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Before The
State Of Wisconsin
Medical Examining Board

In the Matter of the Disciplinary Proceedings
Against **STEVEN B. GREENMAN, M.D.**,
Respondent

FINAL DECISION AND ORDER

ORDER 0000714

Division of Enforcement Case Nos. 10 MED 370, 09 MED 143, 09 MED 142 & 09 MED 081

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, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision 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 at Madison, Wisconsin on the 19th day of October, 2011.

Sandra L Osborn, MD
Member
Medical Examining Board

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Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against
STEVEN B. GREENMAN, M.D., Respondent

NOTICE OF PROPOSED
DECISION AND ORDER
DHA Case No. SPS-11-0029

Division of Enforcement Case Nos. 10 MED 370, 09 MED 143, 09 MED 142 and 09 MED 081

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

Steven B. Greenman, M.D., by

Attorney Paul Sicula
135 West Wells Street, Suite 604
Milwaukee, WI 53203-1807

Wisconsin Medical Examining Board
P. O. Box 8935
Madison, WI 53708-8935

Department of Safety and Professional Services
Division of Enforcement
P. O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The procedural matters leading up to this hearing are as follows: On or about March 17, 2011, the Department of Safety and Professional Services (previously known as the Department of Regulation and Licensing), Division of Enforcement (Division) filed a formal Complaint against Respondent Greenman, alleging that his treatment of six (6) patients from 2005 through 2010 was below the minimum standards for the profession in that: (1) his prescription of pain relievers and other medications for those six (6) patients was done is such a way that it tended to constitute a risk of harm to those patients, in violation of Wis. Admin. Code § 10.02(2)(h) (unprofessional conduct); and (2) his medical charting for all six (6) those patients was partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

On or about April 25, 2011, Respondent Greenman filed an Answer to the Division's Complaint, denying all violations of code and law.

A prehearing conference was held by telephone on April 27, 2011, Amanda Tollefsen, administrative law judge (ALJ), presiding. Respondent Greenman reiterated his desire to contest the Complaint, and a contested case hearing was scheduled to commence on June 13, 2011.[1]

On or about May 31, 2011, the Division (as Complainant) and Respondent filed a stipulation of all facts and violations, leaving as the only issue for hearing the discipline to be imposed for Respondent Greenman's various violations.

On or about June 9, 2011, the parties filed an amended stipulation with regard to all of the underlying facts and violations and also a second stipulation, with regard to an agreement to maintain the identities of the patients confidential by sealing the patient health care records following the proceedings.

The contested case hearing in this matter was held, as scheduled, at the Department of Safety and Professional Services on June 13, 2011. Post-hearing briefing was ordered and completed on July 25, 2011.

This decision follows.

FINDINGS OF FACT

The undersigned ALJ makes the following findings of fact, based on the parties June 9, 2011, Amended Stipulation of Complainant and Respondent :

1. Respondent, Steven B. Greenman, M.D., (date of birth June 1, 1947) is duly licensed and currently registered by the Medical Examining Board to practice medicine and surgery in the State of Wisconsin, pursuant to license number 18938, which was first granted July 11, 1974. The Respondent's specialty is internal medicine.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 3900 West Brown Deer Road, Milwaukee, WI 53209.

PRIOR DISCIPLINE

3. On October 18, 1990, the Board issued a Final Decision and Order in a Disciplinary Proceeding against the Respondent, which suspended the Respondent's license for 30 days beginning October 18, 1990 for violating Wis. Admin. Code § Med 10.02(2)(p) based on allegations that he inappropriately prescribed Tussionex and Valium to a patient at the same time without monitoring to ensure that the patient would not develop respiratory depression and that he inappropriately prescribed Dilaudid, Percodan, Methadone and Valium to another patient. Following the suspension, the Respondent's license was limited to require that he surrender his DEA registration and complete 30 category I credits of continuing medical educations courses on the subject of prescribing controlled substances. He could petition the Board for removal of the limitation after one year. He could not petition to prescribe Schedule II controlled substances.

[1] The parties moved to combine this hearing with the "show cause" hearing for the Medical Examining Board's summary suspension of Respondent Greenman's medical license. Due to the failure of the Memorandum of Agreement in effect between the Department of Safety and Professional Services (then known as the Department of Regulation and Licensing) to address "show cause" hearings, and conflicting arguments from different Division attorneys regarding whether it was permissible for DHA ALJs to hear "show cause" hearings, the motion was denied.

4. On January 15, 1992, he petitioned the Board to permit him to prescribe and dispense all but schedule II medications. On January 31, 1992, the Board permitted him to apply for and hold a DEA registration for controlled substances which was limited to Schedules III, IV and V. He could not prescribe Schedule II's and could not petition for further modification until January 31, 1994. He has not yet petitioned for ability to prescribe Schedule II's.

5. On March 20, 1997, the Board issued a Final Decision and Order in a Disciplinary Proceeding against the Respondent, in which he was Reprimanded for unprofessional conduct for prescribing benzodiazepines, codeine, hydrocodone, butalbital, amitryptiline and other drugs to a patient under circumstances where he did not document any physical or neurological exam despite the fact that the patient complained of migraine headaches.

ALLEGATIONS RELATING TO 10 MED 370 (Patient P.K.)

6. Patient P.K., a now 59-year-old female, treated with the Respondent during the period of October of 1992 through November of 2010. Patient P.K. initially treated with the Respondent from 1992 through 1997 during which time her primary medical problem was chronic headaches. From April 9, 1997 through July 8, 2005, Patient P.K. ceased treating with the Respondent.

2005 Treatment Summary

7. On July 8, 2005, Patient P.K. returned to the Respondent's care at which time her chief complaint was of migraine headaches. The Respondent did not conduct a physical or neurological exam or an exam for a headache disorder. His barely legible notes indicate objective findings of "gen appearance, gait nl." He failed to document a diagnosis of headache or of any medical condition. The Respondent's impression was "not happy in marriage, (illegible), husb quite involved in children & grandchildren, and allergy to Imitrex? – problem." For this, he prescribed Fioricet #30 one refill, 1 q4h.

8. Fioricet is a combination of butalbital, acetaminophen and caffeine, and is used primarily to treat complex and muscle contraction headaches (the same combination comes in generic form which will hereinafter be referred to as "BUT/APAP/CAF").

9. On July 22, 2005, Patient P.K. returned for a re-check. The Respondent did not document a physical exam but noted the following: "Pt insist she (illegible) off Fioricet with Dr. Bubolz." The Respondent's impression is "↑ HA with acute (illegible) – losing best (illegible) 40 yr. has 1 other (illegible)." No plan of treatment is noted. The Respondent prescribed Fioricet #50, with four refills.

10. On August 8, 2005, the Respondent authorized another refill of Fioricet #50, with one refill and noted it must last five days. This is approximately ten Fioricet tablets per day. The Respondent did not see or examine Patient P.K. on this date.

11. On August 16, 2005, Patient P.K. returned for a re-check. Physical exam findings included "(illegible) good talk." The Respondent's impression included four items: "friend dying, (illegible) of Fioricet", husb., and cigarettes. He prescribed Fioricet #63 which must last seven days and one refill.

12. On August 25, 2005, the Respondent authorized Fioricet #63 (to be filled on August 28) with two refills. He did not see the patient on this date.

13. On September 14, 2005, Patient P.K. returned for a re-check. The Respondent did not note any physical exam findings but noted that Patient P.K. reported being anxious about her mood and apologetic about early refills and calls. The Respondent did not note a diagnosis or impression. The Respondent prescribed Fioricet #70 with four refills.

14. On October 12, 2005, Patient P.K. returned for a re-check. The Respondent did not note any physical exam findings. His impression was "Fioricet being (illegible)." He prescribed Fioricet #70 with two refills.

15. On October 31, 2005, Patient P.K. returned for a re-check. The Respondent did not note any physical exam findings. He noted that the patient reported "I'm pissed off!! about Fioricet." The Respondent's impression was "Difficulty getting over desire for Fioricet, maintains asexual nature of marriage." He prescribed Fioricet #70 with six refills and amitryptiline #60, a tricycle antidepressant, with three refills.

16. On November 22, 2005, Patient P.K. returned for a re-check. The Respondent noted that the patient called in to two other doctors (Hellerman and Jablonsky) but did not see either. The objective portion of the Respondent's office note indicated the following: "anxiety, tearful, apologetic, alert NAD (illegible) no edema." A urine screen was performed and revealed positive results for the presence of barbiturates and tricyclic antidepressants. In addition, it also revealed the presence of methadone, benzodiazepines, phencyclidine (PCP) and marijuana (THC). The Respondent noted that a urine screen on that date was positive for methadone and PCP however he then noted the following: "I was going to send urine for confirmation re: Methadone + other drugs but urine was accidentally discarded after pt left!" On that date, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a Gamma Glutamyl Transferase (GGT) level of 258 U/L (the normal range is 7-64 U/L). An elevation in the GGT level is an indication that there is irritation or damage occurring in the liver.

17. During 2005, the Respondent prescribed amitryptiline, Fioricet, and BUT/APAP/CAF to Patient P.K. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at four different pharmacies.

18. During the course of his treatment of Patient P.K. in 2005, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

19. The Respondent's conduct in 2005 was below the minimum standards for the profession in the following respects: the Respondent's initial evaluation of Patient P.K. on July 8, 2005 contained no physical or neurological exam, no headache disorder exam, and no documentation of a diagnosis of a headache condition; the remainder of physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications or amitryptiline prescribed; the pain medications were prescribed in escalating doses without justification; the Respondent continued to prescribe pain medications (Fioricet and BUT/APAP/CAF) in the face of contraindications to their use (urine screen positive for presence of methadone, benzodiazepines and PCP); and the Respondent inappropriately continued to prescribe Fioricet, which contains acetaminophen, in the presence of an abnormal liver function test on November 22.

2006 Treatment Summary

20. In the year 2006, Patient P.K. presented to the Respondent for re-check on fifteen dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date	Objective/Physical Exam Findings	Impression/Medical Diagnosis(es)
January 6	None	"I agree with pt (illegible)"; (numerous statements regarding marital/social issues)
January 24	"mild to mod anx – can relax (illegible)"	"anxiety similar to events of '92-97 Fioricet helps anxiety, HA, def pursuing divorce"
February 21	"(illegible) lot of (illegible) no signif deep (illegible) guarding (illegible)"	"Pt is at major life decision time; appear to have decide upon pro-se divorce proceeding with (illegible) his being (illegible) ↑↑ stress more (illegible) on Fioricet (illegible)"
March 8	"not too tense (illegible)"	"hopefully (illegible) amenable split (illegible) anxious re: husb; using Fioricet liberally; increased GGT chronic, nl SGOT, SGPT (illegible)"
March 29	"looks good (illegible)"	"anxiety, migraine"
April 14	None	"still stable on Fioricet; read When Families Feud, Ira Westfield"
May 16	"looks OK/(illegible)"	"feels caged"
June 2	"(illegible) fairly relaxed"	"still (illegible)"
June 21	None	"Chronic HA's, hiding methadone use? (illegible)"
July 5	"(illegible)"	"Chronic HA – still weaning Fioricet (illegible), diverting methadone from dt; (illegible)"
August 23	"alert (illegible)"	"still (illegible)"
September 8	"looks relaxed"	None
October 16	None	"Divorce (illegible) with attendant (illegible) trying to work as CNA (illegible) anxiety"
November 17	"some tremor handwriting is (illegible) (sample above) NO toxicity GEN APP orient mem intel stance gait fine, few spider (illegible) HEAD eye ears nose lips/oral cav. Checked no edema presac upper leg lower leg feet toe"	"Remains very anxious Hopefully out of husb's house in (illegible) Fioricet, (illegible) LFTs (illegible) tremor (illegible)"
December 21	None	"out of Michael home in with dtr for (illegible) new job – new line of work Anx/dep, PSTD – divorce process (illegible)"

21. During 2006, the Respondent prescribed Phenobarbital, amitryptiline, Fioricet, and BUT/APAP/CAF to Patient P.K. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent which also show that the prescriptions were to be filled at five different pharmacies.

