main contacts with the complainant were as a colleague, Dr. Goodrich did not step back and examine the situation, and properly terminate the physician-patient relationship in a timely fashion.

(4) A failure to recognize that even greater caution is required when a patient is being treated for any sort of a mental

health problem.

(5) The fact that Dr. Goodrich was at the time somewhat needy, struggling with depression and some somatic problems related to physical illness/injury. This did not cause the events in questions, but helped in some manner to increase the likelihood.

It is my professional opinion that Dr. Goodrich has learned a great deal from having toface this complaint and review the situation. He has attended workshops which examine professional boundaries and is I think clear on the rules and expectations of family & general practice, and also the added responsibilities if there is the diagnosis or treatment of a mental or emotional illness. Were it not the case that he had received such training, and that he appears to have learned a good deal from it, I would recommend that it be required.

Likewise, Dr. Goodrich has been receiving treatment for his emotional distress and that seems to have been generally helpful via medications. The consequences of this situation, of course, have left wounds in terms of his marriage and the final disposition of that marital situation remains to be seen.

Recommendations

(1) Continue to seek either to improve the marital relationship or to otherwise resolve the situation. It would be inappropriate to have a specific goal in this regard, but it remains an issue in his life. The concern here is physician health and wellness;

(2) Continue to work with his physician in terms of periodically reviewing his medications. When I interviewed him his distress was generally mild enough that the choice or dosage of medications was not in question. However, at times during the past several years he has found himself experiencing symptoms;

(3) Continue counseling as needed to help with any adjustment problems. It would seem that either personal or marital counseling might be helpful in dealing with (1) above;

(4) I do not have a concern about Dr. Goodrich providing health care services to colleagues or employees, since that does not violate the standard of care. But it is essential that he continue to realize that anyone for whom he provides health care is then a patient even if the health care services are minimal, and as such doctor-patient boundaries need to be observed. Furthermore, if any mental health care is provided the rule for post-termination contact of a sexual nature which applies is the psychiatric standard based on the Code of Medical Ethics - which is that a sexual relationship is never permissible.

Summary Conclusions

It is my professional opinion, to a reasonable degree of psychological certainty, that Dr. Goodwin can safely practice medicine under the conditions above. This situation has had a dramatic emotional impact on him and he has "gotten the message." I believe that he has in fact sought and received some key remedial training as regards professional boundaries and believe he is clear about them. It is important for him to continue his current treatment regime and to work towards remedying his troubled marital situation."

III Analysis of Evidence

Count I

The Division of Enforcement alleges in Count I of its Complaint that Dr. Goodrich, by having a sexual relationship with a patient, engaged in conduct which tends to constitute a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (h). The Division did not establish by a preponderance of the evidence that the violation occurred.

Wis. Admin. Code § MED 10.02 (2) (h) reads as follows:

(2) The term “unprofessional conduct” is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

The Division of Enforcement argues that, during the entire year that Dr. Goodrich and Ms. A had a sexual relationship, Dr. Goodrich was violating Wis. Admin. Code § MED 10.02 (2) (h). The Division further argues that the rule on its face prohibits a physician from engaging in conduct which tends to constitute a danger to the health, welfare or safety of a patient. The rule does not require that the conduct be a medical procedure; "any practice or conduct" is sufficient. The rule also does not require that there be actual harm to a patient. It only requires that there be a risk of harm to the patient: "tends to constitute a danger."

The Division also argues that the five-pronged test set out in *Gilbert v. Medical Examining Board*, 119 Wis. 2d.168, 349 N.W. 2d 68 (1984) and clarified in *Gimenez v. State Medical Examining Board*, 203 Wis. 2d 349, 552 N.W. 2d. 863 (Ct. App. 1996) to guide the Board in its determination of whether a physician improperly treated a patient, primarily apply to cases in which the physician's conduct is part of the medical treatment. The elements of the five-pronged test are as follows:

1. What course of treatment the physician provided;
2. What the minimum standards of treatment required;
3. How the physician's treatment deviated from the standard;
4. How the treatment created an unacceptable level of risk;
5. What course of treatment a minimally competent physician would have taken.

