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Before The
State Of Wisconsin
Medical Examining Board

In the Matter of the Disciplinary Proceedings
Against **NARENDAR K. JAIN, M.D.,**
Respondent

FINAL DECISION AND ORDER

ORDER 0000554

Division of Enforcement Case No. 07 MED 208

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Narendar K. Jain
208 E 39th Street. #233
South Sioux City, NE 68776

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

PROCEDURAL HISTORY

On or about July 20, 2010, the Department of Regulation and Licensing, Division of Enforcement filed a formal Complaint against Respondent Narendar Jain, alleging that on or about March 21, 2007, Respondent Jain: (1) issued an open-ended order for 10 mg of morphine IV titrated every five minutes, with no physician reassessment, for a 37-year old female patient (S.C.) complaining of "writhing" lower left back pain; and (2) restated this Order after an emergency room nurse questioned the order, raising a concern about the possibility of respiratory depression, in violation of Wis. Stats § 448.02(3) and Wis. Admin. Code § Med 10.02(2)(h).

On or about July 31, 2010, Respondent Jain filed an Answer denying the allegations of misconduct against him and affirmatively alleging that his order for 10 mg of morphine every five minutes was to be done with close clinical monitoring of vital signs and pulse oxygen, and that he told the emergency room nurse that he would reassess the patient every five minutes, and depending on the pain status and vital signs, repeat the dose.

A Prehearing Conference was held by telephone on August 30, 2010. Respondent Jain was given until September 14, 2010, to determine whether he wanted to retain counsel. He declined.

A continued Prehearing Conference was held on September 20, 2010. Respondent Jain reiterated that his March 21, 2007, order of 10 mg of morphine every five minutes for Patient S.C. was to be done with close clinical monitoring and reassessment every five minutes, and that he therefore did not wish to enter into any stipulation. A hearing was thus set by the ALJ for Wednesday, December 1, 2010.

Respondent Jain further indicated, (at the September 20, 2011, prehearing conference), that his employer at the time of the alleged events, Upland Hills Health, had denied him access to the original March 21, 2007, physician notes for Patient S.C., and requested subpoenas commanding Upland Hills Health to: (1) to produce the original notes for his inspection, and (2) to produce these records for the hearing in this matter.

The ALJ issued Respondent Jain's first requested subpoena, but indicated that she would wait to issue a subpoena commanding Upland Hills Health Emergency Department to produce the original March 21, 2007, physician notes for the December 1, 2010, hearing until after Respondent Jain had had the opportunity to inspect them.

On or about October 15, 2010, Respondent Jain sent a letter to the ALJ indicating that he had gone to the Upland Hills Health Center on October 7, 2010, to inspect the original March 21, 2007, physician notes for Patient S.C., but, despite serving the subpoena the ALJ issued on September 20, 2010, was given photocopies of these records, and told the originals had been destroyed. Respondent Jain thus requested that the ALJ issue a second subpoena, commanding Upland Hills Health Center to produce the originals of these records for the December 1, 2010, hearing.

Upon the above information, the ALJ scheduled a telephone hearing to take place on October 26, 2010, and ordered Respondent Jain to obtain written verification from Upland Hills Health Center that the original March 21, 2007, physician's notes for Patient S.C. had been destroyed.

On October 26, 2010, just a couple of hours before the hearing on the matter, the ALJ received a letter from Phyllis A. Fritsch, Administrator for Upland Hills Health, confirming that the medical records Respondent Jain requested existed in scanned in form only, and that the originals had indeed been destroyed.

At the hearing that took place later that day, the ALJ explained to Respondent Jain that she could not command Upland Hills to produce documents that did not exist. The parties agreed to stipulate that the original records had indeed been destroyed, and that they existed in scanned in form only.

On or about November 3, 2010, the Division, by Attorney Pamela Stach, filed a motion with the Medical Examining Board for an order closing from the public all disciplinary

proceedings in this matter, all recordings and transcripts thereof, and all pleadings, medical records, and other documents including all depositions, other discovery, motions and motion hearings, documents and other evidence obtained or generated for the disciplinary proceedings. The Board granted this motion at its meeting on November 17, 2010.