22. On January 6, 2006, the Respondent prescribed Phenobarbital 60 g #60 with three refills. No diagnosis is provided to justify the prescription of Phenobarbital.

23. Phenobarbital is a barbiturate used primarily as an anticonvulsant, and is a Schedule IV Controlled Substance pursuant to Wis. Stat. § 961.20(2)(m).

24. On February 21, 2006, the Respondent noted that he had a telephone call with a pharmacist regarding prescriptions from Dr. Jablonsky and another physician in September of 2005 for Fioricet. This time period coincides with the period of treatment by the Respondent during which time he was also prescribing Fioricet for Patient P.K.

25. On January 24, 2006, Patient P.K. presented to the Respondent for a re-check at which time the Respondent noted that three other physicians (Helleman, Jablonsky and Smith) were also prescribing Fioricet to the patient. He advised the patient that she must stop seeing multiple doctors.

26. On May 15, 2006, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a Gamma Glutamyl Transferase (GGT) level of 328 U/L (the normal range is 7-64 U/L). The Respondent continued to prescribe Fioricet (and BUT/APAP/CAF), which contains acetaminophen, in the presence of an abnormal liver function test.

27. On June 21, 2006, a urine screen was performed and revealed positive results for the presence of methadone, in addition to barbiturates and tricyclic antidepressants. The Respondent noted the following in his record: "Misunderstood & discard both urines! (&did panel dip in (illegible); pt will need to be contacted for urine dip screen with Methadone confirmation."

28. On July 5, 2006, Patient P.K. returned to the Respondent for a check-up at which time she admitted using methadone, which she was diverting from her daughter.

29. On November 17, 2006, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a Gamma Glutamyl Transferase (GGT) level of 330 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe Fioricet (and generic Fioricet), which contain acetaminophen, in the presence of an abnormal liver function test.

30. On December 21, 2006, Patient P.K. discussed with the Respondent the pharmacies where she got her prescriptions filled and the Respondent noted the following in her records: "#5, 1 out, #2, 4 in." The Respondent maintained a chart in Patient P.K.'s medical records which contained the names of numerous pharmacies in the area. Each pharmacy was designated with a number.

31. The Respondent intentionally sent Patient P.K. to different pharmacies because he knew she could only get her prescription filled every two weeks with her insurance and that she needed refills every three days so going to different pharmacies would prevent any questions about overprescribing. The Respondent also told Patient P.K. that he could not call in prescriptions to Ozaukee or Washington County anymore because they were questioning the prescriptions and that he wanted her to go to pharmacies in Waukesha, Racine and Kenosha as he did not feel they would question the prescriptions.

32. During the course of his treatment of Patient P.K. in 2006, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

33. The Respondent's conduct in 2006 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications or amitryptiline prescribed; the pain medications were prescribed in escalating doses without justification; the Respondent continued to prescribe pain medications (Fioricet and BUT/APAP/CAF) in the face of contraindications to their use in that he was aware that Patient P.K. was also getting prescriptions for Fioricet from other physicians; the patient's urine screen was positive for barbiturates, methadone and antidepressants; the patient was diverting methadone from a family member; and the patient was filling prescriptions at numerous pharmacies.

2007 Treatment Summary

34. In the year 2007, Patient P.K. presented to the Respondent for re-check on nine dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date	Objective/Physical Exam Findings	Impression/Medical Diagnosis(es)
January 29	None	"Anx/dep (illegible)"
February 27	Alert no distress, happy, mild (illegible) basically hopeful (illegible) no ed (illegible)	"HA's Fioricet amitryptiline"
April 25	None	"HA Fioricet (illegible)"
June 8	None	"Continued HA's, ↑financial (illegible)husb (illegible) are evaporating mother undergoing surg – need to be there"
July 23	(illegible)	"Showing + sign; needs to (illegible) divorce (illegible)"
August 27	Looks fine slightly tense (illegible)	"Seen some improvement as 'exit plan' evolves; has hopes; seems to have reasonable plan; tense cephalgia persist"
October 31	(illegible)	"Cont get well very (illegible)"
December 4	Look OK; usual stressed tense appearance	"Still imprisoned; needs job so can get a place ready to get out ASA; needs a place to go (illegible)"
December 21	None	"Remain greatly stressed in current (illegible); headache; myalgia; needs to leave (illegible)"

35. During 2007, the Respondent prescribed large amounts of amitryptiline, Fioricet, BUT/APAP/CAF, and alprazolam to Patient P.K. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent which also shows that the prescriptions were to be filled at five different pharmacies.

36. On July 23, 2007, Patient P.K. advised the Respondent that she was now taking two Fioricet tablets every one to two hours, which was in a higher dose than what the Respondent had prescribed.

37. On November 1, 2007, the Respondent prescribed alprazolam for Patient P.K. He did not see her or conduct a physical exam on that date. The Respondent's medical charts do not justify the prescription of alprazolam.

38. During the course of his treatment of Patient P.K. in 2007, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

39. The Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; and the diagnoses do not justify the pain medications or alprazolam prescribed.

2008 Treatment Summary

40. In the year 2008, Patient P.K. presented to the Respondent for re-check on eight dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date	Objective/Physical Exam Findings	Impression/Medical Diagnosis(es)
January 15	None	None
May 19	None	"remains with her headaches"
June 23	Alert; reasonably (illegible) embarrassed, apologetic	"Recently using dtrs methadone; back pain; HA's divorce in progress; I'm trying to appreciate current dx, Rx (illegible) since 1992 (or earlier)"
June 27	Embarrassed; usual appearance; (illegible)	"Headache; back pain; intense anxiety; remorse over behavior re (illegible) Rx; same sx of (blank)"
July 29	None	"Seem not to be getting proper respect from sister."
August 27	Appears anxious otherwise usual	"Sold into slavery"
September 23	Seems more relax; mood good; thought OK; no toxicity or neuro impairment; painful shoulder; head, neck, arms, lungs, chest, heart, abd, leg and ankle/feet all checked.	"Pt (illegible) self (illegible)"; has negative self belief that she has an addictive personality and is an addictive person which she must cast away.
October 29	None	"Still having stress – no lighter; same sx"

41. During 2008, the Respondent prescribed large amounts of amitryptiline, Fioricet, BUT/APAP/CAF, and hydrocodone 5/500 and 10/325 to Patient P.K. The increasing amounts and increasing frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent which also shows that the prescriptions were to be filled at six different pharmacies.

42. On January 15, 2008, despite not conducting a physical exam or documenting a diagnosis, the Respondent started Patient P.K. on hydrocodone 50/500 APAP (contains 50 mg of hydrocodone and 500 mg of acetaminophen).

43. Hydrocodone APAP is a combination of hydrocodone and acetaminophen, is used to treat moderate to severe pain, and is a Schedule III Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7.

44. On May 19, 2008, Patient P.K. presented to the respondent after missing several appointments in April and early May. She reported that her son admitted using heroin intravenously and that she found needles on his computer desk.

45. On June 23, 2008, Patient P.K. reported to the Respondent that she had been getting methadone from her daughter. The Respondent's office note reflects that he told her it was illegal to pass narcotics from one family member to another. He then gave her a prescription for hydrocodone APAP 10/325, 1-2 Q4h. On that date, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a GGT level of 399 U/L (the normal range is 7-64 U/L).

46. On June 27, 2008, Patient P.K. reported to the Respondent that her son was taking some of her hydrocodone pills. The Respondent prescribed hydrocodone again on that date.

47. On July 29, 2008, Patient P.K. reported to the Respondent that she was taking 7-8 Fioricet tablets and 8-10 hydrocodone/APAP per day.

48. On August 27, 2008, Patient P.K. reported to the Respondent that she was taking 8-10 Fioricet tablets and 18-20 hydrocodone/APAP per day, which is significantly more than what she was taking the previous month. The high dose combination of analgesics amounts to approximately 10 g (325 mg x 30 tabs) of acetaminophen a day which is in excess of the accepted maximum daily level of acetaminophen, which is 4 g.

49. During the course of his treatment of Patient P.K. in 2008, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

50. The Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; and the Respondent inappropriately continued to prescribe pain medications to the patient in face of contraindications to their use in that he was aware the patient was diverting methadone from a family member and that another family member was an IV heroin user and was taking the patient's hydrocodone pills.

2009 Treatment Summary

51. In the year 2009, Patient P.K. presented to the Respondent for re-check on nine dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date	Objective/Physical Exam Findings	Impression/Medical Diagnosis(es)
January 28	Alert looks fine; family calm (illegible)	"Many stressors are falling into place

	agitated can't stay long (illegible)	and not really stressors anymore"
February 16	"I am totally devastated"; son in jail	Continued HA (illegible); son in jail
March 2	None	"Pt being secretive re: pills being taken from her implying . . .; Pt still very unsettled claim she will be settled in 3 wks with herself & all possession in 1 place; lab (illegible)"
June 17	None	None
October 30	Looks excellent; nice hairdo; relaxed – can talk calmly; gait/NCS –nl.; H/F/N nl; (illegible)	"Pt has found a place to live (in husbands house) but relationship is platonic and now pleasant (several statements regarding marital history) Continued incapacitating headaches; Back myalgia (illegible)"
November 20	None	"Dramatic response to buprenorphine in reasonably low dose; back on hydrocodone/APAP and Fioricet for short time; chronic pain HA, (illegible) – probable/possible fibromyalgia (illegible); pain relief is partial but acceptable to pat; still on ibuprofen 800 BID (OTC)."
December 4	A little anxious	"Wants to renew buprenorphine after family get together lasting several day; family doesn't know she injects Rx"
December 10	None	"Chronic HA, (illegible)"
December 15	None	(illegible)

52. During 2009, the Respondent prescribed large amounts of amitryptiline, Fioricet, BUT/APAP/CAF, hydrocodone 10/325, buprenorphine, and alprazolam to Patient P.K. The increasing amounts and increasing frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent which also shows that the prescriptions were to be filled at eight different pharmacies.

53. As of January 28, 2009, Patient P.K. reported taking approximately 24-26 tablets of hydrocodone APAP 10/325 per day and 14 Fioricet tablets per day. The high dose combination of analgesics amounts to approximately 13 g (325 mg x 40 tabs) of acetaminophen a day which is in excess of the accepted maximum daily level of acetaminophen, which is 4 g. On that date, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a GGT level of 795 U/L (the normal range is 7-64 U/L).

54. On March 2, 2009, Patient P.K. reported to the Respondent that "Everybody has access to my purse." The Respondent noted in his impression section that the patient was being "secretive" regarding pills being taken from her. On that date, labs were drawn which revealed that Patient P.K.'s liver function tests were abnormal, including a GGT level of 826 U/L (the normal range is 7-64 U/L).

55. On June 24, 2009, Patient P.K. telephoned the Respondent and advised that she was going to "flush" her Fioricet and needed hydrocodone APAP.