The Division further argues that the five-pronged test does not apply to "other non-medical conduct" which a physician engages in while providing treatment to a patient. Therefore, the Division is not required to present evidence by an expert witness in order to prove that the violation occurred. The Division also argues that even when it is judged by the elements necessary to determine if a treatment decision created an unreasonable risk of harm, Respondent's conduct violated the rule. In this case:

1. Respondent established a physician-patient relationship with Ms. A and became her primary care physician.
2. Minimum standards of treatment required him not to have sexual contact with Ms. A, while she was his patient.
3. He deviated from that standard by having sexual contact with her for a year while she was his patient.
4. By having sexual contact with Ms. A while she was his patient, he created an unacceptable level of risk that could lead to less than optimal care, could obscure his objective judgment and be detrimental to the patient's well being. It also created an unacceptable level of risk that it could create anxiety and stress and aggravate her depression to the point that she became suicidal.
5. A minimally competent physician would not have had sexual contact with his patient while she was his patient.

Dr. Goodrich argues that Count I of the Division's Complaint should be dismissed because the Medical Examining Board presented no expert testimony to support a finding that Dr. Goodrich's conduct tended to constitute a danger to the health, welfare, or safety of his patient or the public. Dr. Goodrich argues that in *Gilbert* the Wisconsin Supreme Court set forth the requirement for prosecution of a disciplinary case against a physician based on an alleged violation of Wis. Admin. Code § MED 10.02 (2) (h). In *Gilbert*, the Supreme Court ruled that the record did not contain substantial evidence to support the Board's finding that Dr. Gilbert demonstrated unprofessional conduct. 119 Wis. 2d at 205. The Court held that in order for the Board to find that Dr. Gilbert's action constituted unprofessional conduct, there must be testimony to the effect that a minimally competent physician would have avoided or minimized the unacceptable risks which Dr. Gilbert's treatment posed. Id. at 204.

Dr. Goodrich further states that the expert testimony required by *Gilbert* was clarified in *Gimenez*. In *Gimenez*, as in *Gilbert,* the physician was charged with violating Wis. Admin. Code § MED 10.02 (2) (h). In *Gimenez*, the Court of Appeals discussed the five-prong test set forth in *Gilbert* to guide the Board in determining whether a physician improperly treated the patient and clarified that the Board must rely on evidence from a qualified medical expert who is able to testify to the factor at issue.

Dr. Goodrich's position is that absent testimony from a qualified expert witness on the issues pertinent to Dr. Goodrich's care of Ms. A, Count I of the Complaint must be dismissed.

In my opinion, following the holdings in *Gilbert* and *Gimenez*, expert testimony is required to establish a violation of Wis. Admin. Code § MED 10.02 (2) (h). The Division identified an expert witness on its witness list, but elected not to call that person as a witness.

Count I contains an allegation of a violation of Wis. Admin. Code 10.02 (2) (h), the "danger rule". In *Gilbert*, the Supreme Court stated that the terms "danger" and "detrimental" refer to those risks and negative results which are unacceptable to other physicians and, therefore, demonstrate incompetence when measured against the standards which have become established in the medical profession. The Court also stated that in order for the Board to find that Dr. Gilbert's action constituted unprofessional conduct, there must be testimony to the effect that a minimally competent physician would have avoided or minimized the unacceptable risks which Dr. Gilbert's treatment posed. Finally, the Court stated that the Board both could not rely on the expert knowledge of its members to make the required inferences from inconclusive testimony and could not substitute its knowledge for evidence which is lacking.

The Division argues, however, that this five-pronged test requiring the submission of expert testimony does not apply to "other non-medical conduct". However, the Division does not cite any legal authority for its position. In addition, there is no indication in the holdings of either *Gilbert* or *Gimenez* that the appellate courts would apply a different test than the five-pronged test in cases involving non-medical conduct.

The Division also stated in its closing arguments that even when judged by the elements necessary to determine if a treatment decision created an unreasonable harm, Respondent's conduct violated the rule. The Division offered its opinion regarding how Dr. Goodrich's conduct violated the rule; however, such opinion does not constitute evidence.

The Division has the burden of proof to establish by a preponderance of the evidence that the violation occurred. It is my opinion, as noted by Dr. Goodrich, that this burden must be met with the inclusion of qualified expert witness testimony on the issues pertinent to Dr. Goodrich's conduct involving Ms. A. Since the Division has failed to meet this burden, Count I of the Complaint must be dismissed.

Count II

The Division of Enforcement alleges in Count II of its Complaint that Dr. Goodrich, by engaging in inappropriate sexual contact, exposure, gratification, and other sexual behavior with or in the presence of Ms. A on or about December 1, 2002 and while she was a patient, has committed unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (zd). The evidence presented establishes that the violation occurred.

Wis. Admin. Code, § MED 10.02 (2) (zd), which became effective on December 1, 2002, reads, in part, as follows:

Med 10.02 Definitions. For the purposes of these rules:

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:
….
(zd) Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient. For the purposes of this subsection, an adult receiving treatment shall continue to be a patient for 2 years

after the termination of professional services. ….

