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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

FINAL DECISION AND ORDER
LS0706261MED

BRUCE E. GREENFIELD, M.D.,
RESPONDENT.

Division of Enforcement Case No 07 MED 100

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered the that Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision and Order of the state of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 15th day of July, 2009.

Gene Musser, MD
Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

PROPOSED DECISION
Case No. LS0706261MED

BRUCE E. GREENFIELD, M.D.,
RESPONDENT.

[Division of Enforcement Case No. 07MED100]

PARTIES

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

Bruce E. Greenfield, M.D.
403 Wisconsin Avenue
Beloit, WI 53511

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 August of 2008. Attorney John R. Zwieg appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Thomas G. Halloran, appeared on behalf of Dr. Greenfield.

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Bruce E. Greenfield, M.D., Respondent, (dob 08/16/34), is licensed by the Medical Examining Board (Board) to practice medicine and surgery in the State of Wisconsin, pursuant to license number 14545, which was first granted February 5, 1963.

2. Respondent's last address reported to the Department of Regulation and Licensing is 403 Wisconsin Avenue, Beloit, WI 53511.

3. Respondent's practice specialty is general practice.

COUNT I

4. Respondent's license to practice medicine and surgery in the State of Wisconsin was suspended from May 18, 2005 through November 13, 2006 pursuant to the Board's Final Decision and Order, dated September 20, 2006. The suspension was based in part on Respondent's inappropriate prescribing of controlled substances to a patient.

5. During the period of time that Dr. Greenfield's Wisconsin license was suspended, he could not legally order controlled substances or legally possess controlled substances.

6. During the period of time that Dr. Greenfield's Wisconsin license was suspended, Dr. Greenfield ordered controlled substances from Henry Schein, Inc., New York, New York, and had the drugs delivered to his office in Beloit, Wisconsin, as follows:

	Date ordered	Drug	Units	Schedule
a.	08/12/05	Hydrocodone APAP 5/500 mg tabs	500	III
b.	08/12/05	Temazepam 15 mg caps	300	IV
c.	08/12/05	Clonazepam 0.5 mg tabs	300	IV
d.	07/17/06	Alprazolam 0.25 tabs	100	IV
e.	07/17/06	Clonazepam 0.5 mg tabs	100	IV
f.	07/17/06	Hydrocodone APAP 7.5/325 mg tabs	100	III
g	07/17/06	Temazepam 15 mg caps	100	IV
h.	07/17/06	Temazepam 30 mg caps	300	IV
i.	08/16/06	Hydrocodone APAP 7.5/325 mg tabs	200	III
j.	08/16/06	Alprazolam 0.25 tab	100	IV
k.	08/16/06	Clonazepam 0.5 mg tabs	200	IV
l.	09/06/06	Temazepam 15 mg caps	200	IV
m.	09/06/06	Hydrocodone APAP 5/500 mg tabs	500	III
n.	09/06/06	Hydrocodone APAP 5/500 mg tabs	1000	III

COUNT II

7. As provided in the Board's Final Decision and Order, dated September 20, 2006, following the end of the suspension of Dr. Greenfield's license, the limitations placed on his license remained. One of the limitations placed on Dr. Greenfield's license prohibited him from prescribing, dispensing, administering or ordering controlled substances in Schedule II.

8. Dr. Greenfield wrote prescriptions to patient Ruth S. for Schedule II controlled substances, as follows:

a. On January 18, 2007, Respondent wrote a prescription to Ruth S. for 20 units of Percocet 2.5 *mg, which was* filled on January 30, 2007. Percocet is a brand of oxycodone which is a Schedule II controlled substance.

b. On March 10, 2007, Respondent wrote a prescription to Ruth S for 50 units of oxycodone/APAP 7.5/500 mg, which was filled on March 22, 2007.

c. *On May 1, 2007, Respondent wrote a prescription to Ruth S. for 60 units of oxycodone/APAP* 7.5/500 mg,

which was filled that same day.