56. On August 18, 2009, Patient P.K. telephoned the Respondent and advised she was in "detox" at Rogers Memorial Hospital where she was receiving Suboxone. As a part of the detox program, she was required to call the Respondent and tell him that he could no longer prescribe narcotics or sedatives to her which Patient P.K. did.

57. On October 3, 2009, Patient P.K. telephoned the Respondent and advised that she had an appointment with a doctor at Rogers Memorial Hospital and that she did well for three weeks but then "blew it." On October 30, Patient P.K. reported to the Respondent that she "owed pills to daughter." On that date, the Respondent's plan of treatment included beginning Patient P.K. on buprenorphine by subcutaneous injection. No justification is provided for the change and/or increase in medication by adding buprenorphine.

58. Buprenorphine is a semi-synthetic opioid of the phenanthrene-morpholine class, is used primarily to treat opioid addiction in higher dosages (>2 mg) and to control moderate pain in non-opioid tolerant individuals in lower dosages, and it is a Schedule III Controlled Substance pursuant to Wis. Stat. § 961.18(5m)(a).

59. On November 20, 2009, Patient P.K. handwrote a note to her file which purported to prevent the release of her records to "any federal, state, country or local or municipal government." The Respondent instructed her exactly what to write in that statement and then told her to sign it which she did. The reason the Respondent told her to write that note was because he said he knew he was overprescribing and that he did not want her records to be released.

60. On December 15, 2009, Patient P.K. admitted to the Respondent that she shot heroin with her son three times.

61. During the course of his treatment of Patient P.K. in 2009, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete and he failed to document that he warned Patient P.K. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

62. The Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and inappropriately continued to prescribe pain medications to Patient P.K. in face of contraindications to their use in that he was aware the patient was shooting heroin with a family member, that family members had access to her medications and were likely taking them and that the patient was in "detox" for drug addiction.

2010 Treatment Summary

63. In 2010, Patient P.K. was seen five times at the Respondent's office (March 3, March 17, April 16, August 10, and October 10). The Respondent failed to document a physical exam for any of these office visits and failed to even include an "objective" section in any of his notes. The Respondent's medical impressions during these five visits included the following: patient seems much more relaxed (March 3); neck back pain/HA (March 17); and patient looks great (April 16). No other medical impressions are given apart from numerous statements about the patient's family and emotional life.

64. During 2010, the Respondent prescribed large amounts of Tramadol, Fioricet, BUT/APAP/CAF, hydrocodone 10/325, buprenorphine, and alprazolam to Patient P.K. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent which also shows that the prescriptions were to be filled at seven different pharmacies.

65. On August 10, 2010, Patient P.K. presented to the Respondent. The Respondent did not perform or document a physical exam and did not document a diagnosis or impression. On this date, he gave the patient a prescription for Tramadol #60, 50 mg. No justification is provided for the change and/or increase in medication by adding Tramadol, an opioid analgesic used to treat moderate to severe pain and has habit-forming potential.

66. Patient P.K. had been a patient of the Respondent for many years; she never had any x-rays done; no alternatives to pain medications were ever explored; the Respondent gave her his private cell phone number to call so that she did not bother his office staff with medication requests; when Patient P.K. called the cell number, the Respondent would ask what medication she wanted and how much; and the Respondent would give her whatever medication she asked for and in whatever amount she asked for.

67. During the course of his treatment of Patient P.K. in 2010, the Respondent's medical charting for Patient P.K. is partially illegible and incomplete and he failed to document that he warned Patient P.K. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

68. The Respondent's conduct in 2010 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the large doses of pain medications prescribed; the Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; and he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal.

69. At no time during the period of treatment from July of 2005 through 2010 did the Respondent ever refer Patient P.K. to a pain management specialist, neurologist or headache clinician despite the fact that he consistently prescribed large amounts of pain medications for her initial complaint of migraine headaches and despite the fact that there were a number indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

70. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 3-69 above, has committed 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).

71. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 6-69 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ALLEGATIONS RELATING TO 09 MED 143 (Patient C.F.)

72. Patient C.F., a now 55 year old male, began treating with the Respondent in 1999 for chronic low back pain with a history of a lumbar laminectomy in 1996. During the period of time of 1999 to 2005, the Respondent prescribed the following medications for pain control: Carisoprodol, Ultram, Darvon, hydrocodone/APAP 10/500, Norco, Cyclobenzaprine, Tramadol, Neurontin, Buprenex, Diazepam, and Gabapentin. Below is a summary of the treatment and medication prescriptions Patient C.F. received from the Respondent in the period of 2005 through 2010.

73. In the year 2005, Patient C.F. presented to the Respondent for re-check on fourteen dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date of service	Objective/Physical exam findings	Diagnosis(es)/Impression
January 13	"moves (illegible)"	None
February 7	None	None
February 24	"moves well (illegible)"	None
March 14	"appear a little spacy, moves well"	Chronic (illegible)
March 21	"(Illegible) not (illegible) at all sober, (illegible)"	None
March 25	None	"uncontrolled substance use?? Who to believe"
April 8	"alert (illegible)"	"Pt been to be auth parameter of narco use, A ----off, no evidence for other diversion or abuse"
May 20	"walk well (illegible)"	"Still using lot of pn Rx (illegible)"
June 20	(illegible)	"chronic LS pn, (illegible) HBP (illegible) 14d. not ready to ↓ (illegible)"
August 11	"alert (illegible)"	"chronic low back pn HBP (illegible)"
August 29	None	"(illegible) behavior is understood"
August 31	None	None
October 6	None	"get all new teeth"
October 25	"throwing up blood"; "able to stand (illegible) radial pulse"	"volume depleted, hypotensive, UGI bleed?, dark emesis – could be small amount of blood, uncontrolled drug abuse?? Other Rx (illegible) suspended, needs IV fluid immediately"

74. During 2005, the Respondent prescribed hydrocodone/APAP 10/325 and 7.5/200, Gabapentin, Tramadol, Clonazepam, hydrocodone/ibuprofen 7.5/200, and Lunesta to Patient C.F. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at four different pharmacies.

75. Tramadol is centrally acting opioid analgesic used to treat moderate to severe pain.

76. Hydrocodone/ibuprofen is a combination of a narcotic and non-steroidal anti-inflammatory drug used short term to treat moderate to severe pain.

77. On January 13, 2005, Patient C.F. advised the Respondent that a relative had given gave him some of her Klonopin. On that date, the Respondent prescribed hydrocodone/APAP 10/325, #150 which was intended to be a 10 day supply (15 tablets per day).

78. On March 10, 2005, the Respondent spoke to a pharmacist and to Patient C.F. during which time he learned that Patient C.F. had recently used 17 Clonazepam tablets in less than 36 hours and that he was taking 15 hydrocodone/APAP 10/325 a day.

79. On March 21, 2005, Patient C.F. reported he was off hydrocodone/ibuprofen and benzodiazepines. The Respondent instructed him that he must stay off benzodiazepines.

80. On August 18, 2005, a urine screen was performed and revealed faintly positive results for the presence of methadone.

81. On September 28, 2005, the Wisconsin Medicaid Recipient Lock-in Program sent a letter to the Respondent advising him that its review of Patient C.F.'s medication use from March to August of 2005 revealed significant quantities of hydrocodone/acetaminophen, hydrocodone/ibuprofen, Tramadol and Oxycodone HCl 20 mg during the review period for the diagnoses of lumbago and backache. It noted that the "extent of use of these medication by Patient C.F. is greater than usually seen for these diagnoses" and that an updated diagnosis was needed. A medication profile was attached to the letter which indicated that Patient C.F. was also receiving prescriptions for hydrocodone/APAP, Oxycodone and Cyclobenzaprine from three other medical practitioners during that same period of time.

82. On October 6, 2005, the Respondent had a telephone call with Patient C.F. regarding a "lost pills" story he told to the pharmacist which the pharmacist will accept if the patient makes a police report. The Respondent noted in his record that the story seemed "believable" and accepted the story as long as the patient makes a police report. The Respondent replaced the lost hydrocodone/APAP 10/325 prescription.

83. On October 25, 2005, after Patient C.F. presented to the Respondent and reported that he had been throwing up blood, Patient C.F. was admitted to St. Michael's Hospital. The Respondent's office notes reflect only that he was admitted on October 25 and discharged to home on November 10, 2005. There is no indication that the Respondent obtained any information or records regarding the reason for the two week admission. He did receive a copy of laboratory reports during the admission which showed that a urine screen was positive for the presence of benzodiazepines and opiates.

84. On December 10, 2005, Patient C.F. presented to Syed Hussaini, M.D., at the Covenant Pain Clinic at St. Francis Hospital at which time Dr. Hussaini began prescribing morphine (under brand name of MS Contin) for Patient C.F. but would not continue him on Vicodin because of the patient's history of Vicodin overdose.

85. During the course of his treatment of Patient C.F. in 2005, the Respondent's medical charting for Patient C.F. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

86. The Respondent's conduct in 2005 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications prescribed; and the

Respondent continued to prescribe pain medications in the face of contraindications to their use (Patient C.F. reported taking Klonopin tablets from another individual; a drug screen positive for the presence of methadone; and a drug screen positive for the presence of benzodiazepines on October 25, 2005 after the Respondent had instructed Patient C.F. to cease taking that medication in March of 2005).

2006 Treatment Summary

87. In the year 2006, Patient C.F. presented to the Respondent for re-check on eleven dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date of service	Objective/Physical exam findings	Diagnosis(es)/Impression
March 28	None	"I'm willing to accept pt (illegible); He seems more humble"
July 18	"look OK (illegible)"	"HBP – not controlled chronic back pn not controlled (illegible) 7/d pain ills no 10/325 (illegible) 2 to unreliability/(illegible)"
July 25	"appears a little 'off'" (illegible)	"behavior is (illegible); pill use out of control; pt has P/H of not accepting wife control of pills; pt try to maintain control over pill, pt needs to (illegible)"
July 27	Calm lucid relaxed (illegible)	"seem better HPB (illegible) chronic back pn disability due to back pn entering new school"
August 3	None	None
August 18	"walks well mild LS tender SLR – mild"	None
September 11	None	"seem very happy with school (illegible) HPB not chronic back pn very stiff"
October 3	None	"chronic low (illegible)HBP (illegible) with Rx"
October 30	None	"gained wt BP good ↑hydrocodone/APAP (14 /d) (illegible) tramadol, gabapentin to control back pn"
November 20	(illegible)	"HBP (illegible) control chronic back pn (illegible)"
December 11	None	"Baptist church seem (illegible)"

88. During 2006, the Respondent prescribed hydrocodone/APAP 10/325 and 7.5/325, Gabapentin, and Tramadol to Patient C.F. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at three different pharmacies.

89. In January, March, April and May of 2006, Patient C.F. continued to see Dr. Hussaini at the pain clinic and continued to receive prescriptions for morphine from him.

90. On June 8, 2006, Dr. Hussaini sent a letter to Patient C.F. discharging him from his care and advising that he will no longer receive any more prescriptions because of dishonesty regarding his drug use and a urine screen which was positive for the presence of benzodiazepines. A copy was sent to the Respondent.

91. In a letter dated June 27, 2006 to the Respondent, the Wisconsin DHS wrote to the Respondent advising that Patient C.F. had been receiving hydrocodone/acetaminophen and hydrocodone/ibuprofen prescriptions and filling them at five different pharmacies. The DHS representative expressed concern that the patient was possibly forging prescriptions or having multiple prescriptions authorized at various pharmacies and that the Respondent was encouraged to contact the pharmacies.