The evidence presented establishes that between July 1997 and March 2003, Dr. Goodrich provided medical care to Ms. A, and that during part of that time period, from approximately March 2002 to March 2003, Dr. Goodrich and Ms. A had a sexual relationship. These facts are not in dispute. Dr. Goodrich admitted these facts in his Answer to the Complaint and during his testimony at the hearing.

Dr. Goodrich argues, in his closing arguments and in his Memorandum of Law in support of his Motion to Dismiss, that Count II should be dismissed because Wis. Admin. Code, § MED 10.02 (2) (zd) is unconstitutionally vague and indefinite. Dr. Goodrich argues that the Board chose to use the word "inappropriate" in the rule; thereby creating the inference that while some physician-patient sexual contact is prohibited, other conduct is not. Dr. Goodrich further argues that if the Medical Examining Board intended to promulgate an absolute prohibition regarding sexual contact between physician and patient, the language of the regulation clearly does not reflect this intent. Finally, Dr. Goodrich argues that the application of Wis. Admin. Code, § MED 10.02 (2) (zd) is particularly problematic here where the relationship was non-exploitive, between two medical professionals, and pre-existed the promulgation of the regulation.

The Division of Enforcement argues, in its closing arguments and in its Memorandum of Law in opposition to Respondent's Motion to Dismiss, that even if the use of the word "inappropriate" in the rule was so ambiguous as to fail to give adequate notice to some of the conduct, not all of the prohibited conduct which the Respondent engaged in is identified as inappropriate. The rule makes it unprofessional conduct for a physician to engage in inappropriate sexual contact, inappropriate sexual exposure and inappropriate sexual gratification. It also makes it unprofessional conduct for a physician to engage in "other sexual behavior". The Division further argues that the Respondent had notice that other sexual behavior with a patient was prohibited. That certainly would include sexual intercourse with his patient.

In general, administrative rules are accorded the same presumption of constitutionality as are statutes enacted by the legislature. *Quinn v. Town of Dodgeville*, 122 Wis. 2d 570, 577. 364 N.W. 2d 149, 154 (1985); *State v. Menard, Inc.*, 121 Wis. 2d 199, 204, 358 N.W. 2d 813, 816 (Ct. App. 1984). The party challenging a rule bears a heavy burden for its unconstitutionality must be established beyond a reasonable doubt. *Quinn*, 122 Wis. 2d 577, 364 N.W.2d 154.
An appellate court will not set aside an agency regulation unless it is clearly unreasonable.
Liberty Homes, Inc. v. DILHR, 136 Wis. 2d 368, 385, 401 N.W. 2d 805, 812 (1987). Every presumption must be indulged to sustain the rule if at all possible and, wherever doubt exists as to its constitutionality, it must be resolved in favor of constitutionality. *Chappy v. LIRC*, 136 Wis. 2d 172, 185, 401 N.W. 2d 568, 574 (1987); State *ex rel. Hammermill Paper Co v. LaPlante*, 58 Wis. 2d 32, 46, 205 N.W. 2d 784, 792 (1973).

The constitutional foundation of a vagueness challenge to a statute is the procedural due process requirement of fair notice. *Metz v. Veterinary Examining Board* 2007 W App 220; 741 N.W. 2d 244 (Ct. App 2007); *State v. Nelson*, 2006 WI App 124; 294 Wis. 2d 578, 718 N.W. 2d 168 (2006).

Dr. Goodrich has not established that the rule is vague or indefinite or that the rule is unconstitutional beyond a reasonable doubt.

In my opinion, Wis. Admin. Code, § MED 10.02 (2) (zd) provides sufficient notice to a physician that having a sexual relationship with a patient is prohibited conduct. The rule, which became effective on December 1, 2002, prohibits a physician from engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient. The term "other sexual behavior" certainly includes sexual intercourse with a patient.

At least between December 1, 2002, the date the rule became effective, and March 2003, the time period when his sexual relationship with Patient A ended, Dr. Goodrich was on notice that a physician is prohibited from having a sexual relationship with a patient. He acknowledged that during the time he was having a sexual relationship with Ms. A, if he had been asked at that time whether having a sexual relationship with Ms. A was a violation of a Board standard, he would have said yes. He acknowledged that, during the residency that he completed in 1989, he was taught that it was wrong to have sexual contact with a patient; that there was an imbalance of power in physician-patient relationships, and that a sexual relationship with a patient could lead to less than optimal care, obscure the physician's objective judgment and be detrimental to the patient's well-being. Transcript p. 120-122.

