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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JOEL S. STOECKELER, M.D., RESPONDENT.	:	ORDER 0000612

[Division of Enforcement Case No. 08 MED 203]

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

Joel S. Stoeckeler, M.D.
311 Galahad Road
Hudson, WI 54016

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

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 this Stipulation and considers it acceptable.

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

FINDINGS OF FACT

1. Joel S. Stoeckeler, M.D., Respondent, date of birth December 2, 1951, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the state of Wisconsin pursuant to license number 31618-20, which was first granted on August 23, 1990.

2. Respondent's last address reported to the Department of Regulation and Licensing is 311 Galahad Road, Hudson, Wisconsin 54016.

3. At the time of the events set forth below, Respondent was board certified in family practice.

4. At the time of the events set out below, Respondent was employed as a physician at Baldwin Area Medical Clinic in Baldwin, Wisconsin.

5. On June 26, 2003, Patient R.S. presented to the Baldwin Area Medical Center emergency room following a skid loader accident in which he sustained a right fibular fracture. Respondent performed the history and physical on that date. He noted that the patient had a prosthetic St. Jude mitral valve and that he took Coumadin daily. An International Normalized Ratio test ("INR") was ordered and revealed an INR of 3.74. Respondent admitted Patient R.S. to the hospital with a treatment plan that included "Continue with current Coumadin" which Respondent noted to be 12.5 mg on Fridays and 15 mg on all other days. He also ordered daily INR's for Patient R.S.

6. On June 27, 2003, Patient R.S.'s INR was 2.83.

7. On June 28, 2003, Respondent conferred with a cardiologist regarding the acceptable INR level for Patient R.S. The cardiologist advised it was acceptable to keep it in the 2 range but that they would prefer to have it above 2.5 because the prosthetic St. Jude's mitral valve carried a risk of thrombotic phenomena. Patient R.S.'s coagulation laboratory report on this date showed that his INR was 1.89. Based on concerns of possible ongoing bleeding in his right thigh, Respondent decided to transfer Patient R.S. to Regions Hospital for observation and ongoing management should he require any aggressive interventions. Patient R.S. was transferred on that date to Regions Hospital where he remained until July 3, 2003. During that time, he was placed on Lovenox for anticoagulation.

8. On July 3, 2003, Jason Caron, M.D., discharged Patient R.S. to home from Regions Hospital with the plan to have Heartland Home Care Network ("Heartland") go to Patient R.S.'s home to check his INR levels. He was given a three days' supply of Lovenox while he was becoming therapeutic on Coumadin and would then resume his pre-hospital Coumadin dose until he met with orthopedics to determine how to manage his anticoagulation, pending surgery on the fracture. Dr. Caron's plan for Patient R.S. was that he would follow up at the Maplewood Veteran's Clinic following surgery for management of his anticoagulation.

9. On July 8, 2003, a Heartland staff member sent a facsimile to the Respondent regarding Patient R.S.'s INR levels which were 1.26 on July 6, 2003, 1.74 on July 7th and 2.76 on July 8th. The staff member reported that the patient had been taking Coumadin 20 mg every day but that Dr. Caron ordered Coumadin 10 mg on this date. In addition, Dr. Caron would no longer be following the patient as the INR's were to be monitored by Respondent as the primary care physician. The staff member inquired if Respondent agreed with the 10 mg dosage. Respondent faxed back an order that the Coumadin dosage be decreased to 7.5 mg and that a repeat INR be performed on July 10, 2003.

10. On July 10, 2003, Heartland staff reported to Respondent (via facsimile) that Patient R.S.'s INR was 2.42. Respondent ordered that his Coumadin be decreased 5 mg daily with a repeat INR to be performed in one week.

11. During the period of time between July 10, 2003 and August 5, 2003, no Coumadin Flowsheet was started to track Patient R.S.'s Coumadin dosage or INR levels. In addition, during the period of time between July 10, 2003 and August 24, 2003, Baldwin Area Medical Center did not have a system in place to record historical patient data related to their INR levels and Coumadin dosage and did not have a system in place to make patient records available to prescribing physicians in a timely fashion.

12. On July 17, 2003 Heartland staff notified Kathleen Farah, M.D., at the Baldwin Clinic that Patient R.S. had an INR of 1.03. Dr. Farah ordered 10 mg of Coumadin with a repeat INR to be performed the following day. Dr. Farah was one of several other physicians at the Baldwin Clinic who worked with the Respondent and intermittently participated in Patient R.S.'s Coumadin management.

13. On July 18, 2003, Dr. Farah ordered Coumadin 10 mg and requested a repeat INR be performed the following day. On July 19, 2003, Todd Capistrant, M.D., was on call and responded to the request for a Coumadin order from Heartland by ordering Coumadin 10 mg. On July 20, 2003, S. Speltz, M.D., was on call and ordered Coumadin 5 mg and a repeat INR the following day.

14. On July 21, 2003, Tammy Giese, L.P.N., took Patient R.S.'s coagulation lab report to Respondent for his review. The report indicated an INR of 1.05. Respondent ordered Coumadin 6 mg on Monday, Wednesday and Friday and 5 mg on all other days. He ordered a recheck in one week. Nurse Giese then notified Heartland of the same.

15. On July 29, 2003, Heartland staff notified Respondent via (facsimile) that Patient R.S.'s INR was 1.04. The staff member also advised that the patient's wife expressed concern that Patient R.S. continued "to be so slow" and that he had been on 12.5 mg of Coumadin daily prior to the accident. Respondent ordered an increase in his Coumadin dosage to 7.5 mg per day and for Patient R.S. to follow up in the clinic in one week.