92. On July 25, 2006, a urine screen was performed at the Respondent's office and revealed faintly positive results for the presence of benzodiazepines and anti-depressants, which were not being prescribed by the Respondent.

93. On July 25, 2006, Patient C.F. presented to the Respondent at which time the Respondent noted that the patient was "out of 7.5/325 used #120 in few days?", apparently referencing hydrocodone/APAP 7.5/325. On that date, the Respondent telephoned the pharmacist at the Pharmacy Shoppe and noted that in the last three months, Patient C.F. had been prescribed Lorazepam and Wellbutrin by Dr. Luck, morphine sulfate by Dr. Hussaini, and hydrocodone by Dr. DeMirciogli. He further noted that the Lorazepam had been prescribed since April of 2006 and the morphine had been prescribed since December of 2005.

94. During the course of his treatment of Patient C.F. in 2006, the Respondent's medical charting for Patient C.F. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

95. The Respondent's conduct in 2006 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications prescribed; the Respondent continued to prescribe pain medications in the face of contraindications to their use in that he was aware that Patient C.F. had been discharged from Dr. Hussaini's care for dishonesty regarding his drug use, had a drug screen at St. Francis Hospital which was positive for the presence of benzodiazepines and that Patient C.F. had been receiving prescription pain medications, benzodiazepines and anti-depressants from other physicians for months during the same time that the Respondent had been treating him.

2007 Treatment Summary

96. In the year 2007, Patient C.F. presented to the Respondent for re-check on five dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date of service	Objective/Physical exam findings	Diagnosis(es)/Impression
January 16	"alert looks fine moves well (illegible)" abd bal (illegible) SLR (illegible)	"(illegible) severe HBP – (illegible) chronic pn"; "HBP (illegible); chronic low back pn in school – doing well on career path with school"
March 2	None	"still (illegible) large dose pn Rx potentially (illegible) life benefit to"
April 11	"exam stable BP 130/86 moves (illegible)"	"chronic low back (illegible) pain control; HBP(illegible)"
August 20	"moves well looks good focused – (illegible)"	"chronic low back pn, new career to begin, HBP – nice control, smoke 1ppd – slowly ↓ing, dyslipidemia – (illegible)"

October 16	"(illegible)"	"seem stable"

97. During 2007, the Respondent prescribed hydrocodone/APAP 10/325, Gabapentin, Carisoprodol, Cyclobenzaprine, buprenorphine and Tramadol to Patient C.F. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at four different pharmacies.

98. Carisoprodol is a centrally-acting skeletal muscle relaxant used to relax muscles and relieve pain associated with muscle injuries.

99. Cyclobenziprine is muscle relaxanthttp://en.wikipedia.org/wiki/Muscle_relaxant used to relieve muscle spasms and pain associated with musculoskeletal conditions.

100. On April 13, 2007, the Respondent started Patient C.F. on buprenorphine by subcutaneous injection. He did not see or evaluate the patient on that date and no justification is provided for the change and/or increase in medication by adding buprenorphine.

101. On November 16, 2007, labs were drawn which revealed that Patient C.F.'s liver function tests were abnormal, including a GGT level of 72 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

102. During the course of his treatment of Patient C.F. in 2007, the Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

103. The Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; and the diagnoses do not justify the pain medications prescribed; the Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and the Respondent continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

2008 Treatment Summary

104. In the year 2008, Patient C.F. presented to the Respondent for re-check on ten dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date of service	Objective/Physical exam findings	Diagnosis(es)/Impression
February 1	"looks good (illegible) HEENT (illegible)abd legs"	"chronic LS back pn (illegible) HBP dyslipid"
May 28	"looks good (illegible)"	"chronic low back pn dyslipid HBP – controlled (illegible)"
July 24	"color good mid (illegible) alert (illegible)"	"chronic low back pn, altered mental function lately – seem (illegible) better

		now (illegible) LFT (illegible) pt cannot be trusted to manage his own Rx"
August 15	None	None
August 28	"(illegible) pasty complexion (illegible)"	"?flu (illegible) nausea lab pend hepatitis"
September 26	"pale not toxic HEENT (illegible)"	"prob pneumonia RLL (illegible) non progress, BP Rx to stay (illegible) usual problem, lab pen"
October 1	"still to BS (illegible)"	"prob (illegible) pneumonia cont 100% R/O (illegible) used 7d pain pills in 6 d"
November 12	"alert – looks (illegible) H/F/N (illegible)"	"syncope (illegible)"
November 13	None	"some confusion poss concussion"
November 17	None	"mentally clear now (illegible) OK to RTW"

105. During 2008, the Respondent prescribed hydrocodone/APAP 10/325, hydrocodone/ibuprofen, Gabapentin, Cyclobenzaprine, buprenorphine and Tramadol to Patient C.F. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at four different pharmacies.

106. On March 2, 2008, the Respondent noted in Patient C.F.'s medical record that the patient called asking for 18 tablets of hydrocodone/APAP 10/325 daily. The local pharmacy had advised that it was not willing to fill that prescription. The Respondent called in a prescription to the pharmacy for 180 tablets of the hydrocodone/APAP which was to be a 10 day supply. The Respondent's file reflects that "The pharmacist was not too upset about this" and that the pharmacist "accepted the prescription." A dose of 18 tablets of hydrocodone/APAP 10/325 contains 5.85 g of acetaminophen. The Respondent prescribed an excessive amount of acetaminophen, exceeding the recommended daily maximum limit of 4 g of acetaminophen.

107. On August 15, 2008, Patient C.F. advised the Respondent that he had purchased some Lorazepam.

108. Lorazepam is high potency benzodiazepine used to relieve short-term anxiety.

109. On July 22, 2008, labs were drawn which revealed that Patient C.F.'s liver function tests were abnormal, including a GGT level of 112 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

110. On August 28, 2008, labs were drawn which revealed that Patient C.F.'s liver function tests were abnormal, including a GGT level of 66 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

111. On November 13, 2008, labs were drawn which revealed that Patient C.F.'s liver function tests were abnormal, including a GGT level of 97 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

112. During the course of his treatment of Patient C.F. in 2008, the Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

113. The Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; the Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; the Respondent continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test; and the Respondent inappropriately continued to prescribe pain medications to the patient in face of contraindications to their use in that he was aware the patient was purchasing Lorazepam off the street.

2009 Treatment Summary

114. In the year 2009, Patient C.F. presented to the Respondent for re-check on nine dates. On those dates, the Respondent documented the following physical exam findings and medical diagnoses in the patient's record:

Date of service	Objective/Physical exam findings	Diagnosis(es)/Impression
March 4	None	"chronic back pn (illegible) HBP (illegible) control"
April 15	(illegible)	"chronic back pn still (illegible) HBP (illegible)"
May 26	"looks good (illegible)"	"HBP (illegible) control chronic back pn"
July 17	Fourteen objective measures are checked off including overall appearance, mood, thought, toxicity, neuro impairment, head neck, arms, lungs, chest, heart, abs, legs and ankle/feet and three hand drawn diagrams	"chronic back pn – stable take 18/d. hydro/APAP HBP fair control still (illegible) still out of (illegible) with (illegible)"
August 4	(illegible)	None
August 26	"look good moves (illegible) a little (illegible) H/F/N/ (illegible)"	"(illegible prescribed (illegible) only with assistance of (illegible) wants to (illegible)"
September 23	(illegible)	"seem calm (illegible) back pn controlled with Rx (illegible)Rx (illegible) smoking a little using Nicotine patch 21 mg/d. HBP nice control"
October 21	None	"chronic back pn (illegible) HBP ↑"
December 16	"looks fine (illegible)"	"BP too high chronic low back pn (illegible LS spinal (illegible) ½ ppd (illegible)"

115. During 2009, the Respondent prescribed hydrocodone/APAP 10/325, hydrocodone/ibuprofen, Gabapentin, Carisoprodol, Cyclobenzaprine, buprenorphine and Tramadol to Patient C.F. The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent. Those prescriptions were to be filled at six different pharmacies.

116. On March 4, 2009, labs were drawn which revealed that Patient C.F.'s liver function tests were abnormal, including a GGT level of 85 U/L (the normal range is 7-64 U/L). The Respondent inappropriately continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

117. On July 17, 2009, the Respondent noted that Patient C.F. was taking 126 tablets of hydrocodone every 7-8 days. His impression included a notation that the patient was taking 18 tablets of hydrocodone/APAP per day and he recommended continuing the same prescriptions. This is the equivalent of approximately 6 g (325 mg x 18 tabs) of acetaminophen a day which is in excess of the accepted maximum daily level of acetaminophen, which is 4 g.

118. On July 30, 2009, Patient C.F. was admitted to St. Francis hospital where he was diagnosed with renal failure.

119. On August 4, 2009, the Respondent noted that he spoke with a pharmacist and authorized the continued prescription of 126 tablets of hydrocodone/APAP 10/325 every 7 days (18 tablets per day). This is the equivalent of approximately 6 g (325 mg x 18 tabs) of acetaminophen a day which is in excess of the accepted maximum daily level of acetaminophen, which is 4 g.

120. Patient C.F. had been a patient of the Respondent for many years during which time the Respondent never ordered any imaging studies with regard to the diagnosis of chronic low back pain.

121. At no time during the period of treatment from January of 2005 through December of 2009 did the Respondent ever refer Patient C.F. to a pain management specialist despite the fact that he consistently prescribed large amounts of pain medications for his chronic low back pain and despite the fact that there were a number indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

122. During the course of his treatment of Patient C.F. in 2009, the Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

123. The Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; the Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; and he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; the Respondent failed to order any imaging studies from 2005 through 2009; the Respondent failed to refer the patient to a pain management specialist; and the Respondent inappropriately continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level in the presence of abnormal liver function tests and a hospitalization for renal failure.

125. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 72-123 above, has committed 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).

126. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 72-123 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ALLEGATIONS RELATING TO 09 MED 143 (Patient T.S.)

2008 Treatment Summary

127. On July 16, 2008, Patient T.S. presented to the Respondent for an initial appointment with a complaint of mid-back pain. The Respondent did not perform or document a physical exam, did not obtain a complete medical history and did not develop a plan of treatment. He diagnosed Patient T.S. with mid back pain and noted that her "picture has a fibromyalgia-like quality." He noted Patient T.S. was previously taking Percocet provided by another physician. The Respondent prescribed hydrocodone/APAP 10/325, #60, 1 - 1 ½ every six hours as needed for pain (two refills). The amounts and frequency of those prescriptions and refills are summarized in the prescription chart maintained by the Respondent.

128. On July 21, 2008, Patient T.S. presented to the Respondent. The Respondent did not perform or document a physical exam and did not note a diagnosis. He prescribed hydrocodone/APAP 10/325, #100 for eight days, 1 – 2 ½ every six hours (two refills) to be filled at Pick N Save pharmacy and hydrocodone/APAP 10/325, #50, 1 – 2 every six hours as needed for pain, to be filled at Walgreens pharmacy.

129. On August 12, 2008, Patient T.S. presented to the Respondent with complaints that she cannot afford her current residence and of pain in and around her spine. The objective findings regarding Patient T.S.'s back are illegible. The Respondent diagnosed her with back pain which could be fibromyalgia. The Respondent prescribed hydrocodone/APAP 10/325, #120, 1 – 2 every four hours as needed for pain (two refills).