The closed contested case hearing in this matter was thereafter held at the Department of Regulation and Licensing on December 1, 2011. A Proposed Decision and Order was issued by the ALJ on March 28, 2011. The Respondent filed Objections and Attorney Pamela Stach filed a Response to Objections on May 11, 2011. The Parties orally argued the matter to the Board on May 18, 2011. Based on a review and consideration of the entire record, including the recommendations of the ALJ, the Objections to the Proposed Decision and Order and the Response to the Objections to the Proposed Decision and Order, the Board issues this Final Decision and Order with an explanation of variance.

FINDINGS OF FACT

1. Narendar K. Jain, M.D., Respondent, is currently registered to practice medicine and surgery in the state of Wisconsin under license number 31801-20. This license was first granted on December 19, 1990. Respondent's specialty is internal medicine. (Answer).

2. Respondent currently resides at 208 E. 39th Street, Apt. 233, South Sioux City, NE 68776. (Answer).

Treatment of Patient S.C., March 21, 2007

3. In March 2007, Respondent was a contract physician through Medical Doctors Associate assigned to provide services to Upland Hills Health Emergency Department, Dodgeville, WI. (Answer).

4. On March 21, 2007, Respondent was scheduled to work at Upland Hills Health in Dodgeville, Emergency Department, for a 24-hour shift beginning at 8 a.m. (Answer)

5. On March 21, 2007, at 16:16, a 37 year-old female patient (Patient S.C.) presented at the Upland Hills Health Emergency Department with complaints of right lower back pain and frequent urination. Patient S.C. was not from the area. (Exhibit 4, Certified Upland Hills Health Medical Record for Patient S.C.).

6. Patient SC was initially assessed by Sue Mieritz, a registered nurse with 24 years of general nursing experience and 16 years experience providing emergency room nursing services. (*See* December 1, 2010, Disciplinary Hearing Transcript at pp. 33-35).

7. Nurse Mieritz assessed the patient with pain at a level 4 on a scale of 10. A urinalysis was ordered and Respondent was contacted to evaluate the patient. Respondent assessed the patient, diagnosed possible renal colic, and ordered the administration of 4 mg

morphine IM. (Ex. 4, p. 6) Patient S.C. requested pain medication to take home (which Respondent refused), and was advised to follow-up with her primary care physician.[1] (Ex. 4, pp. 6, 8). Respondent told Nurse Mieritz to administer the medication and then Patient SC could leave. (Tr. at p. 4). Patient S.C. then contacted someone to provide her with a ride and the morphine was administered. (Tr. at p. 45, Ex. 4, p. 8).

8. It is possible that Patient S.C. was a "drug seeker." (Tr. at p. 84). There is nothing in her medical record, however, to indicate that she was morphine-resistant.

9. At 17:10, while Patient S.C. was awaiting the individual who would give her a ride from the emergency room, she described her pain as only slightly improved. (Tr. at p. 48).

10. At 17:45, Nurse Mieritz reassessed Patient S.C., who was complaining of the pain worsening and now going down her right buttock and the back of her right leg. Nurse Mieritz contacted Respondent, who was in the physician's on-call room by the telephone. Nurse Mieritz relayed to Respondent that Patient S.C. was in significant pain and requested the Respondent return to the emergency department to reassess the patient. (Answer).

11. Respondent was initially reluctant to come down to the emergency room to further assess Patient S.C., as she had already been discharged[2], but after being told that Patient S.C.'s ride had not yet arrived, and that she was complaining of more pain than when she got there, he agreed to return to the Emergency Department and reevaluated Patient S.C. at 17:55. (Ex. 4, p 13, Tr. at pp. 48, 102).

12. Upon emerging from the room where the patient was located, Respondent appeared irritated and told Nurse Mieritz something akin to, "we'll give her morphine. Giver her what she wants. She can have 10 milligrams, 100 milligrams, whatever it takes for her pain relief. Go ahead and give it to her til [sic] she passes out; then we'll intubate her." (Tr. at pp. 50, 105, 120-21).

13. Respondent intimates that he made this statement to make a point. (Ex. 5b) Nurse Mieritz further admits that she did not take the above statement to be a "serious" order, but interpreted it as Respondent "blowing off steam." (Tr. at p. 50).

14. Nurse Mieritz told Respondent that that was a "ridiculous" order and she was not going to give that amount of pain medication. (Tr. at pp. 51, 120-21).

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[1] It appears that this was done out of concern that patient SC was as "drug seeker." She was from out of state, and did not identify a primary care physician on her consent for services. (Exhibit 4, p. 2).