COUNT III

9. On May 11, 2007, representatives of the U. S. Drug Enforcement Administration (DEA) served an Administrative Inspection Warrant on Respondent at his office in Beloit, Wisconsin, which is his registered location with the DEA. Among other things, the DEA asked to see Dr. Greenfield's inventories and records of dispensing of controlled substances that he had ordered from distributors. Dr. Greenfield told the DEA representatives that he did not have inventories or records of the controlled substances he had ordered and dispensed.

10. During the inspection of Dr. Greenfield's Beloit office, on May 11, 2007, the DEA representatives found numerous Schedule III-V controlled substances in the cabinets and the refrigerator in the office supply room.

11 Respondent is required by 21 CFR §§ 1304.03 (b), 1304.04 and 1304.22 (c) to keep inventories and records of his dispensing of controlled substances at his registered location.

12. Respondent failed to take and maintain inventories of the controlled substances kept at his registered location.

CONCLUSIONS OF LAW

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

2. By ordering and receiving controlled substances while his license was suspended by the Board, Dr. Greenfield obtained controlled substances otherwise than in the course of legitimate professional practice and as prohibited by law, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (p).

3. By writing prescriptions for Schedule II controlled substances while prohibited from doing so by a valid order of the Board, as described in Findings of Fact 7 and 8 herein, the Respondent has violated an order of the Board, which is unprofessional conduct as defined by Wis. Admin. Code § MED l0.02 (2) (b).

4. By failing to make and retain required inventories and records of dispensing of controlled substances, as described in Findings of Fact 9-12 herein, Respondent has dispensed controlled substances as prohibited by law and has violated a law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (p) and (z).

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (#14545) of Bruce E. Greenfield to practice medicine and surgery in the State of Wisconsin be, and hereby is, REVOKED.

IT IS FURTHER ORDERED that, pursuant to Wis. Stats., § 440.22, the full cost of this proceeding shall be assessed against Respondent, and shall be payable to the Department of Regulation and Licensing.

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:

Count I. By ordering and receiving controlled substances while his license was suspended by order of the Board,

Dr. Greenfield obtained controlled substances otherwise than in the course of legitimate professional practice and as prohibited by law, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (p).

Count II. By writing prescriptions for Schedule II controlled substances while prohibited from doing so by a valid order of the Board, Dr. Greenfield violated an order of the Board, which is unprofessional conduct as defined by Wis. Admin. Code § MED l0.02 (2) (b).

Count III. By failing to make and retain required inventories and records of dispensing controlled substances, Dr. Greenfield dispensed controlled substances as prohibited by law and has violated a law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine, which are unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (p) and (z).

Dr. Greenfield admits to the allegations contained in Count II, but denies the allegations contained in Counts I and III.

The evidence presented establishes that the violations occurred.

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:

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 961.01 (4), Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

II. Analysis of Evidence

Background

Dr. Greenfield has been licensed to practice medicine and surgery in Wisconsin since February 5, 1963. His practice specialty is general practice. He obtained his medical degree from the University of Florida College of Medicine in 1960. Exhibit 16.

Count I

The Division of Enforcement alleges in Count I of its Complaint that by ordering *and* receiving controlled substances while his license was suspended by order of the Board, Dr. Greenfield obtained controlled substances otherwise than in the course of legitimate professional practice and as prohibited by law, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02 (2) (p). Dr. Greenfield denies that the violations occurred.

Wis. Admin. Code § MED 10.02 (2) (p) 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:
>
> (p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 961.01 (4), Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

On September 20, 2006, the Medical Examining Board issued a Final Decision and Order suspending Dr. Greenfield's license to practice medicine and surgery from May 18, 2005 until November 13, 2006, for a total period of 18 months. The Board's Order also provided that, following the period of suspension, Dr. Greenfield's license would be limited. One of the limitations placed on Dr. Greenfield's license prohibited him from prescribing, dispensing, administering or ordering controlled substances, in any schedule.

In December of 2006, the U. S. Drug Enforcement Administration (DEA) initiated an investigation against Dr. Greenfield based upon the limitations placed on Dr. Greenfield's license by the Medical Examining Board in its September 20, 2006 Order. Chad Scheuler, who is a Diversion Investigator with the DEA's Milwaukee field office, testified that the reason the DEA opened the investigation was to attempt to limit Dr. Greenfield's DEA registration in the same manner as the Board had in its Order. Transcript p. 18-19.

