WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."
  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
JOHN W. INGALLS, M.D., RESPONDENT.	:	ORDER 0001043

[Division of Enforcement Case No. 08MED358]

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

John W. Ingalls, M.D.
Ingalls Family Medicine Clinic
7456 Main Street
Webster, WI 54893

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

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

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Medical Examining Board. The Board has reviewed this Stipulation and considers it acceptable.

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

FINDINGS OF FACT

1. John W. Ingalls, M.D., Respondent, date of birth September 22, 1958, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the state of Wisconsin, pursuant to license number 31328-20, which was first granted July 1, 1990.

2. Respondent's address on record with the Department of Regulation and Licensing is Ingalls Family Medicine Clinic, 7456 Main Street, Webster, WI 54893.

3. Respondent's practice specialty is family practice; Respondent is not certified by any Board recognized by the American Board of Medical Specialties.

4. At the time of the events set out below, Respondent owned, and was employed as a supervising physician at, Ingalls Family Medicine Clinic in Webster, Wisconsin.

5. Patient SM, while receiving residential treatment for alcoholism in December, 2006 and January, 2007, learned that he was a diabetic. On January 23, 2007, after his AODA treatment, Patient SM presented to Respondent for followup care. SM's patient health care record included Respondent's discussion with SM about SM's substance abuse history and his use of alcohol and marijuana. Him

6. On June 7, 2007, Patient SM returned to Respondent's clinic and saw an APNP. Patient SM, for the first time, complained of pain associated with diabetic neuropathy. The APNP prescribed a hydrocodone product. The APNP failed to attempt pain relief with a non-opioid medication, nor was there a patient opioid agreement or other means of setting forth consequences of noncompliance with medical orders.

7. According to Respondent, an opioid agreement was going to be signed when they found the medication that best controlled Patient SM's pain. Respondent signed the medical record for June 7, 2007, thereby approving the care provided and assuming responsibility for its contents.

8. Between June 2007 and December 2008, Respondent and his staff wrote and/or approved prescriptions as follows:

a. Between June 2007 – June 2008, 18 prescriptions for hydrocodone/APAP 5 mg/500 mg, 15-60 tablets;
b. Between June 2008 – December 2008, 7 prescriptions for hydrocodone/APAP, 7.5 mg/500 mg, 45-120 tablets;
c. 2 prescriptions for tramadol;
d. 6 prescriptions for oxycodone;
e. 1 prescription for fentanyl;
f. 1 prescription for propoxyphene.

9. Patient SM admitted using quantities greater than the prescribed dose. Respondent and his staff failed to see Patient SM on a regular basis to monitor compliance, to discuss pain, evaluate functional objectives, or assess treatment progress. Respondent conducted no toxicology screening. Respondent nevertheless approved refills of Patient SM's opioid prescriptions, despite Patient SM's non-compliance with the APNP's orders and without regular visits to the clinic.

10. On August 8, 2008, Patient SM had received a prescription from the APNP for fentanyl 50 mcg patch, #10, to last 30 days, 1 patch to skin every 72 hours. Later in August 2008, Patient SM presented to Burnett Medical Center because he had overdosed on fentanyl. Patient SM put the patch in his mouth, he said, because after 6 hours of wear, the patch would

not adhere to skin. Patient SM had also obtained opioids from another source, without Respondent's knowledge.

11. After the overdose, Respondent continued prescribing opioids to Patient SM.

12. In July 2008, Respondent ordered an EMG that objectively documented the presence of neuropathy. Neuropathy can present itself as numbness—not being able to feel what other would typically feel on the feet or legs--combined with a deeper neurological pain that is frequently difficult to treat. Opioids are frequently ineffective for this kind of pain; SSRI's, tricyclics, and selected anticonvulsants are often effective, and should be attempted first, for this kind of pain. At no time did Respondent attempt a trial course of any of these medications for this patient.

13. Respondent viewed Patient SM as a problematic patient because he was non-compliant in following up with scheduled appointments and referrals. Respondent indicates that Patient SM frequently called demanding pain medications before arranged refill dates. Patient SM had serious financial and social issues that interfered with his care. At the same time, Respondent believes his overall management of SM's care was exceptional under the circumstances.

14. It was Respondent's duty to insure that pain medications were appropriately prescribed to SM for diabetic neuropathy and to follow Patient SM's progress.

15. As a result of the Department's investigation, Respondent represents to the Board him that he and his staff reviewed prescribing practices and management of short and long term opioid use among their patients. Respondent represents to the Board him that he identified areas that needed improvement and implemented new procedures, including improved record keeping.

16. The standard of care requires that physicians view effective pain assessment and management, which may include the use of opioid analgesics, as part of quality medical care for all patients with pain, including patients with a history of drug abuse. Because opioid analgesics are subject to abuse by individuals who seek them for mood altering effects, a standard of care requires that physicians who prescribe these drugs shall incorporate established safeguards into their practices to minimize the potential for their diversion and abuse.

17. Respondent's care of SM fell below the standard of care when, following a opioid overdose, Respondent failed to respond appropriately to SM's history of chemical dependency, failed to document all prescriptions in the patient health care record, failed to consider opioid treatment options, failed to assess SM's compliance through toxicology testing, failed to require a opioid use agreement (or other means of setting forth recognition and agreement of consequences of noncompliance), and failed to establish goals of improved functioning.

18. Respondent's conduct as set forth above created an unacceptable risk that Patient SM would overdose and/or use opioid pain medications for reasons other than pain relief, and that Patient SM would not have adequate pain relief.