130. On September 4, 2008, Patient T.S. presented to the Respondent. The Respondent did not perform or document a physical exam. He diagnosed Patient T.S. with fibromyalgia. The Respondent prescribed hydrocodone/APAP 10/325, #120, 1 -2 every 4 hours as needed for pain (two refills).

131. On September 10, 2008, Patient T.S. reported to the Respondent that she lost her purse and her prescription. The Respondent authorized another prescription and noted that she would need to provide a police report. No police reports are found in the Respondent's records.

132. On October 24, 2008, Patient T.S. requested an early refill of her hydrocodone/APAP which the Respondent authorized with three refills.

133. On November 4, 2008, Patient T.S. presented to the Respondent with complaints of back pain made worse by standing. The Respondent did not note any physical exam findings, and his impression and recommendations are illegible.

134. On November 10, 2008, the Respondent received a letter from the Wisconsin Drug Utilization Review (DUR) Project. The drug utilization review of Patient T.S.'s medication use showed that this patient may be taking more than 4 grams of acetaminophen per day, which may cause hepatoxicity. The letter asked the Respondent to voluntarily respond to this information including any action taken by him. There is no response contained in the file from the Respondent.

135. On November 23, 2008, Patient T.S. called the Respondent and discussed overuse and getting an early refill.

136. On December 12, 2008, without having an appointment with Patient T.S., the Respondent prescribed hydrocodone/APAP 10/325, #120, 1 – 3 every 4 hours as needed (four refills).

137. During 2008, Patient T.S. filled her prescriptions at six different pharmacies.

138. During the course of his treatment of Patient T.S. in 2008, the Respondent's medical charting for Patient T.S. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

139. The Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the Respondent's initial evaluation of Patient T.S. on July 16, 2008 contained no physical exam findings to support his diagnosis of back pain with fibromyalgia-like quality; the remainder of physical exams documented by the Respondent are insufficient and do not support the diagnosis of fibromyalgia; the diagnosis of fibromyalgia does not justify the pain medications; and the Respondent continued to prescribe pain medications in the face of contraindications to their use (early refills, stolen medication prescriptions with no supporting police reports, concerns about overuse).

2009 Treatment Summary

140. On January 8, 2009, Patient T.S. presented to the Respondent for a re-check and complained that both shoulders hurt. The Respondent's objective findings consisted of "looks fine, H/F/N illegible." The Respondent subcutaneously injected Patient T.S. with buprenorphine in the right anterior abdominal wall and Patient T.S. assisted in pushing the plunger. Blood chemistry tests on this date revealed mildly hyperglycemic results. The Respondent prescribed buprenorphine (injectible) #20, 1 cc every eight hours (four refills); hydrocodone/ibuprofen 7.5/200, #80, 1 – 2 every 8 hours (four refills); and hydrocodone/APAP 10/325, #170 for 7 days, 1 – 2 every four hours (four refills).

141. On February 2, 2009, Patient presented to the Respondent with no documented complaints. The Respondent noted only the following objective finding: "looks fine." The Respondent's impression was largely illegible but he noted that recent labs were normal in spite of the high dose of hydrocodone/APAP. The Respondent prescribed hydrocodone/APAP 10/325, #72 (four refills).

142. On March 30, 2009, Patient T.S. presented to the Respondent with a complaint of personal issues. The Respondent's objective findings were "looks good, calm." Blood chemistry tests on this date revealed mildly hyperglycemic results. The Respondent failed to address the mildly hyperglycemic test results with Patient T.S. on either this date or from January of 2009. He diagnosed her with "(illegible) fibromyalgia." He prescribed Tramadol 50 mg, #120 (three refills).

143. On May 1, 2009, the Respondent received a letter from the State of Wisconsin Department of Health Services. The Wisconsin ForwardHealth drug utilization review of Patient T.S.'s

medication use showed that she obtained up to 1.8 times the maximum recommended daily dose for hydrocodone/acetaminophen during a 6-month review period. Patient T.S.'s prescriptions in this period were attributed to three physicians and were filled at seven different pharmacies. The letter asked the Respondent to respond to this information including any action taken by him. There is no response contained in the file from the Respondent.

144. On May 28, 2009, Patient T.S. presented to the Respondent reporting that she was taking 12-15 hydrocodone/APAP tablets per day. The Respondent drew several diagrams in the chart but does not document any other apparent physical exam findings. His impression was "doing well on current Rx, fibromyalgia, most pain is upper back." The Respondent prescribed Tramadol 50 mg, #120 for 14 days, 1 – 2 every four hours (six refills); hydrocodone/APAP 10/325, #126 for 7 days, 1 – 3 every 4 – 6 hours as needed, (5 refills); and buprenorphine (injectible) #40 for 7 days (five refills).

145. On July 24, 2009, the Respondent received a letter from the Wisconsin Drug Utilization Review Project (DUR). The letter was sent in response to a recent review of drug claims for Patient T.S. The letter expressed concern that Patient T.S. may be taking more than four grams of acetaminophen per day, which may cause hepatoxicity. The letter asked the Respondent to review and evaluate Patient T.S.'s drug therapy and voluntarily provide a reaction to the letter to DUR. There is no response contained in the file from the Respondent.

146. On September 1, 2009, Patient T.S. presented to the Respondent for a check-up and refills. No physical exam findings are noted. The Respondent's legible impressions were that she seemed to be stable and was a "picture of innocence." He prescribed Tramadol 50 mg, #120 for 15 days, 1 – 2 four times daily (five refills) and hydrocodone/APAP 10/325, #126 for 7 days (four refills).

147. On September 4, 2009, the Respondent received a copy of a toxicology report from Columbia St. Mary's in Milwaukee for Patient T.S. The report indicated that her urine drug screen was positive for the presence of cocaine and marijuana. The test results also show that Patient T.S.'s urine tested negative for opiates. The Respondent sent Patient T.S. a copy of her urine drug screen results that same day with a note that read "Dear Tina, You are a master at appearing sincere and innocent. You have 10 days to come in for an appointment."

148. On October 6, 2009, the Respondent received a letter from a pharmacist expressing concern that Patient T.S. is exceeding the recommended 4000 mg (4 g) acetaminophen intake as she is taking 18 tablets a day totaling 6000 mg. The pharmacist recommended that the Respondent reduce future prescriptions to #84 to last 7 days, which would keep Patient T.S. at the 4000 mg Tylenol limit.

149. On December 18, 2009, without an appointment, the Respondent prescribed Patient T.S. Tramadol 50 mg, #120, 1 – 2 every 4 hours (five refills) and hydrocodone/APAP 10/325, #126, 1 – 3 every 4 – 6 hours as needed.

150. During 2009, Patient T.S. filled her prescriptions at six different pharmacies.

151. During the course of his treatment of Patient T.S. in 2009, the Respondent's medical charting for Patient T.S. is partially illegible and incomplete, and he failed to document that he warned Patient T.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

152. The Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not

support the diagnosis of fibromyalgia; the diagnosis of fibromyalgia does not justify the pain medications; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; he continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level of 4 g; he failed to address the patient's mildly hyperglycemic test results; and the Respondent continued to prescribe pain medications in the face of contraindications to their use (drug screen positive for presence of marijuana and cocaine and concerns from pharmacists and state agencies regarding toxic levels of acetaminophen being prescribed).

2010 Treatment Summary

153. On January 4, 2010, Patient T.S. presented to the Respondent for a re-check. The Respondent conducted a physical exam and noted Patient T.S. had "extremely good ROM in her head neck and arms"; had "no back tenderness"; and the review of systems were all negative. His impression was chronic upper back pain. The Respondent prescribed hydrocodone/APAP 10/325, #126 for 10 days, 1 – 2 every 4 hours (five refills); buprenorphine, #40 for 10 days, every 6 hours as needed (five refills); and Tramadol 50 mg, #80, 1 – 2 every 6 hours as needed (five refills).

154. On May 13, 2010, Patient T.S. presented to the Respondent for a check-up and refill request with complaints of pain in the lower and mid back. The Respondent noted that Patient T.S. is getting good to excellent pain relief and overall feels fine and is happy with current prescription of hydrocodone and buprenorphine. The Respondent discussed Patient T.S.'s misuse of buprenorphine and notes that she knows the danger and has pledged that she quit. The remainder of treatment plan notes are illegible.

155. On June 23, 2010, Patient T.S. presented to the Respondent for a re-check. The Respondent's physical exam notes and treatment plan are largely illegible. The patient reported taking at least 15 tablets of hydrocodone/APAP 10/325 a day. He noted that the patient's liver function test results from May 13, 2010 were "good" on that date despite the fact that her GGT level was 40 U/L when the normal range is 9-36 U/L. The Respondent noted fibromyalgia as his impression and prescribed an increase in hydrocodone/APAP due to Buprenex not being available. The high dose combination of analgesics amounts to approximately 5 g (325 mg x 15 tablets) of acetaminophen a day which is in excess of the accepted maximum daily level of acetaminophen, which is 4 g.

156. During the course of his treatment of Patient T.S. in 2010, the Respondent's medical charting for Patient T.S. is partially illegible and incomplete, and he failed to document that he warned Patient T.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

157. The Respondent's conduct in 2010 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnosis of chronic back pain; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and he continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level of 4 g in the presence of an abnormal liver function test.

158. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 127-157 above, has committed 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).

159. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 127-157 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ALLEGATIONS RELATING TO 09 MED 142 (Patient P.S.)

2007 Treatment Summary

160. On August 14, 2007, Patient P.S. presented to the Respondent for an initial appointment seeking pain management. Patient P.S. completed a medical history worksheet in which he informed the Respondent that he had been in prison for burglary, had a cocaine habit, had an ulcer and hiatal hernia, and had an artificial stomach causing chronic pain, for which he was previously taking Percocet. The Respondent's primary impression was abdominal pain status post "prosthestic gastric device which is unremovable source of chronic pain." He prescribed hydrocodone/APAP 10/325. The amounts and frequency of prescriptions and refills are summarized in the prescription chart maintained by the Respondent.

161. On September 5, 2007, Patient P.S. presented to a gastroenterologist for evaluation upon referral from the Respondent for epigastric abdominal pain, history of peptic ulcer disease status post gastric bypass surgery. In his letter report to the Respondent on this date in which he summarizes his evaluation and treatment plan, the gastroenterologist's differential diagnosis included gastritis, esophagitis, peptic ulcer disease, versus other etiologies. There is no mention of a gastric prosthesis.

162. On September 11, 2007, Patient P.S. presented to the Respondent with no complaints. The Respondent prescribed hydrocodone/APAP 10/325 and Tramadol 50 mg.

163. On November 9, 2007, Patient P.S. presented to the Respondent reporting he needed to increase his dosage of hydrocodone and Tylenol #4 in order to get relief. The Respondent's objective findings included an indication that he palpated a gastric prosthesis, but the remaining objective findings are illegible. The results of Patient P.S.'s blood chemistry test revealed a GGT level of 265 U/L (normal range is 7 – 64 U/L). The Respondent prescribed Tramadol 50 mg and hydrocodone/APAP 10/500.

164. During the course of his treatment of Patient P.S. in 2007, the Respondent's medical charting for Patient P.S. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

165. The Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical exams documented by the Respondent are insufficient and do not support the diagnosis of a gastric prosthesis (the gastroenterologist only noted a history of gastric bypass); he prescribed pain medications containing acetaminophen in the presence of an abnormal liver function test on November 9, 2007; and the Respondent prescribed opioid pain medications in the face of contraindications to their use (criminal background with history of substance abuse).