During his investigation of Dr. Greenfield, Mr. Scheuler requested and received information from Henry Schein Inc., a New York distributor, detailing the orders for controlled substances that had been delivered to Dr. Greenfield's Beloit office during a certain time period. Mr. Scheuler determined that the following controlled substances were shipped from Henry Schein to Dr. Greenfield's Beloit office during the time that Dr. Greenfield's license was suspended by the Board [Exhibit 4]:

	Date ordered	Drug	Units	Schedule
a.	08/12/05	Hydrocodone APAP 5/500 mg tabs	500	III
b.	08/12/05	Temazepam 15 mg caps	300	IV
c.	08/12/05	Clonazepam 0.5 mg tabs	300	IV
d.	07/17/06	Alprazolam 0.25 tabs	100	IV
e.	07/17/06	Clonazepam 0.5 mg tabs	100	IV
f.	07/17/06	Hydrocodone APAP 7.5/325 mg tabs	100	III
g	07/17/06	Temazepam 15 mg caps	100	IV
h.	07/17/06	Temazepam 30 mg caps	300	IV
i.	08/16/06	Hydrocodone APAP 7.5/325 mg tabs	200	III
j.	08/16/06	Alprazolam 0.25 tabs	100	IV
k.	08/16/06	Clonazepam 0.5 mg tabs	200	IV
l.	09/06/06	Temazepam 15 mg caps	200	IV
m.	09/06/06	Hydrocodone APAP 5/500 mg tabs	500	III
n.	09/06/06	Hydrocodone APAP 5/500 mg tabs	1000	III

Mr. Scheuler further testified that when someone first orders controlled substances from a distributor such as Henry Schein, they initially provide their DEA number, their address and their contact information. The distributor does a credit check and a business check. After that, "it's just more of a phone call". At least for Schedules III-V, when an order is placed for controlled substances after the initial order, the person placing the order does not have to provide the same information as given initially because the information is already on file. Transcript pages 20, 44.

In reference to the delivery of controlled substances, Mr. Scheuler said that federal regulations permit a distributor to send controlled substances only to the address on a registrant's DEA license. He said that the person who receives a shipment of controlled substances has to sign for the shipment.

During cross examination, Mr. Scheuler testified that he spoke with someone personally at Henry Schein about his request for records, but he did not ask that person specifically who had made the orders for the controlled substances. Mr. Scheuler admitted that, based upon the information that he obtained from Henry Schein, he did not know who ordered the drugs from Henry Schein. He knows that it was ordered from Dr. Greenfield's office under his DEA number. Finally, Mr. Scheuler said that the person who received the shipments would have had to sign for them. He said that he did not discover who signed for the shipments. An inquiry was made to the carrier, but after a certain amount of time, the information was purged from the carrier's system. Transcript p. 46-50.

On May 9, 2007, Mr. Scheuler obtained an Administrative Inspection Warrant for the purpose of verifying the

correctness of controlled substance inventories, records, reports, and other documents required to be kept under the Controlled Substances Act. Transcript p. 19-27; Exhibits 4-6.

On May 11, 2007, Diversion Investigators Scheuler, Kathy Federico and Adam Quirk, as well as, Special Agent Yvonne Jarosz from the Madison DEA office went to Dr. Greenfield's Beloit office to execute the inspection warrant. They presented their identification to Dr. Greenfield and explained the parameters of the inspection. When the DEA representatives arrived at Dr. Greenfield's Beloit office for the inspection, Patient MP, the patient referred to in paragraph 7 of the Board's September 20, 2006 Final Decision and Order, was in Dr. Greenfield's office.

Dr. Greenfield admits that during the time period that his license was suspended by the Board, he could not legally order or possess controlled substances. He testified that he did not order controlled substances during the period of time his license was suspended and he did not ask anyone else to order drugs for him during that time period. He said that he had nothing to do with and was not aware that the drugs had been ordered and was not aware of the invoices and other documents contained in Exhibit 7 until the DEA representatives showed him the receipt for papers that they took from his office. He said that he did not know who was ordering and receiving the drugs from Henry Schein. Transcript page 111, 115, 119, 163-164; Exhibit 7.