[2] The record shows that Respondent initially challenged the fact that he discharged patient S.C, a fact the Division makes much to do about. As Respondent seems to have relinquished this challenged at hearing, and as this fact is not material the ALJ's findings, it need not be discussed in any more detail.

15. Respondent then wrote an order for 10 mg morphine IV every five minutes until pain relief in the medical records. (Ex. 4, p. 12. *See also* Division Exhibit 5b, March 26th 2010, letter from Respondent to Division (Respondent wrote that he "prescribed morphine 10 mg q 5 minutes"). He also ordered a series of other tests, including blood work, and a CAT scan. (Tr. at p. 50, Ex. 6, Statement of Susan Mieritz p. 9). His written order did not include any limitations on the amount of morphine to be administered, or any instructions regarding close monitoring of the patient's vital signs and/or pulse oxygen or physician reassessment. (*See* Ex. 4, p. 12). Respondent claims, incredibly, that his order included a x 3, which was omitted, and that he verbally ordered Nurse Mieritz to reassess Patient S.C. every five minutes. (Tr. at pp. 205, 221).

16. When interventions are ordered, nurses are expected to assess and reassess the intervention. (Tr. at pp. 76-77).[3]

17. When a nurse feels that an order might cause harm to the patient, however, it is her professional obligation to challenge that order. (Tr. at p. 125).

18. Nurse Mieritz had no intention of administering 10 mg of morphine to Patient S.C. every five minutes until pain relief, identifying such as a "very large dose," that could lead to overdose, respiratory depression and/or unconsciousness. (Tr. at p. 68). Her plan was to start an IV and titrate morphine in small increments until the patient had relief from the pain. (Ex. 6, p. 2. *See also* Tr. at p. 68).

19. Nurse Mieritz made numerous attempts to establish an IV line. (Ex. 4, p. 9). When she was unsuccessful, she asked another nurse, Brian Michek, R.N., for assistance and he also was unable to establish a line. (Tr. at p. 57, Ex. 4, p. 9). At 18:40, Nurse Mieritz contacted the lab and requested assistance from a lab technician in establishing a line. The technician was not able to place the line. (Tr. at p. 58, Ex. 4, p. 10).

20. At 18:40, Nurse Mieritz notified Respondent that they were unable to establish an intravenous line and requested orders for other routes of administration of pain medication. (Tr. at p. 61, Ex. 4, p. 10). She again indicated that she thought his order was irresponsible. (Tr. at p. 87). Respondent did not offer any further orders, claiming "he was not given the opportunity to do so," as Nurse Mieritz refused his offers of help.[4] A confrontation ensued. (Tr. at p. 61, 109, 222-227).

21. Respondent then stated he wanted to leave the hospital and go home. (Tr. 63, 110, 228-29). There were no other physicians on duty and none expected until the end of Respondent's shift at 8:00 a.m. the following morning. (Answer).

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[3] In the instant case (order for iv morphine), this would likely have included taking the patient's vital signs and monitoring her visually for sedation, at which point further interventions might be given, but would not have included continuous cardiac monitoring and/or oxygen. (*See Id.).*

[4] Respondent further claimed that Nurse Mieritz refused his explanations of the appropriateness of his order. (*See* Ex. 5b).

22. Emergency department staff advised Respondent that he could not leave the department until his shift ended or alternative physician coverage was obtained. (Tr. at p. 111). The Nursing Supervisor spoke with Respondent and he agreed to remain until a physician arrived. (Tr. at pp. 122-23, 228).

23. Another physician arrived shortly thereafter to take over Respondent's duties and Respondent provided an update on the patients' conditions, including Patient S.C. (*See* Ex. 4, p. 4). Respondent did not reassess Patient S.C. after ordering 10 mg of morphine every five minutes until pain relief. (Answer).

24. At 19:30, the physician who had assumed coverage omitted Respondent's order to administer 10 mg morphine every five minutes and ordered administration of 10 mg of morphine IM and 2 mg of Lorazepam IM since intravenous access was still impossible. (Ex. 4, p. 10).

25. At 21:30 the doses of morphine and Lorazepam were repeated once with pain improvement and the patient was released with 30 tablets of Darvocet and 30 tablets of Cyclobenzaprine. The patient was eventually discharged at 21:37 with a diagnosis of lumbar spasm, with possible bulging disc and a prescription for Darvocet N 100 and Flexeril 10 mg # 30 and instructions for follow up with her primary care physician. (Ex. 4, p. 13).

