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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
SHELLY JOHNSEN, M.D.	:	LS0904151MED
RESPONDENT.	:	

[Division of Enforcement Case #08 MED 121]

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

Shelly Johnsen, M.D.
307 Ogden Avenue
Clinton WI 53525

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. Shelly Johnsen, M.D. ("Respondent") was born on January 31, 1972, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 45814. This license was first granted on June 24, 2003.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 307 Ogden Avenue, Clinton, Wisconsin 53525.

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

4. Patient M.N. was a man born on June 16, 1958. He was a diabetic, poorly compliant with diabetes management, who had a below the knee amputation of his right leg, and who required assistance with wound care on his ulcerated stump and pain control for cellulitis, and the abscess on his stump. Patient M.N. was also under treatment for

depression, hypertension, and peripheral neuropathy.

5. Patient M.N. was admitted to Beloit Health and Rehabilitation Center in Beloit, Wisconsin, on January 11, 2008, for continued wound care of his right stump following an eighteen day hospitalization.

6. Respondent ordered nursing staff at the nursing home to give Patient M.N. the following medications: Lexapro, for treatment of depression and anxiety disorder, 10 mg. daily; Cymbalta, for treatment of depression and anxiety disorder, 30 mg. daily; Lasix, a diuretic for support of hypertension treatment, 20 mg. daily; Lisinopril, for treatment of hypertension, 20 mg. daily; Metoprolol, for treatment of angina and hypertension, 25 mg. three times daily; MS Contin, a narcotic for pain relief, 45 mg. two times daily; Lyrica, a non-narcotic for relief of pain from diabetic peripheral neuropathy, 150 mg. three times daily; Ambien, a sleep aid (hypnotic), 10 mg. at bedtime; Percocet, a combination narcotic and acetaminophen for pain relief, 5/325 mg. as needed four times daily; Lovenox, a blood thinner, 40 mg. daily; Glucophage, for control of blood sugar levels, 1000 mg. twice daily; Insulin, depending on blood sugar.

7. On his first day at the nursing home, Patient M.N. complained of chest pain and was taken to the emergency room, where diagnostic tests and CT scan suggested the possibility of non-typical angina but did not support other cardiac or pulmonary diagnoses. During his emergency room visit, Patient M.N. received repeated doses of Dilaudid, a narcotic analgesic, and requested additional doses. He was discharged back to the nursing home that evening, with no new orders.

8. Two days later, on January 13, 2008, Patient M.N. was taken to the emergency room, again complaining of chest pain. Electro-cardiogram and cardiac enzyme analysis did not support a diagnosis of a cardiac incident, and Patient M.N.'s complaints appeared to resolve with Haldol and Ativan, two psychotropic medications. He was discharged back to the nursing home, with orders to follow up with his physician for anxiety and panic attacks.

9. Three days later, on January 16, 2008, Patient M.N. was again taken to the emergency room complaining of chest pain radiating down his left arm. He was discharged back to the nursing home with diagnoses of atypical chest pain, anxiety, and infection of his stump. The emergency room physician spoke with Respondent, who said she would review the chart, make appropriate medication changes, address the stump infection, and follow up with Patient M.N.'s private physician.

10. Respondent saw Patient M.N. on his return to the nursing home, and she changed his medication orders by discontinuing the Lexapro, increasing the Cymbalta from 30 mg. to 60 mg. daily, adding Ativan, for treatment of anxiety, 0.5 mg. four times daily as needed, and adding methadone, a synthetic narcotic for pain relief, 10 mg. twice daily, and to discontinue the MS Contin (time release morphine) when the methadone was started.

11. Patient M.N. received his first dose of methadone on the PM shift on January 17, 2008.

12. On January 18, 2008, Patient M.N. complained of anxiety and generalized pain at 1:00 p.m. Respondent was called, and ordered an increased dose of Ativan from 0.5 mg. to 1.0 mg., and increased the methadone from 10 mg. twice daily to 20 mg. twice daily.

13. On January 21, 2008, Patient M.N. was found rocking, shaking, and non-responsive to noxious stimuli; he was again taken to the emergency room on suspicion of a seizure. At the emergency room, Patient M.N. complained of knee and low back pain, which he attributed to being jostled by the paramedics during transport from the nursing home. The emergency room physician diagnosed malingering in order to obtain pain medication, based in part on the physician's conversation with a nurse from the nursing home who reported that Patient M.N. had been "really watching the clock" wanting more pain medication. The emergency room physician spoke with Respondent, who asked him to increase Patient M.N.'s methadone dose from 20 mg. twice daily to 40 mg. twice daily.