In reference to Patient MP, Dr. Greenfield acknowledged that she is the same person as Ms. A, who is referred to in Findings of Fact 7 of the Board's September 20, 2006, Final Decision and Order. In that Order, the Board found that Dr. Greenfield prescribed controlled substances to Ms. A and provided her with replacement prescriptions on occasions when she reported them lost or stolen. The Board also found that the doses, quantities, routes of administration and frequency of the drugs were not warranted by Ms. A's medical conditions. The Board ordered Dr. Greenfield not to provide any medical care to patient M.P. or her children. At the time that Dr. Greenfield was prescribing medications to Patient MP, he was having a sexual relationship with her. Transcript p. 85-87, 108; Exhibit 2.

Dr. Greenfield further testified that Patient MP has been in his office several times since the suspension of his license was removed in November of 2007. He said that all of Patient MP's visits were for non-medical purposes. He said Patient MP's last visit was on the day the DEA representatives conducted their inspection of his office. When the agents arrived at his office, he and Patient MP were sitting in the waiting room talking. According to Dr. Greenfield during his conversation with Patient MP, she admitted to him that she had stolen prescription pads from his office; that she had forged his name to prescriptions and that she had taken a key without his knowledge so that she could access his office to obtain those prescription pads. He said that she handed the key back to him at that time; that he was shocked and had no idea; that he had never given her permission to enter his office or to sign his name to prescriptions for controlled substances and that he had never given per permission or authority to order prescription substances on behalf of his office. Transcript pages 108-112, 163-164.

In my opinion, Dr. Greenfield's statement that he did not know controlled substances had been ordered from Henry Schein using his DEA number and other confidential information or that the drugs had been delivered to his office is incredible. He is asking the Board to believe that Patient MP or some other phantom person had enough knowledge of his office operations and procedures (which distributor he ordered drugs from; the fact that certain information had already been provided to the distributor; whether the distributor did or did not send written confirmations to him regarding the shipments, and when he would be out of his office so the person could meet the delivery truck to sign for the drugs) to be able to order drugs without his knowledge. Keep in mind that this alleged intruder would have ordered drugs from August 12, 2005 to September 2006, a little over a year. The truth is that Dr. Greenfield ordered those drugs from Henry Schein and does not want to face the consequences of his decisions. The Board ordered Dr. Greenfield not to order controlled substances. He simply ignored the Board's Order.

Count II

The Division of Enforcement alleges in Count II of its Complaint that, by writing prescriptions for Schedule II controlled substances while prohibited from doing so by a valid order of the Board, Dr. Greenfield violated an order of the Board, which is unprofessional conduct as defined by Wis. Admin. Code § MED l0.02 (2) (b). Dr. Greenfield initially denied the violations in his Answer to the Complaint, but admitted to the violation at the hearing held in this matter.

Wis. Admin. Code, § MED 10.02 (2) reads 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:

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

As noted previously, the Board's September 2006, Order provided that Dr. Greenfield was prohibited from prescribing, dispensing, administering or ordering controlled substances, in any schedule. Exhibit 2.

At the start of the hearing held in this matter, the parties agreed to the following relating to Count II of the Complaint [Exhibits 1 and 2]:

1. Pursuant to the Board's Final Decision and Order dated September 20, 2006, Dr. Greenfield was prohibited from prescribing Schedule II controlled substances.

2. Percocet is a brand of oxycodone which is a Schedule II controlled substance.

3. On January 18, 2007, Respondent wrote a prescription to Ruth S. for 20 units of Percocet 2.5 mg, which was filled on January 30, 2007.

4. On March 10, 2007, Respondent wrote a prescription to Ruth S. for 50 units of oxycodone/APAP 7.5/500 mg, which was filled on March 22, 2007.

5. On May 1, 2007, Respondent wrote a prescription to Ruth S. for 60 units of oxycodone/APAP 7.5/500 mg, which was filled that same day.

