## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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# STATE OF WISCONSIN BEFORE THE DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

IN THE MATTER OF THE DISCIPLINARY :

PROCEEDINGS AGAINST

FINAL DECISION AND ORDER

RONALD J. GAMMON, RESPONDENT.

ORDER 0001169

#### Division of Enforcement Case # 10 RSA 014

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

Ronald J. Gammon W246N5950 Grouse Court Sussex, WI 53089

Division of Enforcement Department of Safety and Professional Services 1400 East Washington Avenue P.O. Box 8935 Madison, WI 53708-8935

Department of Safety and Professional Services 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 Department of Safety and Professional Services (Department). The Department has reviewed this Stipulation and considers it acceptable.

Accordingly, the Department adopts the attached Stipulation and makes the following:

#### FINDINGS OF FACT

1. Ronald J. Gammon, ("Respondent") was born on October 19, 1970, and is certified by the Department of Regulation and Licensing as a Clinical Substance Abuse Counselor in the state of Wisconsin, pursuant to certificate number 2136-132 which was first granted on April 3, 1998. Respondent is also certified as an Intermediate Clinical Supervisor in the state of Wisconsin, pursuant to certificate number 12102-134 which was first granted on June 27, 2001.

- 2. Respondent's last known address reported to the Department of Regulation and Licensing is W246N5950 Grouse Court, Sussex, WI 53089.
- 3. Respondent was an alcohol and other drug abuse ("AODA") counselor employed as an independent contractor at the Mary Determan MSW, LLC Clinic ("Determan Clinic"). Respondent is not a psychologist.
- 4. Respondent provided AODA therapy and counseling to a seventeen year old female patient, Patient A, from December of 2009 through March of 2010. Patient A was in treatment for opiate use, and was currently using 320mg of OxyContin a day.
- 5. On March 22, 2010, PZ, a Licensed Clinical Social Worker and a Clinical Substance Abuse Counselor, was supervising MSW Intern LD complete an assessment on Patient A. During this therapy session, when PZ and MSW Intern LD recommended referring Patient A to a psychiatrist so that Patient A could obtain a prescription order for Suboxone, Patient A told PZ and MSW Intern LD that for the last two weeks, Respondent was already prescribing her Suboxone. Suboxone is prescribed to help reduce the withdrawal symptoms when patients are being detoxed from the use of opiates.
- 6. Patient A saw Respondent three times a week to obtain Suboxone from Respondent. Respondent would give Patient A Suboxone from a prescription bottle that he maintained in his office. Patient A confirmed that she had not met with a doctor, that she was not being medically managed, and that she was unaware of the exact dosage she was receiving. Patient A believed the pills of Suboxone that Respondent dispensed to her were between 4mg and 8mg.
- 7. MSW Intern LD also noted that Patient A believed she was taking a total dosage of 12 mg of Suboxone daily. Patient A would take 4mg to 8mg in the morning and 4mg at night. Patient A reported that some of her withdrawal symptoms had been reduced, but that they had not been stopped completely. PZ and MSW Intern LD suggested that Patient A cancel her next visit with Respondent, but Patient A was hesitant because she feared running out of Suboxone before she began treatment with a psychologist.
- 8. Patient A reported that Respondent gave her the prescription medications Suboxone, Vicodin, and Clonidine without a prescription.
- 9. Respondent also would make inappropriate comments to Patient A such as "so when do you turn eighteen?" and "just get rid of your boyfriend".
- 10. Another female, Patient B, reported that on June 1, 2010, Respondent gave her four tablets of Diazepam from what appeared to be his own supply and some of his "blood pressure medication" to help Patient B sleep. Respondent suggested to Patient B that she obtain a prescription order from her doctor. Patient B later saw her doctor, and her doctor refused to prescribe any Diazepam for her.

- 11. After the reports from patient's A and B surfaced, an internal investigation of Respondent's practice at the Determan Clinic discovered that Respondent had been seeing clinic patients and calling in prescription orders to pharmacies under the name of the clinic's medical director, Dr. A. Dr. A has never seen the patients, did not authorize the prescription orders, and did not authorize Respondent to call in any prescription orders for those patients. Over fifty patients have received these types of prescription orders from Respondent, but no patient medical records were created documenting any of them.
- 12. A pharmacy contacted the Determan Clinic for authorization to refill a prescription for Diazepam for Respondent that Dr. A had allegedly prescribed. Dr. A never prescribed this medication for Respondent. According to receipts in the clinic, Respondent was also taking a Hydrocodone product, but Dr. A has no idea how this product was prescribed to Respondent or how Respondent obtained it. Respondent was terminated from the Determan Clinic.

#### **CONCLUSIONS OF LAW**

- 1. The Wisconsin Department of Safety and Professional Services has jurisdiction over this matter pursuant to Wis. Stat. § 440.88(6) and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).
- 2. Respondent, by the conduct set out above, violated laws and rules substantially related to practice as a substance abuse professional, which is defined as unprofessional conduct by Wis. Admin. Code § RL 164.01(2)(b), and is subject to discipline pursuant to Wis. Stat. § 440.88(6).
- 3. Respondent, by the conduct set out above in paragraphs 5 through 11, performed services for which Respondent was not qualified for by education, training, or experience, which is defined as unprofessional conduct by Wis. Admin. Code § RL 164.01(2)(f), and is subject to discipline pursuant to Wis. Stat. § 440.88(6).
- 4. Respondent, by the conduct set out above in paragraphs 8, 9, and 10, failed to avoid a dual relationship that could impair his objectivity and create a conflict of interest, which is defined as unprofessional conduct by Wis. Admin. Code § RL 164.01(2)(n) and is subject to discipline pursuant to Wis. Stat. § 440.88(6).

#### <u>ORDER</u>

### NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The VOLUNTARY SURRENDER of Respondent's certificate and right to renew his certificate as both a Clinical Substance Abuse Counselor (license number 2136-131) and an Intermediate Clinical Supervisor (license number 12102-134) is ACCEPTED, effective immediately.

2. Within fourteen (14) days of the effective date of this Order, Respondent shall deliver the original certificates of his Clinical Substance Abuse Counselor certificate and his Intermediate Clinical Supervisor certificate to the Department Monitor at the address below:

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

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

### DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

By: **(1)** (1)

Michael J. Berndt, General Counsel

On behalf of the Department