14. Patient M.N.'s records from Beloit Health and Rehabilitation Center show that he had received seven doses of Percocet in the eight day period January 11 through January 17, 2008, but twenty doses of Percocet in the six day period from January 18 through January 23, 2008.

15. Nursing notes for Patient M.N. at 5:00 p.m. January 23, 2008, document that he woke up "at supper time,

making strange statements re: not being able to ambulate, ordering staff to leave, manipulating the wound vac, and being uncooperative with prompts to stop. Dr. Johnsen notified and orders received to leave wound vac off tonoc and replace in AM, and (change) methadone to 30 mg. BID."

16. Nursing notes for Patient M.N. at 1:15 a.m. January 24, 2008, document that he requested a pain pill, and was sitting up in a wheelchair, very drowsy but refusing to go to bed, and that he refused the pain pill he had requested.

17. Nursing notes for Patient M.N. at 3:15 a.m. January 24, 2008, document that he had climbed half way out of his wheelchair onto his stump, which began bleeding. He was put to bed with the assistance of four staff, the wound was dressed, and he settled to sleep. Vital signs were recorded as temperature 97º, pulse 71, respirations 18, blood pressure 100/64, and oxygen saturation at 91%.

18. Nursing notes for Patient M.N. at 9:00 a.m. on January 24, 2008, document that Respondent was called and informed of the fall and Patient M.N.'s condition.

19. Nursing notes at 11:45 a.m. January 24, 2008, document that Respondent was called and informed that Patient M.N. had been sleeping all day, and was not responding to staff, and that he did not awake when staff performed treatments to his stump. She was also informed that he had had no food or medications during the shift, and that his vital signs were pulse 88, respirations 18, blood pressure 104/68, and his blood sugar was 105.

20. Nursing notes at 12:10 p.m. document that Respondent returned the call from the nursing home, and that she told the nurse that she would come to the nursing home later to see Patient M.N.

21. Nursing notes at 3:30 p.m. document that Patient M.N. was asleep, and could not be aroused, and that his hands were cool to the touch. His vital signs were recorded as temperature 98º, pulse 68, respirations 16, blood pressure 108/68, and that he had regular, unlabored breathing.

22. Nursing notes at 5:10 p.m. document that Patient M.N. was snoring, with regular rhythmic breathing. Vital signs were recorded as blood pressure 90/70, pulse 68, respirations 16, and noted that no medications had been given and he had not eaten.

23. At 7:00 p.m. Respondent was contacted and informed that there was no change in Patient M.N.'s condition, and that he had been sleeping and snoring.

24. Respondent states that she attributed Patient M.N.'s condition to the methadone "catching up" to his pain, and to him being tired from not sleeping until after the fall from his wheelchair the night before.

25. Respondent was present in the nursing home at 8:00 p.m. and asked the nurses which patient needed to be seen, and was told that Patient M.N.'s condition had not changed; therefore Patient M.N. was not seen at that time.

26. At 8:30 p.m., nursing notes document that Patient M.N. was asleep, unarousable, and drooling, with vital signs of blood pressure 106/70 and pulse of 62.

27. At 9:00 p.m., Patient M.N. was found in the same position, cool to the touch, pulseless and non-breathing with mottled skin.

28. The coroner declared that Patient M.N.'s death was accidental due to polypharmaceutical toxicity.

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 10 - 27, above, constitutes a violation of Wisconsin Administrative Code § MED 10.02(2)(h).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Respondent Shelly Johnsen, M.D., is REPRIMANDED.

IT IS FURTHER ORDERED that:

2. The license of Shelly Johnsen, 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, she shall complete six hours of continuing medical education in the topic of physicians' responsibility for patient safety; an additional six hours of continuing medical education in the topic of managing drug interactions in patients with multiple diagnoses; and an additional six hours of continuing medical education in the topic of the use of methadone as an analgesic, with emphasis on the safe transition from narcotic medications to methadone, to include recent understanding of dose equivalencies dependent on patient characteristics and narcotic medication history.

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 she intends to take in compliance with this Order. The Board or its designee may approve or reject any program in whole or in part; if only part of any program is approved, may accept the partial approval for that program, or forego that program. No part of the continuing education required by this Order may be credited towards completion of any other continuing education requirement to which Respondent may be subject.

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

3. Respondent shall, within ninety (90) days from the date of this Order, pay costs of this proceeding in the amount of One Thousand Five Hundred ($1500.00) 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 (#45814) 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 4/15/09
A Member of the Board Date