6. By writing each of the prescriptions, Respondent violated a valid order of the Medical Examining Board.

The Division alleges in its Complaint that Dr. Greenfield wrote prescriptions to patient Ruth S. for Schedule II controlled substances in violation of the Board's Order as follows:

a. Percocet 2.5/325 mg, 20 units filled on 01/30/07.

b. Oxycodone/APAP 7.5/500 mg, 50 units, filled on 03/22/07.

c. Oxycodone/APAP 7.5/500 mg, 60 units, dated and filled on 05/01/07.

Dr. Greenfield admitted that during January, March and May of 2007, he prescribed oxycodone or, by its brand name Percocet, to a patient referred to as Ruth S. He said that he knew that he was prohibited from prescribing Schedule II controlled substances, but he did not know that Percocet was a Schedule II controlled substance. He said that Ruth S. was a new patient who came in with chronic pain and a long record from other physicians saying that she had been on Percocet for relief of pain. She was very unwilling to go to any other medication on her first and second visits with him. He told her that it was not a medication he was familiar with and that he was not comfortable prescribing medications that he did not have an experience with. Transcript p. 81-87, 166.

Dr. Greenfield testified initially that prior to writing a prescription for Ruth S., he had never prescribed oxycodone, or the brand name Percocet, to a patient. Later during the hearing, Dr. Greenfield admitted that paragraph 7 of the Board's September 20, 2006 Order, states that Dr. Greenfield gave replacement prescriptions on occasions to Patient MP, referred to in the Order as Ms. A., and that one of the prescriptions included a Schedule II controlled substance known as oxycodone. Transcript p. 83, 86-87.

In my opinion, Dr. Greenfield was aware that Percocet (oxycodone) was a controlled substance at the time that he prescribed it for Ruth S. in January, March and May of 2007. He had prescribed the drug for Patient MP, which he acknowledged in paragraph 7 of the Board's September 20, 2006 Final Decision and Order. It should also be noted that Dr. Greenfield wrote the first oxycodone prescription for Patient Ruth S., a few months after receiving extensive training on prescribing controlled substances. In order to comply with the Board's September 20, 2006 Order, Dr. Greenfield was required to take and complete a three day course in prescribing controlled substances that was offered by the University of South Florida from October 4-6, 2006. Transcript, p. 120.

Count III

The Division of Enforcement alleges in Count III of its Complaint that, by failing to make and retain required inventories and records of dispensing controlled substances, Dr. Greenfield violated Wis. Admin. Code § MED 10.02 (2) (p) and (z). Dr. Greenfield denies that the violations occurred.

Wis. Admin. Code, § MED 10.02 (2) reads 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:

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 961.01 (4), Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

The Division of Enforcement specifically alleges that on May 11, 2007, representatives of the U. S. Drug Enforcement Administration (DEA) served an Administrative Inspection Warrant on Dr. Greenfield at his office in Beloit, Wisconsin, which is his registered location with the DEA. Among other things, the DEA representatives asked to see Dr. Greenfield's inventories and records of dispensing of controlled substances that he had ordered from distributors. The Division also alleges that Dr. Greenfield is required by 21 CFR §§ 1304.03(b), 1304.04 and 1304.22 (c) to keep inventories and records of his dispensing of controlled substances at his registered location. Finally, the Division alleges that Dr. Greenfield told the DEA representatives during the inspection that he did not have inventories or records of the controlled substances he had ordered and dispensed.

Dr. Greenfield admits that representatives of the DEA served an Administrative Inspection Warrant on him at his office in Beloit on May 11, 2007, and that among other things, they asked to see his inventories and records of dispensing of controlled substances that he had ordered from distributors. He also admits that he is required by 21 CFR §§ 1304.03 (b), 1304.04 and 1304.22 (c) to keep inventories and records of his dispensing of controlled substances at his registered location. Dr. Greenfield denies that he told the DEA representatives that he did not have inventories or records of the controlled substances he had ordered and dispensed. Answer to Complaint, paragraph 11-12.

Testimony of Chad Scheuler

Chad Scheuler has been a Diversion Investigator with the DEA for three years. He works in the Milwaukee office. As a Diversion Investigator, he performs a regulatory function for DEA registrants who are licensed to provide controlled substances to people in need, and he also investigates the diversion of controlled substances from the legal market into the illegal market. Transcript p. 15-16.

