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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
LARRY B. DEAN, M.D., RESPONDENT.	:	ORDER 0000311

Division of Enforcement Case No. 08 MED 261

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

Larry B. Dean, M.D.
901 East Circle Dr.
Milwaukee, WI 53217

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A disciplinary proceeding was commenced in this matter by the filing of a Notice of Hearing and Complaint with the Medical Examining Board on September 25, 2009. Prior to the hearing on the Complaint, the parties in this matter, Larry B. Dean, M.D., Respondent herein, his attorney, Mary K. Wolverton, Peterson, Johnson & Murray SC, and Pamela M. Stach, Attorney for the Department of Regulation and Licensing, agreed to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Larry B. Dean, M.D., Respondent herein, whose date of birth is December 15, 1947, is duly licensed to practice medicine and surgery in the State of Wisconsin under license number 19763-20, which was granted on November 24, 1975.

2. Respondent's last known address filed with the Department of Regulation and Licensing is 901 East Circle Dr., Milwaukee, WI 53217.

3. Respondent's practice specialty is internal medicine.

4. During the events of this matter, Respondent practiced medicine and surgery at Aurora Advanced Health in Milwaukee, WI.

5. Respondent provided medical care and treatment for Patient TH from the mid 1980s through March of 2004.

6. Patient TH had a history of smoking, hypertension, hyperlipidemia and a possible family history of cardiac disease during the time period Respondent provided medical care and treatment.

7. On November 11, 2002, Patient TH was evaluated at the Emergency Department at Community Memorial Hospital for complaints of mid sternal burning radiating to the anterior neck, tingling of the hands and feet, sweating and some difficulty breathing. Cardiac evaluation was essentially normal; however Respondent was consulted and ordered a stress test with a follow up visit.

8. On November 13, 2002, Patient TH presented to Respondent's partner, Dr. BC who performed and interpreted the stress test.

9. The initial report filed by Dr. BC indicated that the patient had denied chest pain throughout the procedure. The report further noted an upsloping ST depression developed in V4-V6 of 1.5mm equivocal for ischemia. Exercise was limited by shortness of breath, with poor exercise capacity at 9METS. Blood pressure was elevated and blood pressure and heart rate response were normal. The patient achieved 87 percent of the maximum predicted heart rate. No significant arrhythmias were noted. The report concluded that the patient was to see Respondent that afternoon to discuss options for further evaluation.

10. At 9:51 a.m., approximately 30 minutes following the filing of Patient TH's stress test report, Dr. BC amended the electronic record to include a recommendation that a Cardiolite stress test be considered.

11. At approximately 4:30 p.m. on November 13, 2002, Patient TH presented to Respondent for his scheduled appointment to review the stress test results.

12. Prior to that appointment, Respondent's medical assistant entered a note in the patient's medical record which reflected that the patient was seen by Dr. BC on that date and that a discussion of a Cardiolite stress test was recommended.

13. The medical note reflected in paragraph 12 above was part of the electronic medical record and available to Respondent at the time of the patient's 4:30 appointment.

14. Respondent reviewed the original stress test report from Dr. BC and assessed the patient with chest pain of mixed etiology with a primary component being stress related. He ordered Ranitidine and Lorazepam medications and an upper GI and chest x-ray.

15. Respondent did not discuss and/or order a Cardiolite stress test for the Patient at the November 13, 2002 office visit.

16. Respondent admits that the stress test was equivocal for ischemia and a Cardiolyte stress test would have been the appropriate follow up test.

17. Respondent believed that the physician conducting the stress test would order a Cardiolyte stress test, if indicated.

18. Respondent admits he could have ordered a Cardiolyte stress test for the patient.

19. Respondent saw the patient on five occasions between November 27, 2002 and March 10, 2004. During those visits the patient continued to complain at various times of chest pain, tightness in the chest and shortness of breath. During that time period the patient's blood pressure and cholesterol varied. Respondent continued to attribute these symptoms, among others, to stress and possible reflux.

20. On September 22, 2004, Patient TH presented at the Community Memorial Hospital complaint of substernal chest pressure with sharp stabbing pain without vomiting, nausea or diaphoreses. His blood pressure was noted at 182/87. The symptoms resolved and final diagnosis at discharge was atypical chest pain with referral for follow up with Respondent.

21. Patient TH did not follow up with Respondent.

22. On December 27, 2004, Patient TH was found at his home pulseless and not breathing. He was transported to the Community Memorial Hospital by emergency medical transport and after multiple attempts at resuscitation was pronounced dead. Cause of death was listed as cardiac arrest.

23. Respondent's conduct in failing to provide appropriate medical follow up of an equivocal street test by ordering further evaluation of the patient's symptoms and risk factors for cardiac disease tended to constitute a danger to the health, welfare and safety of the patient and created that risk that the patient's cardiac condition would not be diagnosed and treated.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3) and authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. Respondent conduct as set forth in paragraph 23 of the Findings of Facts is a violation of violation of Wis. Stats. § 448.02(3) and Wis. Admin. Code § MED 10.02(2) (h).

ORDER

IT IS HEREBY ORDERED that the stipulation of the parties is approved.

IT IS FURTHER ORDERED that Larry B. Dean, M.D. is hereby REPRIMANDED.

IT IS FURTHER ORDERED that:

4. Respondent shall within 90 days of this Order pay costs of this proceeding in the amount of four thousand dollars fifty dollars ($4,050.00). Payment shall be made 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

5. In the event Respondent fails to timely submit payment of the costs as set forth above, the Respondent's license (# 19765-20) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs.

6. This Order is effective on the date of its signing.

MEDICAL EXAMINING BOARD

By: _____ 7/21/10

A Member of the Board Date