In addition, Dr. Goodrich said that he came to the realization that he was having a sexual relationship with a patient in October of 2002, before the effective date of the rule in December of 2002. He admitted that he knew at that time that the relationship was wrong and that not only was his personal life going to be changed forever but his professional life very well could be. Despite that fact, Dr. Goodrich continued the sexual relationship with his patient until March of 2003. Transcript, p. 123-125.

IV Discipline

Having found that Dr. Goodrich violated laws relating to the practice of medicine, a determination must be made regarding whether discipline should be imposed, and if so, what discipline is appropriate.

The Medical Examining Board is authorized under s. 448.02 (3) (c), Stats., to warn or reprimand a person, or limit, suspend or revoke any license, certificate or limited permit granted by the board to a person if it finds that the person is guilty of unprofessional conduct or negligence in treatment.

The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct and to promote the rehabilitation of the licensee. State v. Aldrich, 71 Wis. 2d 206 (1976). Punishment of the licensee is not a proper consideration. State v. MacIntyre, 41 Wis. 2d 481 (1969).

The Division of Enforcement recommends that Dr. Goodrich's license be suspended for one year and that after the suspension is complete that his license be limited in a manner to impose the conditions recommended by Gary Schoener. (Exhibit 16, p. 6-7) Dr. Goodrich recommends first, that no discipline be imposed and that this matter be dismissed and second, if discipline is imposed, that it be a one year suspension, stayed, or a short suspension of 2-3 months.

Based upon the evidence presented, the Administrative Law Judge recommends that Dr. Goodrich's license to practice medicine and surgery be suspended for a period of not less than 6 months and that his license be limited for an indefinite period of time. These measures are designed primarily to assure protection of the public; deter other licensees from engaging in similar misconduct, and promote Dr. Goodrich's rehabilitation. The factors listed below were taken into consideration in recommending that Dr. Goodrich's license be suspended for 6 months (instead of a lesser or greater period of time) and that his license be limited for an indefinite period of time.

First, consideration was given to the fact that Ms. A suffered harm as a result of her sexual relationship with Dr. Goodrich. In my opinion, proposed Findings of Fact 13 summarizes the harm that Ms. A suffered as a result of her sexual relationship with Dr. Goodrich. Findings of Fact 13 reads as follows:

> 13. By the end of March of 2003, Ms. A's personal and sexual relationship with Dr. Goodrich had ended; she had been fired by Dr. Goodrich's wife from employment at Dr. Goodrich's office clinic; her husband had filed for divorce; her two sons had been placed principally with her husband, and she had moved back home with her dad. She also had lost weight; she had GI (gastrointestinal) upset and symptoms; she was constantly crying, and she had suicidal thoughts and ideation.

Second, some consideration was given to the fact that, as noted by Dr. Gary Schoener, a Licensed Clinical Psychologist, after Dr. Goodrich commenced a sexual relationship with Ms. A, he failed to properly terminate the physician-patient relationship in a timely fashion. Although Dr. Goodrich said that he came to the realization that he was having a sexual relationship with a patient in October of 2002, he continued the sexual relationship until March of 2003. Dr. Goodrich testified as follows:

> Q Do you recall you and she ever having a discussion in

which the issue was whether she should have another doctor?

A Yes. In October of 2002, for some reason, I was driving along to the emergency room, and I got this terrible feeling that went throughout my body and I realized that I was having sex with a patient, that my relationship with ----- constituted that and that night I wasn't able to sleep. I got in the office early the next morning, as did -----, and I spoke to her at length about the problems inherent in what I basically just realized and suggested that her care be transferred. I also suggested that we decrease our relationship contact.

Q Did you decrease your relationship contact?

A I think so.

Q And --

A About 50 percent I'd say.

Q When you're talking about relationship contact, you're talking about personal relationship?

A Right. Because we were seeing each other every day in the office.

Q And what did you suggest about the professional relationship?

A I suggested that she pursue obtaining a psychiatrist and that she should consider Dr. Brockman as her ongoing primary care physician for the variety of things that she would come to me for, like urinary tract infections and bronchitis and whatever.

Q Do you know if she did that at that time, either one?

A Well, she was already seeing Dr. Brockman and so I assumed that she shifted her care in that regard, although, she did manage to schedule a couple more visits with me, and I'm not sure as to the exact timing of the psychiatrist, but I don't think it was shortly -- it was too long after that discussion that she established with a psychiatrist.

Q Doctor, do you know what triggered this realization for you in October?