According to Mr. Scheuler, the DEA initiated an investigation against Dr. Greenfield in December of 2006, to attempt to get Dr. Greenfield's DEA registration limited consistent with the Medical Examining Board's September 20, 2006 Final Decision and Order. In his affidavit for the administrative inspection warrant, Mr. Scheuler stated that Dr. Greenfield had been registered with the DEA for 15 years, but had never been inspected. Transcript p. 18-19; Exhibit 5, page 2, paragraph 6.

During his investigation of Dr. Greenfield, Mr. Scheuler determined that the following controlled substances had been shipped from Henry Schein, Inc., to Dr. Greenfield's Beloit office during the time that Dr. Greenfield's license was suspended by the Medical Examining Board [from May 18, 2005 to November 13, 2006]:

	Date ordered	Drug	Units	Schedule
a.	08/12/05	Hydrocodone APAP 5/500 mg tabs	500	III
b.	08/12/05	Temazepam 15 mg caps	300	IV
c.	08/12/05	Clonazepam 0.5 mg tabs	300	IV
d.	07/17/06	Alprazolam 0.25 tabs	100	IV
e.	07/17/06	Clonazepam 0.5 mg tabs	100	IV
f.	07/17/06	Hydrocodone APAP 7.5/325 mg tabs	100	III
g	07/17/06	Temazepam 15 mg caps	100	IV
h.	07/17/06	Temazepam 30 mg caps	300	IV
i.	08/16/06	Hydrocodone APAP 7.5/325 mg tabs	200	III

j.	08/16/06	Alprazolam 0.25 tabs	100	IV
k.	08/16/06	Clonazepam 0.5 mg tabs	200	IV
l.	09/06/06	Temazepam 15 mg caps	200	IV
m.	09/06/06	Hydrocodone APAP 5/500 mg tabs	500	III
n.	09/06/06	Hydrocodone APAP 5/500 mg tabs	1000	III

On May 9, 2007, Mr. Scheuler obtained an Administrative Inspection Warrant for the purpose of verifying the correctness of controlled substance inventories, records, reports, and other documents required to be kept under the Controlled Substances Act. Transcript p. 19-27; Exhibits 4-6.

On May 11, 2007, Diversion Investigators Scheuler, Kathy Federico and Adam Quirk, as well as, Special Agent Yvonne Jarosz from the Madison DEA office went to Dr. Greenfield's Beloit office to execute the inspection warrant. They presented their identifications to Dr. Greenfield and explained the parameters of the inspection.

Among the records that the DEA representatives were looking for were dispensation records, which consist of a log that shows how controlled substances are dispensed, the names of the patients and the use of the drugs. Mr. Scheuler testified that they were looking for records that included the time period that Dr. Greenfield's license was suspended by the Board. He said that when he asked Dr. Greenfield to produce the dispensation records, Dr. Greenfield initially said he had the records, but was not willing to produce them. When Dr. Greenfield was asked if he kept the dispensation records in the patient charts, Dr. Greenfield initially said no, then he said yes. According to Mr. Scheuler, after Dr. Greenfield conferred with his attorney, he said he did not keep dispensation records. Mr. Scheuler admitted during cross-examination that if Dr. Greenfield had followed the Board's Order and had not dispensed controlled substances, there would not have been any dispensation records for the period of the suspension. Transcript p. 32-37; 40-41.

In addition to maintaining dispensation records, DEA registrants who order controlled substances are required to do an audit of the controlled substances that they have on the premises and keep a biennial inventory (log) of those drugs. According to Mr. Scheuler, Dr. Greenfield told him that he could not produce a biennial inventory because he never took an inventory of the controlled substances that he ordered. Transcript p. 42-43; Exhibit 3, p. 9.

Testimony of Kathy Fredrico

Diversion Investigator Fredrico testified that during the inspection, they found Schedule III-V controlled substances in the cabinets and in the refrigerator in the office supply room of Dr. Greenfield's office. Those drugs are identified in Exhibit 3. Exhibit 3, p. 7-8.