2008 Treatment Summary

166. On January 9, 2008, Patient P.S. presented to the Respondent for a medication refill and with complaints of stomach pain, insomnia and dyspnea issues. The Respondent's objective and impression notes are illegible, and he did not list any recommendations or a treatment plan. The Respondent prescribed hydrocodone/APAP 10/500, Zolpidem Tartrate 10 mg, and Carisoprodol 350 mg.

167. Zolpidem Tartrate is a sedative-hypnotic used primarily to treat insomnia, and a Schedule IV Controlled Substance pursuant to Wis. Stat. § 961.20(2)(p).

168. On January 30, 2008, Patient P.S. presented to the Respondent for a re-check. Patient P.S.'s record shows no patient complaints, no physical exam, no assessment and no treatment plan. The Respondent prescribed Tylenol #4.

169. Tylenol #4 is a combination of codeine and acetaminophen, and is a Schedule II controlled substance pursuant to Wis. Stat. § 961.16(2)(a)4.

170. On April 7, 2008, Patient P.S. presented to the Respondent complaining he is constantly in pain. The Respondent did not perform a physical exam or document any physical exam findings. The Respondent prescribed Tramadol 50 mg.

171. On April 29, 2008, Patient P.S. presented to the Respondent. Patient P.S.'s complaint, and the Respondent's objective, impression and recommendation notes are illegible.

172. On June 20, 2008, Patient PS presented to the Respondent with complaints of back pain while he sleeps. The Respondent noted Patient P.S. is alert, but the remainder of his objective notes are illegible.

173. On July 1, 2008, Patient P.S. presented to the Respondent with the complaint that his overall energy is not better, but he feels decent and has decent pain control. The Respondent's objective and assessment notes are largely illegible. Patient P.S. admitted that he had been giving some of his hydrocodone/APAP and Tylenol #4 to a friend. The next day, the Respondent prescribed hydrocodone/APAP 10/325, #180 (four refills).

174. On November 26, 2008, Patient P.S. presented to the Respondent complaining of chronic abdominal pain and inadequate pain control. The Respondent does not perform a physical exam. He gave Patient P.S. an injection of buprenorphine in his abdominal wall on that date and gave him a prescription for buprenorphine (injectible).

175. During the course of his treatment of Patient P.S. in 2008, the Respondent's medical charting for Patient P.S. is partially illegible and incomplete, and he failed to document that he warned Patient P.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

176. The Respondent's conduct in 2008 was below the minimum standards for the profession in that the following ways: he prescribed multiple analgesics concurrently including hydrocodone/APAP, Tramadol, buprenorphine, Carisoprodol and Zolpidem and continued to prescribe opioid pain medications in the face of contraindications to their use (sharing medications with others).

2009 Treatment Summary

177. On January 15, 2009, Patient P.S. presented to the Respondent. The Respondent referenced a "he said/she said" situation with a friend of Patient P.S. and that Patient P.S. denied prescription trafficking. The Respondent noted that he would review a fax sent to his office by D.P. at the next visit with Patient P.S. The fax at issue contained two signed agreements in which Patient P.S. verifies that he owed D.P. money and that he also owed D.G. "50 pills" and "130 pills."

178. On March 13, 2009, Patient P.S. presented to the Respondent. He did not record any discussion regarding the agreement to give D.G. pills and did not perform or document a physical exam notes. The Respondent prescribed hydrocodone/APAP 10/325, #180 (four refills) on that date and continued to prescribe Tramadol, buprenorphine, hydrocodone/APAP, acetaminophen with codeine (Tylenol #4), and Zolpidem from March through December of 2009.

179. On May 29, 2009, the Respondent received notification that the Wisconsin ForwardHealth program conducted a drug utilization review of Patient P.S.'s medications during a six month period. The review showed that prescriptions the Respondent wrote included significant quantities of Buprenex 0.3 mg/ml ampoules, hydrocodone with acetaminophen, acetaminophen with codeine, and Tramadol. Recent diagnoses submitted did not provide clear indication for these drugs. The Respondent was asked to provide an update of diagnoses. No response was provided.

180. On June 11, 2009, based on the acetaminophen with codeine prescription from June 9, 2009, the Respondent received a message from Walgreens pharmacy that said, "Why did you prescribe T4? He is taking 5850 mg APAP and 180 mg Hydrocodone (3 times limit) daily. Also pt said you were d/c the T4. Even if you are monitoring liver, pt might be noncompliant/diverting meds. Please advise on T4."

181. On June 16, 2009, the Respondent received notification from the Wisconsin Drug Utilization Review (DUR) project informing him that they reviewed medication records for Patient P.S. Patient P.S.'s drug profile indicated that this patient may have been taking more than 4 grams of acetaminophen per day, which may cause hepatotoxicity. The letter asked the Respondent to provide a reaction to this letter. No response was provided.

182. On July 6, 2009, Patient P.S. presented to the Respondent. The Respondent's complaint notes and impression are illegible.

183. On July 22, 2009, the Respondent received a message from Walgreens pharmacy regarding an early refill request on buprenorphine by Patient P.S.

184. On September 28, 2009, the Respondent received a message from Walgreens pharmacy regarding a buprenorphine prescription he wrote for Patient P.S. The message said "Per review of current literature, there is no data regarding SQ administration of Buprenex. Would you consider ordering the IM route of administration instead? If so, the dose could than be lowered and yet be more therapeutic." The Respondent replied "Would you like to give yourself IM? This works well subcutaneously. The reason he needs a lot is he is P.S. I've used this drug 10 years – never given it IM; always subcut. All narcotics are well absorbed subcut." The Respondent later replied "On further reflection: Your thought, however deserves a test. I'll discuss it with him next visit. The pain of IM may make him use less. I can't dismiss your thought even though my clinical experience says otherwise."

185. During the course of his treatment of Patient P.S. in 2009, the Respondent's medical charting for Patient P.S. is partially illegible and incomplete, and he failed to document that he warned Patient P.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

186. The Respondent's conduct in 2009 was below the minimum standards for the profession in that the following ways: he prescribed multiple analgesics concurrently including hydrocodone/APAP, Tramadol, buprenorphine, Carisoprodol and Zolpidem; continued to prescribe pain medications

containing acetaminophen in excess of the accepted maximum daily level of 4 g; and continued to prescribe opioid pain medications in the face of contraindications to their use (sharing medications with others; requests for early refills; and concerns by state agencies and pharmacists regarding his prescribing practices).

187. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 160-186 above, has committed 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).

188. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 160-186 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ALLEGATIONS RELATING TO 09 MED 142 (Patient L.U.)

189. On April 4, 2007, Patient L.U. presented to the Respondent reporting with ongoing sciatica since 2004. Patient L.U.'s current medications were oxycodone and Oxycontin. The only legible exam findings noted were that the patient walked best holding a walking stick, was able to get up on the table and had mild diaphoresis. The results of Patient P.S.'s blood chemistry test revealed a GGT level of 66 U/L (normal range is 7 – 64 U/L). The Respondent diagnosed Patient L.U. with chronic low back pain and "huge use of narcotics." The Respondent prescribed hydrocodone/APAP 10 /325, #200, 1 – 2 every 4 hours as needed (two refills). The amounts and frequency of prescriptions and refills are summarized in the prescription chart maintained by the Respondent.

190. On April 23, 2007, Patient L.U. presented to the Respondent with a complaint of a panic attack. The Respondent's objective findings and impression are illegible. The Respondent prescribed Lorazepem 1 mg, #90, 1 – 2 every 8 hours as needed (two refills).

191. Between May 18, 2007 and June 17, 2008, Patient L.U. did not follow up with the Respondent.

192. On June 17, 2008, Patient L.U. called the Respondent and requested a prescription for hydrocodone until he can see the Respondent for an appointment. The Respondent noted, "Can't get MD locally to Rx hydrocodone/APAP—everyone seems afraid—all referring to pain specialist." Without seeing or evaluating Patient L.U., the Respondent prescribed hydrocodone/APAP 10 /325, #150, 1 – 2 every 6 hours as needed (two refills).

193. On July 5, 2008, Patient L.U. called the Respondent and reported that he lost his pills while camping in upper Wisconsin "boundary waters." The next day, without seeing or evaluating the patient, the Respondent prescribed hydrocodone/APAP 10/325, #150 to last 12 days, 1 – 2 every 4 hours (two refills).

194. On July 25, 2008, Patient L.U. called the Respondent and reported he had tripped over a tractor and had aggressive pain. He requested a refill 3 ½ days early of #150. The Respondent called the pharmacy and authorized the early refill, without seeing or evaluating the patient.

195. On November 20, 2008, Walgreens sent a fax to the Respondent that read, "Please review medication history. He comes in every other day for meds. Is it possible to treat [Patient L.U.] so we do

not have to see him so frequently? He requests many early refills and now his Buprenex only lasts 2 days. Walgreens. We need to figure out a better treatment option for [Patient L.U.]."

196. On November 24, 2008, the Respondent noted in Patient L.U.'s record: "open (illegible) discussed re: letter. Will leave this as is for now. (Illegible) for relief/recent trauma." The Respondent prescribed Buprenex 0.3 mg, #60 for 3 days, 1 – 2 every 4 hours (2 refills) without seeing or evaluating the patient.

197. On December 12, 2008, the Respondent authorized a 1-day early refill of hydrocodone and Buprenex.

198. On January 11, 2009, Patient L.U. called the Respondent and discussed that he is using 20 vials/day (buprenorphine). On this same day, Patient L.U. filled the following prescriptions: Tramadol HCL 50 mg, #30 for 4 days, prescribed by SH, D.O.; hydrocodone/APAP 10/325, #180; and Burprenex 0.3 mg/mL, Ampul #60 for 5 days.

199. On March 23, 2009, Patient L.U. presented to the Respondent reporting he is out of Vicodin and he recently was in the emergency room in Shawano, Wisconsin. Patient L.U. admitted to occasional marijuana use. The Respondent's objective findings are illegible. His impression was chronic back pain and dental pain. The Respondent prescribed hydrocodone/APAP 10/325, #180, and Lorazepam 1 mg, #100.

200. Three days later, on March 26, 2009, the Respondent prescribed hydrocodone/APAP 10/325, #90, 1 – 2 every 3 hours (three refills). This prescription was to be filled at a different pharmacy than the one used on March 23, 2009.

201. On June 1, 2009, Patient L.U. filed a police report for burglary of his home in Gresham, Wisconsin, claiming that on May 30, 2009 all his medications were stolen. Patient L.U. told police he cleaned up everything that could have been evidence. The police report noted there was no sign of a forced entry. Patient L.U. told the police that he had to file a report so he could get new meds.

202. On April 30, 2010, Patient L.U. presented to the Respondent for follow-up. Patient L.U. told the Respondent that he lost his pills and shots en route to his appointment by leaving a bag on top of his car and driving off. The Respondent told him to bring in some evidence.

203. During the course of his treatment of Patient L.U. in 2007 - 2009, the Respondent's medical charting for Patient L.U. is partially illegible and incomplete, and he failed to document that he warned Patient L.U. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

204. The Respondent's conduct in 2007 - 2009 was below the minimum standards for the profession in that the following ways: he prescribed pain medications to the patient without conducting an adequate physical exam; the physical exams documented by the Respondent are insufficient and do not support the diagnosis of chronic back pain; he prescribed hydrocodone/APAP in the presence of an abnormal liver function test on April 4, 2007; he prescribed additional hydrocodone/APAP only three days after giving the patient a prescription for 180 tablets of hydrocodone/APAP; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and he prescribed opioid pain medications in the face of contraindications to their use (multiple reports of stolen and lost medications; large gaps in treatment; reports by Patient L.U. of marijuana use; requests for early refills).

205. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 189-204 above, has committed 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).

206. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Adm. Code § MED 10.21, as set out above in paragraphs 189-204 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ALLEGATIONS RELATING TO 09 MED 081 (Patient N.C.)

2008 Treatment Summary

207. On October 22, 2008, Patient N.C. presented to the Respondent for an initial appointment seeking treatment for his back. Notably, the spelling of the last name that Patient N.C. used to sign into the office that day did not match the spelling of the name on his driver's license. He reported a back injury in July of 2006 work incident. The Respondent did not perform or document a physical exam of Patient N.C. He diagnosed him with chronic low back pain and prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every six hours (two refills). The amounts and frequency of prescriptions and refills are summarized in the prescription chart maintained by the Respondent.

208. On November 12, 2008, Patient N.C. next presented to the Respondent at which time the Respondent did not perform or document a physical exam. He diagnosed him with "chronic back pain" and prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every six hours (four refills).

209. During the course of his treatment of Patient N.C. in 2008, the Respondent's medical charting for Patient N.C. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

210. The Respondent's conduct in 2008 was below the minimum standards for the profession in that the following ways: he failed to perform or document any physical exams before prescribing hydrocodone/APAP 10/325 and he prescribed opioid pain medications in the face of contraindications to their use (using an apparent alias on the sign-in sheet on his first visit).

2009 Treatment Summary

211. On January 8, 2009, Patient N.C. next presented to the Respondent at which time the Respondent did not perform or document a physical exam. The patient advised he was taking 2-4 hydrocodone/APAP 10/325 tablets at a time. He diagnosed him with "significant untreated HBP" and prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every six hours (four refills).

212. On January 29, 2009, Patient N.C. next presented to the Respondent at which time the patient advised he was also seeing Dr. Murphy who had been prescribing morphine to him since 2008 and that Dr. Murphy did not know that Patient N.C. was seeing the Respondent. The Respondent did not perform or document a physical exam and did not indicate a diagnosis, but prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every 3-4 hours (four refills).

213. On February 23, 2009, the Respondent received one refill authorization request from the Wal-Mart Pharmacy in Delafield on which the pharmacist wrote "He has many aliases, goes to multiple

MDs & pharmacies" and "we will not fill for him or A.J. any longer" and another refill request which advised that the patient received hydrocodone/APAP 7.5/325, #210, at another Walgreens from Dr. Murphy.

214. On February 7, 23 and March 26, 2009, the Respondent gave Patient N.C. prescriptions for more hydrocodone/APAP 10/325 without seeing or evaluating the patient.

215. On April 30, 2009, Patient N.C. next presented to the Respondent. The Respondent did not perform or document a physical exam but documented an impression of chronic pain in his spine. His impression also included the following note: "sneaky, greasy beyond belief – even our staff feels contaminated in dealing with this pt" and "character/personality disorder." His recommendation was "no early refills under any circumstances." The Respondent prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every 4 hours (three refills).

216. On May 22, 2009, Patient N.C. next presented to the Respondent at which time the Respondent finally performed a physical exam. The objective findings included "minimally toxic, (illegible), HEENT (illegible)". His impression was chronic back pain and he prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every 4 hours (four refills).

217. On June 23 and August 6, 2009, the Respondent gave Patient N.C. prescriptions for more hydrocodone/APAP 10/325 without seeing or evaluating the patient.

218. On September 16, 2009, Patient N.C. last presented to the Respondent at which time the Respondent failed to perform or document a physical exam. He diagnosed chronic back pain and he prescribed hydrocodone/APAP 10/325, #100, 1-2 tablets every 4 hours (five refills).

219. During the course of his treatment of Patient N.C. in 2009, the Respondent's medical charting for Patient N.C. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3).

220. The Respondent's conduct in 2009 was below the minimum standards for the profession in that the following ways: the physical exams documented by the Respondent are insufficient and do not support the diagnosis of chronic back pain and he prescribed opioid pain medications in the face of contraindications to their use (seeing multiple physicians for pain medications; using aliases in obtaining prescriptions).

221. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 207-220 above, has committed 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).

222. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 207-220 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. §§ 448.02(3).

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).

4. Pursuant to Wis. Stat. § 448.02(3)(c), the Medical Examining Board has authority to "revoke, limit, or suspend" a person's medical license, if it finds a person guilty of "unprofessional conduct or negligence in treatment."

5. Wis. Admin. Code § MED 10.02(2)(h) defines "unprofessional conduct," to include "[a]ny practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public."

6. Wis. Admin. Code § MED 10.02(2)(za) further defines "unprofessional conduct," to include, "failing to maintain patient health care records consistent with the requirements of Wis. Admin. Code § Med 21.03."

7. Pursuant to Wis. Admin. Code § MED 21.03(2), the minimum standards for maintaining patient health care records require that a patient health care record prepared by a physician "... contain the following clinical health care information *which applies* to the patient's medical condition:

(a) Pertinent Patient history.

(b) Pertinent objective findings related to examination and test results.

(c) Assessment or diagnosis.

(d) Plan of treatment of the patient.

8. Pursuant to Wis. Admin. Code § MED 21.03(3), the patient health care record entry shall be sufficiently legible to allow interpretation by other practitioners for the benefit of the patient.

9. Respondent, by engaging in conduct that tends to constitute a risk of harm to Patients P.K., C.F., T.S., P.S., L.U., and N.C., as stipulated to above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02(2)(h), and is thus subject to discipline pursuant to Wis. Stat. § 448.02(3). (June 9, 2011, Amended Stipulation of Complainant and Respondent (reproduced in this decision's Findings of Fact), ¶¶ 70, 125, 158, 187, 205, 221).

10. Respondent's medical charting for Patients P.K., C.F., T.S., P.S., L.U., and N.C. is partially illegible and incomplete, in violation of Wis. Admin. Code §§ Med 21.03(2) and (3). By failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as stipulated to above, Respondent has committed unprofessional conduct, as defined by Wis. Admin. Code § 10.02(2)(za), and is thus subject to discipline pursuant to Wis. Stat. § 448.02(3). (Amended Stipulation of Complainant and Respondent, (reproduced in this decision's Findings of Fact), ¶¶ 71, 126, 159, 188, 206, 222).

DISCUSSION

Because Respondent has stipulated to all facts and rule violations alleged by the Division in their Complaint, admitting that he: (1) engaged in practice or conduct which tended to constitute a danger to the health, welfare, or safety of patients or the public in his treatment of patients P.K., C.F., T.S., P.S., L.U., and N.C., in violation of Wis. Admin. Code § Med 10.02(2)(h); and (2) failed to maintain patient health care records consistent with the requirements of Wis. Admin. Code § Med. 21.03 for patients P.K., C.F., T.S., P.S., L.U., and N.C., in violation of Wis. Admin. Code § 10.02(2)(za)[2], the only question that remains for review is what sort of discipline is appropriate in light of Respondent's violations

Appropriate Discipline

The Division argues that, in light of the above-stipulated facts and violations of law, the only appropriate discipline is revocation of Respondent's medical license. (Complainant's Final Argument, p. 30, *et. al.*; Tr. p. 14, ll. 13-19, p. 51, ll. 22-24).

In support of this recommendation, the Division points to the three purposes of discipline as identified in *Galang v. State Medical Examining Board*, 168 Wis.2d 695, 700484 N.W.2d 375, 377 (Wis. App. 1992) – rehabilitation, protection of the public, and deterrence of other licensees from engaging in similar conduct – and notes that:

(1) The conduct which is alleged (and, indeed, stipulated) to have posed a risk of harm to patients P.K., C.F., T.S., P.S., L.U., and N.C. was not isolated either in time or to a particular patient, but spans over the course of five years and involved all six patients. (Complainant's Final Argument, p. 21).

(2) Respondent's conduct with respect to the above patients was excessively dangerous in that "there is ample evidence in the medical records that Patients P.K., C.F., T.S., P.S. and L.U. had issues with drug abuse, addiction or diversion[3], and yet, Respondent continued to prescribe controlled substances to them "indiscriminately," posing a risk of overdose, (and in the case of patients P.K., and P.S., who admittedly shared their prescription pain killers with others[4], of the drugs falling into the hands of persons with allergies, or children). (*See* Complainant's Final Argument, pp. 27-29, 33, Tr. p. 47, ll. 7-14).[5]

(3) Patient P.K., (of whom Respondent was aware had gone through at least one detox program[6]), testified, without any apparent challenge, that just prior to reporting to a jail term[7], she called Respondent and asked for prescription pain medications because she wanted to have a "last hurrah"

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[2] *See* Amended Stipulation of Complainant and Respondent, as reproduced in this decision's Findings of Fact, (hereinafter "Amended Stipulation/Findings of Fact"), particularly ¶¶ 70, 71, 125, 126, 158, 159, 187, 188, 205, 206, 221, and 222; *see also* Transcript of June 13, 2011 Hearing, p. 6, l. 22 – p. 8, l. 16).

[3] *See* Amended Stipulation/Findings of Facts, above, particularly ¶¶ 69, and 121.

[4] *See* Stipulation of Facts/Findings of Fact, ¶ 46, 173, 177.

[5] Respondent further stipulated that he prescribed excessive amount of acetaminophen to these patients, in the face of abnormal liver tests, and after a number of state agencies and pharmacists warned him that he was prescribing at excessive levels, which could be toxic to his patients. (*See* Complainant's Final Argument pp. 25-26; Amended Stipulation/Findings of Fact ¶¶ 19, 26, 29, 48, 53, 101, 103, 106, 109, 110, 111, 113, 116, 117, 119, 124, 134, 145, 148, 152, 155, 157, 165, 180, 181, 186).

[6] *See* Amended Stipulation/Findings of Fact, ¶ 56.

[7] The reason for this patient's jail sentence is unknown to this ALJ.

before jail, and Respondent honored her request.[8] (*See* Complainant's Final Argument, p. 29, (citing May 25, 2011 Deposition Transcript of P.A.K.). *See also* Tr. pp. 8-9, 32, 42-44; Joint Ex. 1-A (Medical Records for Patient P.K. for 2011)).

(4) The Medical Examining Board has twice before disciplined Respondent for unprofessional conduct in his prescription of controlled substances[9], but despite having his license suspended, limited with respect to prescribing narcotics and reprimanded, and taking at least 30 continuing medical education credits in the area of prescribing narcotics[10], he has failed to rehabilitate his practices and/or be deterred from prescribing controlled substances "indiscriminately," (Tr. pp. 48-49, Final Argument, pp. 2-34), and

(5) Most concerning of all, Respondent (a) was intentionally directing patients P.K., C.F., T.S., P.S., L.U. and N.C. to multiple pharmacies to get their prescriptions filled[11], and (b) had patient P.K. write a note in her medical record prohibiting government agencies from obtaining her medical records[12], showing that he knew that what he was doing was wrong. (Complainant's Final Argument, p. 32 (citing Tr. p. 36. *See also* Joint Exhibit 1, Medical Records for Patient P.K., pp. 132-143; Joint Ex. 2, Medical records for Patient C.F., pp. 66-75; Joint Exhibit 3, Medical Records for Patient T.S., pp. 31-32; Joint Ex. 4, Medical Records for Patient P.S., pp. 67-69; Joint Ex. 5, Medical Records for Patient L.U., pp. 28-30; Joint Ex. 6, p. 30, Medical Records for Patient N.C.; and State's Exhibit 3, Deposition Transcript of P.A.K., pp. 13-14); Tr. p. 50, ll. 4-25).