CONCLUSIONS OF LAW

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

B. Respondent's prescribing of opioid medications, as described above, constitutes a danger to the health, safety and welfare of the patient and public, and constitutes unprofessional conduct as defined by Wis. Admin. Code § MED 10.02(2)(h).

C. Respondent's failure to provide competent care in the treatment of Patient SM's diabetic neuropathy constitutes unprofessional conduct as defined by Wis. Admin. Code § MED 10.02(2)(h).

D. Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

IT IS HEREBY ORDERED that Respondent, John W. Ingalls, M.D., is REPRIMANDED.

IT IS FURTHER ORDERED that Respondent's license to practice medicine and surgery is hereby LIMITED and restricted as set forth in Wis. Stat. § 448.02(3)(e), and as follows:

1. On or before December 31, 2011, Respondent shall provide proof sufficient to the Board or its designee, of Respondent's satisfactory completion of the following courses, which must first be preapproved by the Board or its designee, except as otherwise indicated:

   a. The Intensive Course in Controlled Substance Management (including the pre-test, post-test, reflective essay and post-reflective essay), a 39 credit program being offered December 6-9, 2011 by Case Western Reserve University School of Medicine. Respondent may, with prior approval of the Board or its designate, take a course that is deemed by the Board or its designee to be substantially equivalent to the course described above.
   b. Not less than 6 hours of continuing medical education on legal requirements of patient health care records. Respondent shall obtain preapproval of the course from the Board or its designee. Said course may be in any format acceptable to the Board or its designee, including but not limited to webinar and/or live lecture.

2. Respondent is responsible for paying the full cost of attending the courses. Respondent is prohibited from applying any of the hours of education completed in satisfaction of this Order toward satisfaction of otherwise required biennial continuing education.

3. Unless and until Respondent completes the education required above to the Board's satisfaction, Respondent shall not prescribe opioids, including tramadol, to any patient for a total of more than 30 days in any 365 day period, except as otherwise authorized, in advance, by the Board or its designee.

4. Respondent shall, for every patient for whom he prescribes opioid medications, do all of the following, with documentation in the patient health care record:

a. A treatment plan that includes: functional goals; re-evaluation to assess whether continuation of the medication is justified; use of non-opioid adjuvants; and expert consultation/referrals;
b. Maintain an accurate drug log for each patient, to be documented within 72 hours of patient contact;
c. Obtain a detailed patient history, to include: diagnostic studies, relevant consultation; past recreational drug use, substance abuse, detoxification therapies.
d. Establish informed consent for opioid use to insure a single prescriber, the use of a single pharmacy, the use of periodic toxicology screening, pill counts, consultation with persons close to the patient to obtain collateral information, and delineation of inappropriate behaviors that will result in the termination of opioid therapy or the therapeutic relationship.

5. Respondent shall practice only under the supervision of a designated Professional Mentor approved by the Board or in a work setting pre-approved by the Board or its designated agent.

a. Respondent shall obtain a Professional Mentor acceptable to the Board. The Professional Mentor shall be the individual responsible for reviewing Respondent's practice of medicine and surgery during the time this Order is in effect. A Professional Mentor shall have no prior or current business or personal relationship with Respondent, or other relationship the could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Department (including but not limited to any bartering relationship, mutual referral of patients, etc.). A Professional Mentor shall be actively practicing in Respondent's field of practice, hold a valid Wisconsin license, shall be board certified by an ABMS-recognized board in a specialty relevant to Respondent's field of practice, and shall have read this Final Decision & Order and agree to be Respondent's Professional Mentor.
b. Supervision shall include weekly meetings, review of charts selected by the Professional Mentor, and any other actions deemed appropriate by the Professional Mentor to determine that Respondent is practicing in a professional and competent manner. The Professional Mentor may designate another qualified physician or other health care provider acceptable to the Board to exercise the duties and

responsibilities of the Professional Mentor in an absence of more than three weeks. In the event that the Professional Mentor is unable or unwilling to continue to serve as Respondent's professional mentor, the Board may in its sole discretion select a successor Professional Mentor.

c. The Professional Mentor shall have no duty or liability to any patient or third party, and the Mentor's sole duty is to the Board.

d. Respondent shall arrange for his Professional Mentor to provide formal written reports to the Department Monitor in the Department of Regulation and Licensing, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin 53708-8935 on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance.

e. Respondent's Professional Mentor shall immediately report to the Department Monitor and the Respondent's Supervising Health Care Provider any conduct or condition of the Respondent which may constitute unprofessional conduct, a violation of this Order, or a danger to the public or patient.

f. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order, including any failures of the Professional Mentor to conform to the terms and conditions of this Order.

6. If Respondent is unable to complete the courses described because of illness or other circumstance found to be acceptable by the Board or its designee, Respondent shall, prior to the required completion date, petition for a reasonable extension of time within which to complete the course or an equivalent course. Respondent is advised, if possible, to allow at least 60 days for processing of extension requests.

IT IS FURTHER ORDERED that Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing the costs of this proceeding in the amount of $2,200.00 pursuant to Wis. Stat. § 440.22(2).

IT IS FURTHER ORDERED that all payments, requests and evidence of completion of the education required by this Order shall be mailed, faxed or delivered to:

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

IT IS FURTHER ORDERED that violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered or fails to comply with the ordered continuing education as set forth above, the

Respondent's license (No. 31328-20) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

Him IT IS FURTHER ORDERED that this Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: Skailer MD MBA
A Member of the Board

August 17, 2011
Date

akt
i:\ingalls.stp.doc