A No. I mean it was totally out of the blue. It was awful. I mean, I don't know if anyone can understand how it felt, but I could see that what I had been

doing over the past eight to ten months was wrong, was completely wrong and that not only was my personal life going to be changed forever but my professional life very well could be, and that's a lot to take in all at once.

Third, consideration was given to the fact that Dr. Schoener stated that in his professional opinion Dr. Goodrich can safely practice medicine under the conditions described in his recommendations (Exhibit 16, p. 6-7). Dr. Schoener performed a psychological evaluation of Dr. Goodrich sometime between August 31, 2005 and January 9, 2006. He concluded that, while no psychological evaluation can rule out some underlying sexual impulse control disorder, it was his professional opinion, to a reasonable degree of psychological certainty, that no such disorder was present in Dr. Goodrich's case. Transcript p. 205-274; 170-171; Exhibits 7, 16.

In his evaluation report, which is dated January 9, 2006, Dr. Schoener stated that it was his professional belief, to a reasonable degree of psychological certainty, that the behaviors which led to the complaint against Dr. Goodrich had their origins in the interaction of a variety of factors which are common in this type of case involving a general or family practitioner:

"(1) Difficulties in intimacy in Dr. Goodrich's marital relationship which despite some attempts to find a remedy were not healed, together with a desire for greater intimacy;

(2) The fact that Dr. Goodrich viewed the complainant as predominantly a colleague, which in fact she was, and a failure to grasp the fact that when she became a patient, the more conservative stance on boundaries due to patients was operative;

(3) As a consequence of (2) above, and the fact that Dr. Goodrich's main contacts with the complainant were as a colleague, Dr. Goodrich did not step back and examine the situation, and properly terminate the physician-patient relationship in a timely fashion.

(4) A failure to recognize that even greater caution is required when a patient is being treated for any sort of a mental health problem.

(5) The fact that Dr. Goodrich was at the time somewhat needy, struggling with depression and some somatic problems related to physical illness/injury. This did not cause the events in questions, but helped in some manner to increase the likelihood."

Dr. Schoener further stated that:

"It is my professional opinion that Dr. Goodrich has learned a great deal from having to face this complaint and review the situation. He has attended workshops which examine professional boundaries and is I think clear on the rules and expectations of family & general practice, and also the added responsibilities if there is the diagnosis or treatment of a mental or emotional illness. Were it not the case that he had received such training, and that he appears to have learned a good deal from it, I would recommend that it be required.

Likewise, Dr. Goodrich has been receiving treatment for his emotional distress and that seems to have been generally helpful via medications. The consequences of this situation, of course, have left wounds in terms of his marriage and the final disposition of that marital situation remains to be seen."

Dr. Schoener recommended that Dr. Goodrich:

"(1) Continue to seek either to improve the marital relationship or to otherwise resolve the situation. It would be inappropriate to have a specific goal in this regard, but it remains an issue in his life. The concern here is physician health and wellness;

(2) Continue to work with his physician in terms of periodically reviewing his

medications. When I interviewed him his distress was generally mild enough that the choice or dosage of medications was not in question. However, at times during the past several years he has found himself experiencing symptoms;

(3) Continue counseling as needed to help with any adjustment problems. It would seem that either personal or marital counseling might be helpful in dealing with (1) above;

(4) I do not have a concern about Dr. Goodrich providing health care services to colleagues or employees, since that does not violate the standard of care. But it is essential that he continue to realize that anyone for whom he provides health care is then a patient even if the health care services are minimal, and as such doctor-patient boundaries need to be observed. Furthermore, if any mental health care is provided the rule for post-termination contact of a sexual nature which applies is the psychiatric standard based on the Code of Medical Ethics - which is that a sexual relationship is never permissible.

Finally, Dr. Schoener stated in his report that it is his professional opinion, to a reasonable degree of psychological certainty, that Dr. Goodrich can safely practice medicine under the conditions above. This situation has had a dramatic emotional impact on him and he has "gotten the message." Dr. Schoener further stated that he believed that Dr. Goodrich has in fact sought and received some key remedial training as regards professional boundaries and believe he is clear about them. It is important for him to continue his current treatment regime and to work towards remedying his troubled marital situation."

Fourth, consideration was given to the fact that Dr. Goodrich has completed ethics course work relating to boundary issues. Dr. Goodrich completed a one-day course entitled Ethics, Boundaries and Practice: Current Issues at the University of Wisconsin-Extension in Madison on March 13, 2004. He also completed a three-day course in professional ethics entitled Professional Renewal In Medicine (through) Ethics, at the Robert Wood Johnson Medical School in New Jersey on November 18-20, 2005. Exhibits 7, 8-11.