In light of the above, the Division argues that the only way to protect the public from Respondent Greenman is to revoke his medical license. (Tr. p. 51, ll. 22-24). In fact, it points out that in a case very factually similar to the instant one[13], the Medical Examining Board revoked the physician's license for the same conduct that Respondent engaged in with regard to the six patients at issue in the instant case. (Complainant's Final Argument pp. 30-31, (*citing In re Disciplinary Proceedings Against Dr. Philip Mussari*, LS9009272MEB); *see also* Tr. pp. 53-54). While the Division notes that the administrative law judge assigned to the above case initially recommended only an indefinite suspension of doctor's license, it underscores that the Board subsequently ordered that the doctor's license be revoked based on the facts that he (1) had intentionally sent the patient to different pharmacies so as not to cause suspicion and (2) tried to prevent government officials, from obtaining copies of the patient's

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[8] The Division presented further testimony from Patient P.K. that she would call Respondent (on his cell phone) complaining of withdrawal symptoms, and he would give her a prescription for more pain medications. (*See* State's Exhibit 3. (Deposition Transcript of P.A.K., p. 9, ll. 2-14, pp. 14-15).

[9] Once for attempting to "wean" a patient, and known addict, off of Tussionex by prescribing said medication for an excessive period of time, while at the same time, failing to monitor said patient to ensure that he would not develop respiratory depression from his concurrent prescriptions of Tussionex and Valium (State's Exhibit 1, DOE Case # 86 MED 475; *see also* Amended Stipulation/Findings of Fact ¶ 3), and once for prescribing several different pain killers and other controlled substances to a patient under circumstances where he did not document any physical or neurological examinations despite the fact that said patient complained of migraine headaches, while at the same time failing to discover the extent to which she was obtaining controlled substances from multiple other practitioners (State's Exhibit 2, DOE case # 93 MED 059; *see also* Amended Stipulation/Findings of Fact, ¶ 5).

[10] *See* State's Exhibits 1 and 2, Orders of Discipline in 86MED475 and 93MED59; Amended Stipulation/Findings of Fact ¶¶ 3-5.

[11] *See* Amended Stipulation/Findings of Fact ¶¶ 17, 21, 30, 31, 33, 35, 41, 52, 64, 74, 88, 91, 97, 105, 115, 128, 137, 143, 150, 200).

[12] *See* Amended Stipulation, Findings of Fact, ¶ 59, (identifying that Respondent did this because "he knew he was overprescribing and did want her records to be released.").

[13] Respondent physician was found to have (1) repeatedly prescribed controlled substances to a patient who claimed to have a brain lesion causing without making an adequate diagnosis, without performing any diagnostic test, and without obtaining prior treatment records or consulting with prior treaters, and (2) failed to maintain adequate health care records with respect to said patient.

medical records. (Complainant's Final Argument, p. 31; *see also In re Disciplinary Proceedings Against Dr. Philip Mussari*). As Respondent Greenman also engaged in both the above practices, the Division alleges that "the only differences between the violations by the Respondent and Dr. Mussari is that the Respondent's conduct extends to multiple patients and is more aggravated in the unquestioning and dangerous compliance with patient requests of pain medications." (Complainant's Final Argument at p. 32).

For his part, Respondent argues that while he realizes that he "failed to perform the duties of a minimally competent physician," in failing to keep adequate records for, and aberrantly prescribing Schedule III narcotics (CIIIN) to patients P.K., C.F., T.S., P.S., L.U., and N.C, in light of all the valuable services he has provided his patients with for the last 34 years – and the fact that his treatment did not, ultimately, harm any of them, outright revocation of his medical license is not appropriate. (*See generally*, Exhibit 113, Respondent's Statement for June 13, 2011, Hearing, (*read into the record at* Tr. p. 20-27); Respondent's Final Argument, pp. 1-2; Respondent's Recommended Proposed Decision and Order, pp. 1-2, Tr. pp. 54-59).

In support of this argument, Respondent points to: (1) the affidavits of three of (former) patients, (Affidavits of A.M., J.C. and S.G.), all of whom contest that they were extremely satisfied with Respondent's treatment of their pain, and did not suffer any adverse health problems, physical or mental, as a result of his treatment[14]; (2) his curriculum vitae (Exhibit 106); and (3) his unsubstantiated, yet unchallenged, claims that that there is no record of any malpractice suit against him that was successful, and that "voluminous amounts" of the patients he treated were not treated for pain management or anxiety issues. (Respondent's Final Argument, pp. 1-2; *see also* Tr. p. 43, ll. 15-24, p. 55, ll. 5-9, p. 58, ll. 2-4; Respondent's Exhibit 113, List of Patient Names).[15]

Respondent further explains that his shortcomings with respect to records keeping and aberrant prescribing of narcotics were merely the result of added time burdens, his inability to prescribe Schedule II narcotics, (which controls pain in lower dosages and does not contain acetaminophen), and his sincere compassion for his patients' pain – many of whom had been rejected by the rest of the medical community. (Respondent's Exhibit 113, Statement for Hearing June 13, 2011; Tr. pp. 21-27, p. 56). Respondent argues that both practices can be rectified by proper education. (Final Argument, p. 3).

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[14] Interestingly, these patients' affidavits further note that as a result of Respondent's current license suspension, they have suffered increased pain and other withdrawal symptoms, and that other doctors who they have seen with respect to their pain since Respondent have not been as willing to prescribe the pain medications Respondent was prescribing, rendering support that Respondent was "aberrantly prescribing," to these patients as well.

[15] To the extent that Respondent also attempted to present evidence that: (1) "five ... of the patients, other than P.K., [whose care is at issue in these proceedings] came to his first hearing and wanted to testify on his behalf about how helpful he had been for them," (Respondent's Final Argument, p. 2); (2) Patient N.C. did testify regarding Respondent's treatment of him at that hearing, and in light of his testimony, the Division's expert (Dr. Rudin) testified that he could not say that Respondent's conduct failed to meet the minimum standards of conduct with respect to him (Respondent's Final Argument, p. 2-3; Recommended Proposed Decision and Order, p. 1, Tr. p. 44, ll. 4-18); and (3) one "Dr. Shewczyk" testified to a reasonable degree of medical certainty that outright revocation would not be appropriate for the Respondent's conduct (Respondent's Final Argument, p. 2, Tr. p. 44, l. 19 0 p. 45, l. 8); such is not supported by the record, and thus, was not considered by the ALJ. Indeed, Respondent's only support for the above statements lies in non-cited references to what the ALJ can only imagine was the show-cause hearing on the Division's summary suspension of Respondent's license, a proceeding she – and the Division of Hearings and Appeals – was not involved in, and to which she had no access to the record of. This fact was made known to both parties many times during the litigation of this case. (*See i.e.*, Tr., p. 38). Moreover, said testimony contradicts the Amended Stipulation of the Complainant and Respondent.

Finally, without citing any sources of law, he avers that revocation is a discipline reserved for more serious infractions than his, such as inappropriate relationships with patients, sexual intercourse with a child, inappropriate treatment resulting in death, severe physical and/or mental illness on the part of doctors, health care fraud, and outright selling of pain pills. (Respondent's Final Argument p. 3). With respect to the Division's discussion of the *Mussari* case (LS9009272MEB), he notes that that "while he does not have full access to the facts of that case," he "seems to remember, Dr. Mussari's conduct was worse than that of the Respondent," (Respondent's Final Argument, p. 3; Respondent's Recommended Proposed Decision, p. 2; *see also* Tr. p. 55, ll. 15-19). In any event, her emphasizes that this case should be decided on its own individual merits. (Respondent's Final Argument, p. 3).

In light of all the above, Respondent, (again, without citing any sources of law), argues that it makes more sense in light of public policy for the Medical Examining Board to restrict his license, limit his prescribing rights and order continued education, than to revoke it, so that may continue to provide valuable service to those who need it. (*See generally,* Respondent's Final Argument and Recommended Proposed Decision and Order, Tr. pp. 54-59).

Despite Respondent's failure to support many of his statements, both parties' arguments are valid. On the one hand, Respondent has continuingly failed in the area of prescribing narcotics, and in the instant case, prescribed them in the face of contraindications to their use, evidence that patients were demonstrating symptoms of drug addiction and/or abuse, and in the presence of abnormal liver function tests. On other hand, Respondent does (or at least did) treat many patients for non-pain issues, and thus may be of some use to profession and community.

If this case had been Respondent's first offense, or was it not obvious that Respondent knew that his prescribing was excessive, and tried to hide that fact, the ALJ may have considered merely limiting Respondent's license so that he would no longer be able to prescribe controlled substances. The ALJ understands that Respondent has many patients who do not have pain issues that he may have been providing valuable services for.

However, the facts that: (1) Respondent's "aberrant prescribing," extended to at least six patients over the course of five years); (2) Respondent failed to learn and/or employ proper prescribing techniques after two previous disciplinary actions, and (3) Respondent obviously understood that what he was doing was wrong, all lead the ALJ to agree with Division that revocation is necessary to protect public from future misconduct by Dr. Greenman, and from others so inclined to conduct themselves as he did. Respondent's actions in continuously prescribing narcotics and other controlled substances to six different patients, despite the numerous contraindications noted in their records, and to the point of at least one patient becoming an admitted addict, evince the opposite of "compassion." As the Medical Examining Board found in *Mussari*, such conduct further "reflects problems of a more serious nature involving his abilities to make rational decisions and exercise good judgment." *See id.* Thus, in the interest of public protection, Respondent's license must be revoked at this time.

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;
7) Any other relevant circumstances

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

Respondent Greenman cooperated in these proceedings – he has stipulated to all facts, and only contests the discipline recommended by the Division.

At the same time, Respondent's stipulated conduct is egregious, there is no evidence that the Division investigated any claims unnecessarily, this is not Respondent's first disciplinary proceeding, and his own argument in support of his recommended discipline was difficult to follow in light of its many deficiencies (*see supra*). Balancing all these factors with the fact that the Department of Safety and Professional Services is a "program revenue" agency, the administrative law judge finds that Respondent should only pay all of the costs associated in investigating and prosecuting this matter.

ORDER

For the reasons set forth above, IT IS ORDERED that, effective the date of this Order, the license of Respondent Steven B. Greenman, M.D. to practice medicine in the state of Wisconsin is REVOKED.

Should Respondent Greenman undertake and successfully complete reformative action on his own initiative, he is of course entitled to seek reinstatement of his medical license. Until he is able to demonstrate such reformation, however, he must be prohibited from the further practice of medicine in this state.

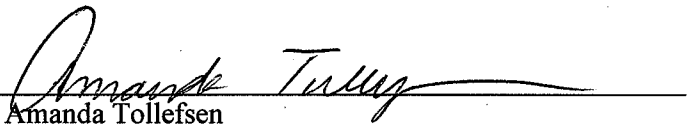
IT IS FURTHER ORDERED that Respondent shall pay all of the recoverable costs in this matter, in an amount to be established pursuant to Wis. Admin. Code § RL 2.18, After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

Department Monitor
Department of Safety and Professional Services
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935
Telephone: (608) 267-3817
Fax: (608) 266-2264

IT IS FURTHER ORDERED that the above matter be and is hereby closed with respect to Respondent Steven B. Greenman.

Dated at Madison, Wisconsin on September 7, 2011.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 
Amanda Tollefsen
Administrative Law Judge

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