Upland Hills Health Emergency Department Medical Records

26. The March 21, 2007 physician's notes for Patient S.C. were destroyed, and exist in scanned in form only. (*See* Procedural History).

27. It is Upland Hills Health policy to scan all paper medical record documents into an electronic (HMS) system, so as to eliminate paper files and allow any health care worker with proper security to access the entire medical record from any computer.[5] (Ex. 10, p. 1, Tr. at pp. 137 – 139). Once scanned, the paper documents are destroyed. (*See Id.*)

28. There is some lag time between when paper medical record documents are completed, and when they are scanned into the electronic (HMS) system). (*See* Tr. at pp. 139-40, 142-43). Patient S.C.'s medical records were not scanned until June 16, 2007. (Tr. at p. 139, Division Ex. 10, p. 16).

29. Prior to being scanned in, paper medical records are maintained in the Central File Department. (Tr. at p. 141). Caregivers who need a paper medical record document for a clinical purpose are able to check that record out from the Central File Department before it is scanned in and destroyed, making it possible for them to alter that record. (Tr. at p.144).

[5] While the ALJ would have preferred to have the original medical record, it appears that Upland Hills scanning and subsequent destruction of paper medical record documents is consistent with law. *See* Ex. 9.

30. Nurse Mieritz did not check out or alter Patient S.C.'s March 21, 2007 physician notes. (Tr. at pp. 55-56).

Administration of Morphine in General

31. Morphine is a powerful opioid narcotic. It is a very good pain reliever that is frequently used. (Tr. at p. 172. *See also* Tr. at p.212, Exhibit 22, Medical Toxicology article regarding morphine).

32. This is because it has a peak serum level that is reached in about five minutes, but it "hangs around" for several hours. (Tr. at p. 172. *See also* Ex. 22).

33. Nevertheless, morphine has multiple side effects, two of which are life threatening. The first is that it causes sedation, which can cause the patient to breathe less deeply or to stop breathing altogether. The second is that it can drop a patient's blood pressure to an unacceptably low level, and even cause cardiac arrest. (Tr. at pp. 179-84. *See also* Ex. 19, PubMed Article entitled "Fatal respiratory depression after multiple intravenous morphine injections," Ex. 20, PubMed Article entitled "Clinical pharmacokinetics of morphine," Ex. 21, British Journal of Clinical Pharmacology article entitled "Respiratory Depression following morphine and morphine-6-glucornide in normal subjects," and Ex. 102, Excerpt from Rosen's Emergency Medicine, 7th Edition, 2009).

34. The drop in blood pressure is usually seen earlier, and would be found by watching the patient every five to ten minutes. (Tr. at 179).

35. The depression of breathing is more delayed, and would not be found by assessing the patient every five minutes until it was too late. (*Id.*).

36. This is because the peak analgesic effect of morphine can be seen in 5 to 15 minutes from each dose, while the respiratory depression depends upon the drug getting into the brain, which can take 20-40 minutes. (Tr. at p. 174. *See also* Exs. 19 and 20).

37. Respiratory depression is rare in patients with acute pain. (Tr., pp. 209-10, Ex. 102). Further, Oxygen and Naxolene can be used to reverse respiratory depression that occurs as a result of morphine. (Tr. at p. 211).

38. Nevertheless, respiratory depression does occur in patients who have received morphine for acute pain, and can be fatal: (*See generally*, Tr. at pp. 179-80, 220, Exhibit 19).

39. Kenneth Johnson, M.D. is the current medical director of the Emergency Department at St. Vincent's Hospital in Green Bay, Wisconsin. He has been board certified in emergency medicine since 1990. He serves on a number of hospital quality of care committees,

has published on emergency medicine subjects, and provides frequent presentations. (Ex. 12. *See also* Tr. at pp. 162-64). As part of his duties as director of the St. Vincent Hospital Emergency Department, he is responsible for overseeing and evaluating the appropriate discharge of duties by the emergency department staff including the prescribing of narcotics and, specifically, the use of morphine in the treatment of acute pain. (Tr. at pp. at 162-63, 166). He also has occasion to prescribe various narcotics, including morphine. (Tr. at pp. at 166-67).

40. In his twenty plus years of practice in emergency medicine, Dr. Kenneth Johnson has seen respiratory depression in patients given morphine five to 10 times. (Tr. at p. 200). One of those patients died. (*Id.*).