Fifth, consideration was given to the fact that Dr. Goodrich has never been disciplined by the Board and that there is no other evidence of professional misconduct. Also, there is no evidence in the record indicating that Dr. Goodrich had a sexual relationship with any patient, other than Ms. A, or that he engaged in any other misconduct.

Sixth, limited consideration was given to the Board's most recent disciplines of non-psychiatrists for sexual misconduct.

The Division of Enforcement argues, in reference to deterrence, that some consideration should be given to the Board's most recent disciplines of non-psychiatrists for sexual misconduct. The Division identified the following instances of discipline imposed by the Board which resulted in a loss of license:

1. Bruce Greenfield, M.D. – 18 month suspension (2006)

2. Nasim Haider, M.D. – Surrender (2005)

3. Khali1 Baroud, M.D. – Revocation (2004)

4. Arkan Alrashid, M.D. – Suspension of at least one year (2003)

5. John Coates, M.D. - Suspension of at least one year (2002)

Dr. Goodrich argues that discipline should be commensurate with the transgression, considering its impact on patients, the community, as well as deterrence of others. Dr. Goodrich noted that four of the five medical licensing cases identified by the Division (Greenfield, Haider, Alrashid and Coates) were resolved by stipulation. The other case (Baroud) was a default.

In my opinion, limited consideration should be given to the prior disciplinary matters identified by the Division primarily because discipline must be imposed based on the specific facts contained in the record of a particular case. Also, the discipline imposed in the cases cited by the Division resulted from instances of sexual misconduct involving multiple patients and/or findings of other misconduct. In addition, it should be noted that four of the five cases were resolved by stipulation without a hearing and without proof of the underlying allegations. In essence, the parties negotiated the type and length of the discipline that would be imposed based upon the facts in those cases. The fifth case (Baroud) was an uncontested default case. Dr. Baroud did not file an Answer to the Complaint filed in that matter and did not appear at the hearing.

Finally, in reference to the recommendation that Dr. Goodrich's license be limited for an indefinite period of time, Dr. Schoener's opinion that Dr. Goodrich can safely practice medicine was based upon Dr. Goodrich's compliance with Dr. Schoener's recommendations set forth on page 6-7 of his Psychological Evaluation Report, dated January 6, 2006. As recommended by the Division, those recommendations, which promote Dr. Goodrich's rehabilitation, have been incorporated into the proposed Order.

V. <u>Costs of the Proceeding</u>

Wis. Stat. § 440.22 (2) provides in relevant part:

> In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the Respondent is a discretionary decision on the part of the Medical Examining Board, and that the board's discretion extends to the decision whether to assess the full costs or only a portion of the costs.

The Administrative Law Judge's recommendation and the Medical Examining Board's decision as to whether the full costs of the proceeding should be assessed against the credential holder, like the supreme court's decision whether to assess the full costs of disciplinary proceedings against disciplined attorneys, *see* Supreme Court Rule 22.24 (1m), is based on the consideration of several factors, including:

1) The number of counts charged, contested, and proven;
2) The nature and seriousness of the misconduct;
3) The level of discipline sought by the parties;
4) The respondent's cooperation with the disciplinary process;
5) Prior discipline, if any;
6) The fact that the Department of Regulation and Licensing is a "program revenue" agency, whose operating costs are funded by the revenue received from licensees, and the fairness of imposing the costs of disciplining a few members of the profession on the vast majority of the licensees who have not engaged in misconduct; and
7) Any other relevant circumstances.

Under the circumstances of this case, it is reasonable to assess the full costs of this proceeding to Dr. Goodrich.

The Division alleges in its Complaint that, by having a sexual relationship with a patient, Dr. Goodrich violated Wis. Admin. Code § MED 10.02 (2) (h) and 10.02 (2) (zd). Although the evidence presented establishes a violation of only 1 of the 2 Counts, the underlying basis of the misconduct for both Counts was the same. Therefore, the recommendation to dismiss Count I of the Complaint does not reduce the recommendation for the assessment of full costs.

In addition, although Dr. Goodrich has no record of prior discipline, the violations established were serious with potential to cause great harm. Dr. Goodrich started the sexual relationship with his patient in March of 2002. He testified that he did not come to the "realization" that he was having a sexual relationship with a patient until sometime in October of 2002.

However, even after his realization that he was having a sexual relationship with a patient, to the detriment of the patient, Dr. Goodrich continued the sexual relationship until March of 2003. The evidence establishes that Ms. A suffered as a result of her sexual relationship with Dr. Goodrich. The recommendation for a 6 month suspension with license limitations is reflective of the serious nature of the unprofessional conduct that has been established by the evidence.