In reference to biennial inventories, Ms. Federico testified that she was present when Investigator Scheuler asked Dr. Greenfield if he had any biennial inventories. She said that Dr. Greenfield said that he had never taken an inventory. She said that there should have been an inventory of the controlled substances that they found in Dr. Greenfield's office. Transcript p. 72.

Dr. Greenfield testified that he does not recall the DEA representatives asking for dispensation records. He said that they were looking for his biennial records. He also said that he told the agents that if there was a record of dispensing to a patient, it would be in the patient's chart. He testified that he does not keep records of dispensing medications because he does not dispense medications to patients. He said that he stopped dispensing medications to patients when his license was suspended by the Medical Examining Board. Transcript p. 87-91.

In reference to biennial inventories, Dr. Greenfield testified that he had not taken an inventory during the last five years. Transcript p. 102-103.

In my opinion, the evidence presented does not establish that Dr. Greenfield failed to make and retain dispensation records of controlled substances, but does establish that he failed to maintain biennial inventories.

In reference to the dispensation records, Dr. Greenfield said that if he had dispensed any controlled substances during that time period in question, the dispensation records would have been included in the patient charts. Admittedly, Dr. Greenfield went back and forth with the DEA representatives regarding whether he had any records. He said that the records were contained in the patient charts. Then, he said he did not have any records because he had not dispensed any drugs. As note previously, the DEA representatives looked at a few patient charts during the inspection, but did not review all of the files. The truth of the matter is that the DEA representatives did not rule out that the dispensations records were contained in the patient charts. Also, neither the Division of Enforcement nor the DEA representatives raised any issue regarding whether it was appropriate for Dr. Greenfield to include the dispensation records in the patient charts or whether by doing so complies with the federal requirements.

In reference to the biennial inventories, Dr. Greenfield admitted to the DEA representatives that he had never taken an inventory of the drugs that he ordered.

III. Discipline

Having found that Dr. Greenfield 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. Greenfield's license be revoked. Dr. Greenfield recommends that Counts I and III be dismissed .

Based upon the evidence presented, the Administrative Law Judge recommends that Dr. Greenfield's license to practice medicine and surgery be revoked. This measure is designed primarily to assure protection of the public and to deter other licensees from engaging in similar misconduct.

In its September 20, 2006 Final Decision and Order, the Board suspended Dr. Greenfield license for a period of 18 months and placed several limitations on his license, including a provision prohibiting him from prescribing, dispensing, administering or ordering controlled substances. The Board also ordered Dr. Greenfield to complete a 24-hour course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing" and a 40-hour course entitled "Intensive Course in Controlled Substance Management". Despite these measures, Dr. Greenfield ordered controlled substances during the time his license was suspended. He also violated the Board Order by writing prescriptions for Percocet and Oxycodone APAP for Patient Ruth S. Dr. Greenfield's response was that he did not know that Percocet is a controlled substance. In my opinion, Dr. Greenfield basically ignored the Board's Order as well as the federal laws relating to maintaining inventories and records of controlled substances. What measure does the Board need to take in order to protect the public and deter other licensees from engaging in similar misconduct? A reprimand? Another suspension? Place more limitations on his license? More education? In my opinion, the only viable measure available to the Board in terms of public protection and deterrence is revocation of Dr. Greenfield's license. Dr. Greenfield will be free to petition the Board in the future for reinstatement of his

license by submitted evidence satisfactory to the Board that he is capable of practicing medicine and surgery in a manner that safeguards the interest of the public.

IV. Costs of the Proceeding

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) Any other relevant circumstances.

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

First, the Division of Enforcement alleged in Counts I-III of its Complaint that Dr. Greenfield violated numerous laws relating to the practice of medicine and surgery. The evidence presented establishes in all 3 Counts that the violations occurred. Second, Dr. Greenfield has a history of disciplinary action taken against him by the Board. Third, the recommendation that Dr. Greenfield's license be revoked reflects the serious nature of the unprofessional conduct established by the evidence. Finally, Dr. Greenfield totally ignored the Board's September 20, 2006 Order and the federal recordkeeping requirements. He did not even make a good faith effort to comply with the Order or the federal requirements.

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 19th day of May 2009.

Respectfully submitted,

Ruby Jefferson-Moore

Administrative Law Judge