41. In 2006, a 26-year-old female died two hours after surgery, after receiving four doses of intravenous morphine, a total of 35 milligrams over two hours. She suffered respiratory arrest followed by fatal cardiac arrest forty minutes after getting good pain relief. (Ex 19. *See also* Tr. at p. 181).

42. The usual morphine dosage for a person is between 0.1 milligram per kilogram of body weight and .15 milligrams per kilogram of body weight for a single dose.[6] (Tr. at pp. 70, 172-73. *See also* Ex. 23, Annals of Emergency Medicine, Volume 49, No. 4, April 2007 article entitled "Randomized Double Blind Placebo-Controlled Trial of Two Intravenous Morphine Dosages (0.1 mg/kg and 0.15 mg/kg) in Emergency Department Patients With Moderate to Severe Acute Pain," and Ex. 24, Annals of Emergency Medicine, Volume 46, No. 4, October 2005 article entitled, "Intravenous Morphine at 0.1 mg/kg is Not Effective for Controlling Severe Acute Pain In the Majority of Patients").

43. .01 mg/kg or even .015 mg/kg, in a single dose, may not be sufficient to alleviate acute pain. (*See* Tr. at pp. 208-09, Exs. 24, 25 and 102).

44. It is appropriate to order morphine in multiple doses. (Tr. at p. 179. *See also* Exhibit 24). However, this has to be done with care so that the patient receives enough morphine to get their pain controlled, but not enough to cause the above-referenced side effects. (Tr. at p. 179. *See also*, Ex. 102 ("[t]he goal of the administration of opioids is to attain effective analgesia with minimal adverse effects....").

45. As identified in Rosen's Emergency Medicine[7], "There is no "ceiling effect" to [morphine's] potency, neither is there a standard, fixed, or weight-related dose that can produce a given clinical effect. [T]he correct dose a particular patient requires at a particular time can only be determined by repeated assessment of the degree of pain relief and any adverse effects the patient may be manifesting. The use of opioids therefore requires titration based on frequent and accurate assessments of the effects of any dose given. The most effective and safest way to

[6] It is unclear what Patient S.C.'s weight was, but it appears to have been around 100 kg. (Tr. at pp. 69-70).
[7] Both Respondent and Dr. Johnson recognize this as an authoritative book in the practice of emergency medicine. (Tr. at pp. 188, 207-08).

achieve pain relief is to use a deliberate IV titration. (Ex. 102 (emphasis added). *See also* Tr. at p. 208)

46. Further, "The optimal use of IV opioids requires administering an initial "loading dose, assessing its analgesic effect, and then administering frequent (every 10-15 minutes) repeated doses until analgesia is achieved, followed by doses at regular intervals to prevent the return of significant discomfort. (Exhibit 102).

47. In reviewing Patient S.C.'s medical records for March 21, 2007, Dr. Johnson found that, while Patient S.C. was a candidate for the use of morphine to treat her acute pain, the amount of morphine ordered by Respondent was excessive, and would not have been ordered by a competent physician. (Tr. at pp. 167-172).

48. Specifically, Dr. Johnson feared that while "ordering [10 mg of morphine] every five minutes, [may have gotten the patient] pain control after four or five doses," it would not have been eliminated from her body that quickly, putting her at risk to "quit breathing and have low blood pressure," 20 to 40 minutes after the last dose. (Tr. at p. 173).

49. Because Respondent's order was without limit, the patient could have received 120 mg of morphine in an hour without reassessment. Dr. Johnson opines that "this is a potentially lethal dose in a narcotic naïve patient." (Tr. at p. 176).

50. Dr. Johnson further opines that even had reassessment occurred every five minutes, given the way the order was structured, the patient would have received a potentially toxic dose of morphine before it was recognized. (Tr. at pp. 174-175).

51. Dr. Johnson proposes that "[a] minimally competent physician would have limited the number of doses without recheck or reassessment of that patient..," and at the time of the last dose, "let a little bit of time pass to make sure that the patient [did not become] sedated." (Tr. at p. 178). While he uses repetitive dosing of morphine, he tends "to use the 10- to 15-minute window as opposed to the five minute window," and writes for a limited number of doses. After that number, he will let the patient have a little bit of time so he can adequately monitor the respiratory effects of the morphine before giving more. (Tr. at p. 198).