Also, Dr. Goodrich acknowledged that at the time he began having a sexual relationship with Ms. A, if he had been asked at that time whether having a sexual relationship with Ms. A was a violation of a Board standard, he would have said yes. Dr. Goodrich acknowledged that, during the residency that he completed in 1989, he was taught that it was wrong to have sexual contact with a patient; that there was an imbalance of power in physician-patient relationships, and that a sexual relationship with a patient could lead to less than optimal care, obscure the physician's objective judgment and be detrimental to the patient's well-being. Tr. p. 120-122.

Finally, the Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding.

EXPLANATION OF VARIANCE

Based upon a review of the record, the written Objections to the Proposed Decision and the Oral Argument of the parties, the Board finds substantial evidence and legal authority to vary the Findings of Fact, Conclusions of Law and Order contained in the *Proposed Decision*. Specifically, the Board adds additional findings in paragraph 14 of the Findings of Fact and reverses the recommendation to dismiss Count I of the Complaint and amends the Conclusions of Law in paragraph 2 to find that the Respondent's conduct constitutes a violation of Med 10.02(2)(h). Finally, the Board modifies the recommended disciplinary order by increasing the overall length of the suspension, but allowing an opportunity for a stay of the suspension provided that the Respondent is compliant with the terms and limitations upon his medical license. The Board explains herein the reasons for the variance of the Proposed Decision.

First, the ALJ's dismissal of Count I was based upon her conclusion that the Division had failed to establish a violation of the "danger rule", set forth in § MED 10.02(2)(h). The ALJ was of the opinion that the legal standard under the holdings in *Gilbert v. Medical Examining Board,* 119 Wis. 2d 184, 205, 349 N.W. 2d 68 (1984) and *Gimenez v. State Medical Examining Board*, 203 Wis. 2d 349, 354-5, 552 N.W. 2d 863 (Ct. App. 1996), required qualified expert testimony. She indicated that in order to find that a physician's conduct constituted unprofessional conduct under the "danger rule" there must be expert testimony to the effect that a minimally competent physician would have avoided or minimized the unacceptable risks which the conduct or treatment posed.

The ALJ also noted that the Division identified an expert witness on its witness list, but elected not to call that witness on the basis that the submission of expert testimony did not apply to "other non-medical conduct." However, according to the ALJ the Division did not cite any legal authority for its position that expert testimony was not required and she was not aware of any indications in the holdings of the appellate courts that a different standard would be applied. It was not until the written Objections to the Proposed Decision were submitted and argued to the Board that the appellate decision in *Krahenbuhl v. Wisconsin Dentistry Examining Board*, 2004 WI App 147 §26, 275 Wis. 2d 626, 685 N.W. 591, was discussed with respect to the use of the five-prong analysis and the requirement for expert testimony.

In *Krahenbuhl* the appellate court described the circumstances when the five-prong test requiring expert testimony as clarified in *Gimenez* would apply:

> … the five factors of the test only make sense when the allegation against the medical professional concern his or her advocating a course of treatment that poses a danger to the health, safety or

> welfare of the patient or the public. The questions are structured so as to discern the competency of the medical professional. They seek to discover the minimum standards of treatment required and how the medical professional's treatment deviated from those standards, thereby creating an unacceptable risk to the patient or public. When dealing with allegations of fraud, on the other hand, the acceptable standard of care and whether the medical professional adhered to the standard are not relevant. In other words, the issue is not medical professional's competency, but rather his or her honesty and ability to abide by the ethical standards of the profession.

Id. at 158.

In *Krahenbuhl*, the appellate court also clearly articulated the distinction between "medical" versus "non-medical" conduct and the application of the five prong analysis in the following excerpt from the opinion:

> The five-pronged test of *Gilbert* and *Gimenez* does not involve cases such as this where fraud and misrepresentation are alleged. First, G*imenez,* which involved an entirely different statute that the one at issue here, expressly limits the application of the test to cases where the medical professional is charged with choosing a course of treatment that is dangerous or detrimental. See *Gimenez,* 203 Wis. 2d at 351, 354 (stating that "with every charge of endangering a patient's health" there are five elements that must be discussed.) Second, the five factors of the test only make sense when the allegations against the medical professional concern his or her advocating a course of treatment that poses a danger to the health, safety or welfare of the patient or the public. The questions are structured so as to discern the competency of the medical professional. They seek to discover the minimum standards of treatment required and how the medical professional's treatment deviated from those standards, thereby creating an unacceptable level of risk to the patient or public. When dealing with fraud, on the other hand, the acceptable standard of care and whether the medical professional adhered to that standard are not relevant. In other words, the issue is not the medical professional's competency, but rather his or her honesty and ability to abide by the ethical standards of the profession.