16. On July 30, 2003, Respondent wrote a letter to Patient R.S. in which he noted they had supervised several changes in Patient R.S.'s Coumadin and that he "strongly" advised him to come to the clinic for a reassessment.

17. On July 31, 2003, Patient R.S. presented to Marvin Klingler, M.D., at the Baldwin Area Medical Center clinic department ("Baldwin Clinic") regarding a recurring cyst on his back. Dr. Klingler drained the sebaceous cyst and started Patient R.S. on Keflex. On this date, a clinic chart was created for Patient R.S.

18. On August 5, 2003, Patient R.S. presented to Respondent at the Baldwin Clinic for an INR recheck. Patient R.S. advised Respondent that he was taking 12.5 mg daily, which the Respondent wrote on the office note but then later crossed out and wrote "6 mg M W F". Respondent performed a physical examination which included listening to Patient R.S.'s heart.

Respondent noted "prosthetic valve clicks are intact with crisp valve clicks." On that date, Patient R.S.'s INR was 1.18, however the Respondent contends that he did not see the INR prior to Patient R.S. leaving the clinic that day. In his plan of treatment, Respondent ordered Coumadin 6 mg on Monday, Wednesday and Friday with 5 mg on all other days and follow up in one month. Respondent should have recognized that Patient R.S.'s INR was clearly subtherapeutic; that Patient R.S. had previously been maintained on a much higher dose of Coumadin; and that he had a prosthetic heart valve which required a dosage of Coumadin greater than 6 mg. A Coumadin Flowsheet was created for Patient R.S. on this date.

19. On August 11, 2003, Respondent reviewed the INR lab results from August 5, 2003. He ordered that the Coumadin dosage be increased to 6 mg daily and to recheck in one week. Respondent should have recognized that Patient R.S.'s INR was clearly subtherapeutic and that he had a prosthetic heart valve which required a higher dosage of Coumadin.

20. On August 13, 2003, Heartland faxed a coagulation lab report to Respondent indicating that Patient R.S.'s INR was 0.99. Respondent questioned whether the patient had been taking 6 mg and, if he had, that the patient should be taking 7 mg of Coumadin daily with a recheck in one week. Respondent's medical assistant, Kim Paul, verified that Patient R.S. had been taking 6 mg and called the patient to advise of the increase to Coumadin 7 mg daily.

21. On August 20, 2003, the laboratory faxed the coagulation lab results indicating that Patient R.S.'s INR was 1.07. Gregory Estlund, M.D., ordered an increase of Coumadin to 8 mg daily and to recheck the INR in one week.

22. On August 24, 2003, Patient R.S. was admitted to Wausau Hospital emergency room with garbled speech and left facial droop of almost six hours' duration. His INR was 1.15. A head CT scan revealed a lacunar infarct of the left parietal lobe. An echocardiogram revealed a density on the mitral valve prosthesis. Mark Hoffman, M.D., diagnosed a stroke which he felt was secondary to an embolic event. Patient R.S. was hospitalized through August 30, 2003, with improved speech but continued facial droop on the left.

23. Respondent's conduct as herein described with regard to Patient R.S. fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to adequately maintain Patient R.S.'s Coumadin dosage in a therapeutic range during the time that he assumed responsibility for his Coumadin management.

b. Respondent failed to adequately monitor Patient R.S.'s INR levels and failed to recognize the subtherapeutic INR levels during the time that he assumed responsibility for his Coumadin management.

24. Respondent's conduct in failing to adequately monitor Patient R.S.'s INR levels and in failing to properly manage his Coumadin dosage posed a substantial danger to Patient R.S. in that it placed him at risk for an embolic event, which ultimately occurred on August 24, 2003. As a result of the embolic event and secondary stroke, Patient R.S. suffered permanent harm in that he

sustained organic personality syndrome, dysarthric speech, functional decline with deficits in abstract thinking abilities, and difficulty with problem solving.

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's conduct as set forth in paragraphs 14 - 21, constitutes a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02(2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

NOW THEREFORE IT IS ORDERED that the Stipulation of the parties is hereby accepted.

IT IS FURTHER ORDERED that Joel S. Stoeckeler, M.D., is hereby REPRIMANDED.

IT IS FURTHER ORDERED that the license of Joel S. Stoeckeler, M.D., to practice medicine and surgery in the State of Wisconsin shall be LIMITED on the following terms and conditions:

1. Joel S. Stoeckeler, M.D. shall, within twelve (12) months of the date of this Order, obtain eight (8) hours of education in Coumadin management.

a) The courses attended for compliance with this requirement may not be used in satisfaction of the statutory continuing education requirements for licensure.

b) Dr. Stoeckeler shall be responsible for obtaining the courses required under this Order, for providing adequate course descriptions to the Department Monitor listed below and for obtaining pre-approval of the course from the Wisconsin Medical Examining Board or its delegee prior to commencement of the programs.

c) Within thirty (30) days following completion of the courses identified in paragraph one above, Dr. Stoeckeler shall file with the Wisconsin Medical Examining Board certifications from the sponsoring organization verifying his attendance at the required courses.

d) All costs of the educational programs shall be the responsibility of Dr. Stoeckeler.

IT IS FURTHER ORDERED that:

2. Respondent shall within 90 days of this Order pay costs of this proceeding in the amount of one thousand nine hundred ($1,900.00) dollars. 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

3. Violation of any 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 timely submit payment of the costs as ordered or fails to comply with the ordered continuing education as set forth above, the Respondent's license (No. 31618-20) 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 or completion of the continuing education.

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

MEDICAL EXAMINING BOARD

By: _____ _____
A Member of the Board Date