52. Dr. Johnson's opinions as to the risks that Respondent's order posed to Patient S.C., and the need to titrate morphine more slowly and to a specific dose are echoed by Nurse Mieritz and Nurse Practitioner Blabaum. (*See* Findings of Fact ¶ 17, Tr. at pp. 126-130).

53. The Board finds Dr. Johnson's above findings regarding Respondent's order of 10 mg of morphine every five minutes convincing.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. §§ 448.02.

2. The burden of proof in disciplinary proceedings before the department or any examining board, affiliated credentialing board or board in the department is a preponderance of the evidence. Wis. Stat. § 440.20(3). *See also*, Wis. Admin. Code HA 1.17(2), ("[u]nless the law provides for a different standard, the quantum of evidence for a hearing decision shall be by the preponderance of the evidence.").

3. "Preponderance of the evidence" is defined as the greater weight of the credible evidence. Wis. Admin. Code § HA 1.01(9). Stated otherwise, is it more likely than not that the alleged events occurred.

4. Pursuant to Wis. Stat. § 448.02(3), the Medical Examining 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 [Medical Examining] board to that person."

5. Pursuant to Wis. Admin. Code § 10.10(2)2: "The term "unprofessional conduct" is defined to mean and include:... (h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public."

6. The Wisconsin Supreme Court has further defined "unprofessional conduct" as conduct that does meet the level of minimal competence accepted in the field, and which poses unacceptable risks the health, welfare or safety of the patients. *See Gilbert v. Medical Examining Board,* 119 Wis.2d 168, 192-93, 196 (1984) (emphasis added).

7. The term "danger" has further been defined by the Wisconsin Supreme Court as "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." *Id.* at 193.

8. The Division has proven, by the evidence described in ¶¶ 12 - 15 of the Findings of Fact, that it is more likely than not that Dr. Jain issued an open-ended order for Patient SC of 10 mg of morphine every five minutes until relief of pain with no physician reassessment after a specific dose.

9. The Division has further proven, by the evidence described in ¶¶ 42 - 50 that said order "would allow for an excessive amount of morphine to be administered to a patient."

10. The Division has further proven, by the evidence described in Findings of Fact ¶¶ 31 - 50, that Respondent's conduct in issuing an open ended order for 10 mg morphine every 5 minutes until pain relief created a unacceptable risk to Patient S.C. that unrecognized respiratory sedation and/or hypotension could occur with the further risk that, if unrecognized and untreated, the patient could suffer cardiopulmonary arrest.

11. The Division has further proven, by the evidence described in Findings of Fact ¶¶ 42 - 51, that Respondent's conduct in issuing an open-ended order for 10 mg morphine every 5 minutes until pain relief fell below the minimum standards in the profession and tended to constitute a danger to the health, welfare and safety of the patient in that no physician reassessment of the patient's response to the drug would occur after a specified dose, and that, even if reassessments had occurred every five minutes, given the way Respondent's order was structured, Patient S.C. would have received a potentially fatal dose before any respiratory depression was recognized.

12. Respondent's conduct, as described in paragraphs 9 and 10, above, constitutes a violation of Wis. Admin. Code § 10.02(2)(h)(unprofessional conduct), and thus subjects Respondent to discipline pursuant to Wis. Stat. § 448.02(3).

DISCUSSION

Violations of Wisconsin Statutes and Administrative Code:

The burden of proof in this case was on the Division. This means that the Division had to prove, by the greater weight of the credible evidence, that Respondent Jain made an open-ended order for 10 mg of morphine every 5 minutes, without limitation, and that this order placed an unacceptable risk to the health, safety or well-being of Patient S.C.

Issuance of Open-Ended Order

After reviewing all the evidence in this case, the Board finds it more likely than not that Respondent Jain issued an open-ended order of 10 mg, every five minutes. Respondent Jain's testimony that he wrote his above order as "x 3" and, that Nurse Mieritz thereafter erased the x 3 from Patient S.C.'s medical record is just not credible in light of the facts that: (1) the physician notes for Patient S.C. clearly contain no "x 3" in the order for "morphine 10 mg IV q 5 min until pain relief," nor would an order for "x 3 until pain relief," even make sense[8]; (2) three witnesses heard Respondent Jain verbally order morphine every five minutes until the patient passes out, a statement he more or less he admits he made out of frustration, and (3) Respondent Jain