Id.

As noted in the Proposed Decision, no one in this matter, including the Respondent, contends that Respondent's decision to have a sexual relationship with his employee, who was also his patient, was about a physician's choice of medical treatment. Nor is there any contention that the sexual conduct was a course of medical treatment. The Respondent's conduct was in plain terms a violation of the moral and ethical standards of conduct; a violation of the professional boundaries between a physician and patient, more analogous to acts of dishonesty or fraud. A violation of ethical principles does not necessarily constitute the practice of medicine or choice of medical treatment simply because it occurs within the context of a patient-physician relationship or is perpetrated by a physician. Nor was there any allegation that the actual medical care which the Respondent did provide while he was engaged in a sexual relationship with his patient fell below the minimum standard of care. For those reasons, the five-prong analysis requiring the submission of expert testimony to establish a violation of the danger rule would not apply under the rationale and holding in *Kranhenbuhl.*

Had the appellate decision in *Krahenbuhl* been presented to the ALJ as authority for the proposition that expert testimony was not required, Count I of the Complaint may not have been dismissed since there was substantial lay evidence in the hearing record from the patient as to the specific harms that occurred to her as a result of the sexual relationship. The patient testified that she suffered both physically and mentally resulting from her sexual contact with the Respondent. The proposed Findings of Fact reflect that the patient sought medical care for anxiety, stress and depression relating to her relationship with Dr. Goodrich. The Respondent also testified that he understood the basis for the prohibition against sex with patients was the risk of harm to which it exposed patients. By having sexual contact with his patient, Respondent created an unacceptable level of risk that could lead to less than optimal care of the patient and obscure the Respondent's objective judgment in providing care. It also created an unacceptable risk that it could cause harm and be detrimental to the patient's wellbeing, as in this case where the evidence showed that the patient sought treatment for anxiety, stress and depression. It would become unnecessarily burdensome for the Division of Enforcement to have to establish by expert testimony that

prohibited non-medical conduct, such as sexual relations with a patient, tends to create a risk of harm to the patient, particularly when the danger rule does not even require proof of actual harm to the patient.

In addition, the Board finds that the requests of the Division and the Respondent to modify the proposed discipline are worthy of consideration. On the one hand, the Division's request to increase the length of the suspension consistent with previous cases has some merit. Yet, the Respondent's request for three month stays of the suspension is also appropriate given the mitigating circumstances of the case. Both the Respondent and the Division indicated that the goals of rehabilitation and protection of the public were not the primary concerns at this stage because the Respondent had a favorable prognosis, did not have an underlying sexual impulse control disorder and had an extremely low risk of recidivism, as determined by Dr. Schoener, a nationally-renowned expert in the field of treatment of sexual disorders. It was the qualified opinion of Dr. Schoener that Dr. Goodrich can safely practice medicine provided that he continues with his treatment regime. In addition, a report from the course director of the *Professional Renewal in Medicine (through) Ethics* course indicated that Dr. Goodrich's capacities for ethical thinking and insight was excellent and that he should be thought to be remediated. It was acknowledged by the parties that the Respondent completed those areas consistently required for meeting the objectives of professional discipline; he obtained an appropriate assessment, which was favorable in terms of his diagnosis and prognosis, and he successfully completed continuing education in the area of professional boundaries.

The parties further acknowledged to the Board that the only remaining goal to be achieved in this case is deterrence; to discourage other licensees from engaging in similar misconduct. To the extent that the overall length of suspension is increased from six to twelve months, this should serve as an adequate deterrent to others who might be tempted to engage in similar conduct. The decision to modify the proposed decision to allow for stays of the suspension is based upon the positive rehabilitative efforts and characteristics of Dr. Goodrich as shown by the record evidence in this case. It also takes into consideration the potential adverse impact of a lengthy suspension on the public and Respondent's patients. Clearly, not all future violators will possess the mitigating characteristics present in this case so as to warrant an option for stays of suspension.

Additionally, should the Respondent fail to fulfill the requirements for a stay of suspension, the stay will be removed and Respondent's license will be suspended until he comes into compliance with the limitations on his license. On balance, this approach achieves a deterrent effect without unduly sanctioning the Respondent beyond what is realistically necessary in this case.

Dated this 17 day of September 2008.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

Gene Musser, M.D.
Chair of the Board