[8] Respondent Jain's claim that his copy of the physician's notes for Patient S.C. (Ex. 100) contains a mark which provides "very subtle evidence" of the fact that Nurse Mieritz overwrote his order with Wite-Out, is desperate, at best. (*See* Tr. at p. 2. *See also* Respondent Brief at p. 1 (Exhibit 100 "has clearly and convincingly captured the falsification/alteration of morphine order [sic[by displaying the indelible mark of number 3..."). Exhibit 100 provides no such evidence.

indicated that he ordered 10 mg of morphine every five minutes in numerous correspondences with the Division dating back to 2007 (*see* Exs. 5a and 5b), and only claims that his order was to be limited after the formal complaint in this matter had been filed alleging that Respondent Jain had engaged in unprofessional conduct by issuing an open-ended order in August of 2010. (*See* Ex. 5c).

Unacceptable Risk to Health, Safety and Well-being of Patient S.C.

This was a somewhat more difficult determination, as it is likely that Respondent Jain intended his order to include at least some kind of patient monitoring by Nurse Mieritz, and that, on some level, Nurse Mieritz understood this. (*See* Findings of Fact, ¶¶ 15- 16)

Regardless of these facts, the Board finds that Respondent Jain's order of "10 mg of morphine every five minutes until pain relief," posed an unacceptable risk to Patient S.C.'s health, safety and well-being. Though Respondent Jain has produced credible evidence that suggest that (1) .10 mg/kg of morphine, in a single dose, may not be enough to alleviate acute pain, and (2) there is no "ceiling effect" to [morphine's] potency; [nor] a standard, fixed or weight-related dose that can produce a clinical effect," the Division, through Dr. Kenneth Johnson, has provided equally credible evidence that the amount of morphine Respondent Jain prescribed, when combined with the frequency of he titrations ordered (which due to the delayed onset of side effects, provided no real opportunity for reassessment), created a risk of respiratory depression in Patient S.C. too great to be ignored by a competent physician. Indeed, Dr. Johnson provided convincing evidence that, while "ordering [10 mg of morphine] every five minutes, [may have gotten the patient] pain control after four or five doses," it would not have been eliminated from her body that quickly, putting her at risk to "quit breathing and have low blood pressure," 20 to 40 minutes after the last dose. (*See generally* Findings of Fact ¶¶ 31-49). Dr. Johnson further established that "even had Respondent Jain or Nurse Mieritz reassessed the patient every five minutes, given the way the order was structured, the patient would have received a potentially toxic dose of morphine before it was recognized." (*See* Findings of Fact ¶ 50). As such, he concluded that "[a] minimally competent physician would have limited the number of doses without recheck or reassessment of that patient..," and at the time of the last dose, "let a little bit of time pass to make sure that the patient [did not become] sedated." *Id.* at ¶ 51.

Save for his own biased rhetoric, Respondent Jain offers no evidence to contradict these findings.[9] In fact, the one authority he cites to support the reasonableness of his order, (Rosen's Emergency Medicine), essentially supports the opinions expressed by Dr. Johnson, asserting that:

[9] Although Respondent Jain offers an excerpt from a treatise (Exhibit 101) which he claims support the concept of unlimited boluses of morphine administered every five minutes, said treatise does not reflect a dosage amount for the morphine boluses, and Respondent Jain has not submitted the entire article despite the ALJ's request that he do so.

> "the optimal use of IV opioids requires administering an initial "loading" dose, assessing its analgesic effect, and then administering frequent (every 10 to 15 minutes) repeated doses until analgesia is achieved, followed by doses as regular intervals to present return of significant discomfort.

Respondent's attempts to downplay the risk his order posed to Patient S.C. by noting that (1) respiratory depression in patients with acute pain is rare[10], and (2) there are interventions that can reverse respiratory depression if and when it occurs, are unconvincing. In the first place, Dr. Johnson's opinion as to whether Respondent Jain's conduct constituted a danger to the health, welfare, and safety of Patient S.C., noted the above definition of "danger," (*see* Tr. at p. 170), and thus necessarily considered the likelihood of respiratory depression, and determined that it was too great. Second, even assuming that interventions would have been readily available had Patient S.C. gone into respiratory depression, (1) the risk to her health would already have been established, and (2) there are no guarantees that the interventions would work. (*See* Findings of Fact, ¶¶ 39-41).

Discipline:

As discipline for Respondent Jain's above-identified violations, the Division requests that his license be suspended for a period of at least 60 days, and that he further successfully complete continuing education in the use of narcotics in pain relief, communication between nurses and physicians, and professional ethics before resuming practice. (*See* Division's Brief in Chief, p. 24).

In support of its recommendation, the Division explains that:

> ... Dr. Jain has demonstrated by his conduct and his continued assertion that the error or fault lies with everyone but himself, that he does require the imposition of significant discipline both to protect the public and deter him from further conduct in this regard.
>
> [Respondent Jain's] failure to take responsibility for his actions requires that a period of suspension be imposed to effectuate ... deterrence. In addition, if Dr. Jain truly believes that his order was appropriate, he requires education on the appropriate use of narcotics for pain relief. Based on the fact that his interrelationships with the nursing and other emergency department staff may have contributed to his conduct, a course in professional ethics and communications between physicians and nurses would be indicated.

Indeed, the purpose of discipline is to: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar contact. *State v. Aldrich*, 71 Wis. 2d 206 (1976).

[10] Due to the fact of acute pain. (*See* Ex. 102).

Assessment of Costs

The ALJ's recommendation and the Board's decision as to whether the full costs of the proceeding should be assessed against the credential holder are 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 respondents 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 licenses, 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;

See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz (LS 0802183 CHI).

Respondent Jain's misconduct is of a very serious nature. While he cooperated in these proceedings, he failed to provide the ALJ with information she requested with respect to his defense (*see* Tr. at p. 237-238), and he was found to have lied to both the Division and the tribunal with respect to what he ordered.

Balancing these factors with the fact that the Department of Regulation and Licensing is a "program revenue," the Board finds that the respondent should pay all of the costs involved in investigating and prosecuting this matter.

ORDER

IT IS HEREBY ORDERED, effective 5 days from the date of this Order, that the license of Narendar K. Jain to practice medicine in the State of Wisconsin be SUSPENDED for a period of 15 (fifteen) days.

IT IS FURTHER ORDERED that the license of Narendar K. Jain, M.D., to practice medicine and surgery in the State of Wisconsin is hereby LIMITED, as follows:

1. Within 6 months of the date of this Order, Respondent shall provide proof sufficient to the Board or its designee of Respondent's satisfactory completion of: a) 8 (eight) hours of continuing education preapproved by the Board or its designee in the use of narcotics in pain relief with an emphasis on an emergency department setting; b) the course entitled "National Center of Continuing Education's Strategies for Developing Communication Between Nurses

and Physicians" or an equivalent course preapproved by the Board or its designee; and c) a course on professional ethics for physicians preapproved by the Board or its designee.

2. Upon Respondent providing proof sufficient to the Board or its designee that he has completed the required continuing education, the limitation is to be removed from Respondent's credential without further action of the Board.

3. Respondent is responsible for paying the full cost of attendance at these courses. Respondent shall not apply the continuing education credits earned in satisfaction of this Order toward satisfaction of any Wis. Stat. sec. 448.13 biennial training requirements.

IT IS FURTHER ORDERED that the full costs of the proceeding are assessed against the Respondent.

IT IS FURTHER ORDERED that 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 the 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 timely submit payment of the costs or fails to comply with the ordered continuing education as set forth above, the Respondent's license 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 or completion of the continuing education.

This Order is effective on the date of its signing.

EXPLANATION OF VARIANCE

The Findings of Fact and the Conclusions of Law proposed by the ALJ have been adopted without modification. The Order has been modified to provide for a 15 day suspension, commencing 5 days from the date of this Order. The Board believes that a 15 day suspension is adequate to expresses the Board's concern with the seriousness of the misconduct. A suspension is warranted because of the Respondent's failure to take responsibility for his actions and because of his willingness to abandon care for this patient due to his perceived conflicts with the nursing staff. Appropriate patient care may not be allowed to be compromised due to personal conflicts.

The Order has also been modified to provide that a failure to comply with the Order may result in a suspension without further notice or hearing. A suspension under this part of the Order would continue until compliance is achieved.

Finally, the Order has been modified to provide that the education must be completed within 6 months, that the education must be preapproved by the Board or its designee, that the Respondent is responsible for payment of all costs related to the courses and that the credits

earned to satisfy this Order shall not be allowed to count toward the satisfaction of the Wis. Stat. sec. 448.13 biennial training requirements.

MEDICAL EXAMINING BOARD

By: _____ MDMBA _____ 6/15/11
A Member of the Board Date