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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
CLIFFORD T. BOWE, M.D., RESPONDENT.	:	ORDER 0001360

Division of Enforcement Case No. 09MED033

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

Clifford T. Bowe, M.D.
P.O. Box 69
Cadott, WI 54727

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

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

PROCEDURAL HISTORY

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

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

FINDINGS OF FACT

1. Clifford T. Bowe, M.D., Respondent (D.O.B. June 10, 1933), 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 13372-20, which was first granted on July 30, 1959.

2. Respondent's last address reported to the Department of Safety and Professional

Services is P.O. Box 69, Cadott, Wisconsin 54727.

ALLEGATIONS RELATING TO PATIENT B.H.

3. On May 28, 2005, Respondent initially evaluated and treated Patient B.H. at L.E. Phillips Libertas Center (L.E. Phillips") in Chippewa Falls. This Treatment Center is affiliated with St. Joseph's Hospital but is a separate rehab and detox unit for treating patients with chemical dependency. On May 28, 2005, the patient's primary complaint was having taken an excess dose of Methadone. Patient B.H.'s history was significant for use of Lortab and OxyContin, being in a Methadone program, chronic anxiety, depression, post traumatic stress disorder ("PTSD"), history of motor vehicle accidents with back and neck injuries, alcohol use, and prior use of Adderall, Percocet and morphine. She also had been in drug treatment on two prior occasions. Respondent diagnosed her with opioid dependency, opioid withdrawal, attention deficient disorder, migraine history, post traumatic stress disorder and chronic depression. His plan was to start her on Suboxone. Respondent discharged her on May 31, 2005, to be treated on an outpatient basis at his office.

4. On August 10, 2005, Patient B.H. reported to Respondent that she had increased her Suboxone dose on her own which gave her a "little high" and that she then stole a check and forged it to use at the drug store. Respondent advised her to return to L.E. Phillips for a relapse assessment and treatment. Respondent's plan was to start Suboxone treatment for Patient B.H.

5. Seven months later, on March 14, 2006, Patient B.H. next presented to Respondent with symptoms of anxiety, craving, restlessness, muscle aches, and hot/cold flashes. He diagnosed her with opioid dependence and withdrawal and prescribed Suboxone.

6. Suboxone is an opioid (narcotic) partial agonist-antagonist used to treat opioid dependence and should be used as part of a complete narcotic dependence treatment plan. It is a Schedule III Controlled Substance pursuant to Wis. Stat. § 961.18, and has habit-forming potential. Respondent has a special DEA number for prescribing Suboxone as part of a narcotic dependence treatment program.

7. On April 18, 2006, Respondent had Patient B.H. sign a "Consent to Treatment with Seboxone" (sic) agreement which provided that two or more aberrations will result in total patient reassessment and medication restriction. The list of aberrations included the following: missed appointment, missed monthly drug screen, loss of Suboxone for any reason, new legal problems, and getting prescriptions filled before previous prescription has been used up.

8. About eleven months later, on March 8, 2007, Patient B.H. was admitted to L.E. Phillips for a relapse on opioids and reported taking 20-30 tablets of Lortab a day. She additionally reported a whiplash injury from the previous month and that she had used marijuana, OxyContin, Oxycodone and methamphetamine. He diagnosed her with opioid dependence, marijuana abuse, alcohol abuse, acute depression and occipital cervical strain. The patient was also seen in consultation by a different physician who diagnosed panic anxiety, depression, and whiplash pain. Respondent started the patient on Gabapentin and Buspar. Patient B.H. was discharged on March 16, 2007 with Clonidine, Hydroxyzine, Suboxone and

acetaminophen for headache.

9. Clonidine is an alpha agonist used to treat high blood pressure. It is also used by addiction specialists to treat opioid withdrawal. Respondent states he prescribed Clonidine to treat her opioid withdrawal, not to treat high blood pressure.

10. On April 10, 2007, Patient B.H. presented to Respondent at his clinic requesting to go on Methadone because the Suboxone was not providing results. His diagnoses on that date included chronic lumbar pain even though he did not document any physical examination findings that day. He prescribed Oxycodone (twelve tablets, a three day supply) and Methadone (to be filled on April 14, 2007).

11. Oxycodone is a narcotic and non-steroidal anti-inflammatory combination used to treat short term, moderate to severe pain and is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential. Respondent states that he prescribed a three-day supply of Oxycondone to this patient to help her transition between treatment with Suboxone and treatment with Methadone. Without such a transition medication, he maintains, a patient may experience opioid side effects.

12. On April 24, 2007, Patient B.H. presented to the Respondent and advised that she had used ahead on her Methadone and that she altered her prescription. Respondent told Patient B.H. that her behavior needs to stop and that she is at high risk for losing her program. He prescribed Ativan for anxiety and Methadone.

13. Methadone is a narcotic pain reliever and is used as part of drug addiction detoxification and maintenance programs. It is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential. Respondent states he started the patient on Methadone because the previously-prescribed Suboxone was not adequate to prevent withdrawal symptoms.

14. Ativan is a benzodiazepine used to relieve anxiety and cause drowsiness before certain medical procedures, and is a Schedule IV Controlled Substance pursuant to Wis. Stat. § 961.20(2)(m). Respondent states that he prescribed Ativan to treat the patient's intense anxiety, as previously diagnosed in March 2007 by another physician.

15. On June 11, 2007, Patient B.H. presented to the Respondent and advised that she had again used ahead on her Methadone. Respondent prescribed Oxycodone. Respondent notes that the patient was transitioning from a Methadone treatment program in Duluth.

16. On September 11, 2007, in order to admit the patient into Respondent's Methadone treatment program, Respondent completed a mandatory History and Physical exam. Respondent prescribed Methadone and Klonopin to Patient B.H. even though she reported on that date that she has an alcohol problem and gets intoxicated when she drinks. She also reported that she uses methamphetamine. Respondent states that alcohol use was included in the patient's history, but was not an active problem at this time.

17. Klonopin is a benzodiazepine used to treat seizures and panic disorder, and is a Schedule IV Controlled Substance pursuant to Wis. Stat. § 961.20(2)(m). Respondent states he

prescribed this medication to help treat the intense anxiety problem.

18. On September 13, 2007 the patient was seen in Respondent's office for a Methadone Clinic visit. On September 14, 2007 the patient was seen in the ER for an overdose and sent to L.E. Phillips for in-patient treatment of opioid overdose and a very lethargic condition. Drug testing revealed the presence of benzodiazepines. She was diagnosed with opioid dependence, opioid intoxication and benzodiazepine intoxication. Respondent's plan was to stop Methadone and restart Suboxone. He instructed Patient B.H. not to take additional medications such as benzodiazepines. Respondent states that the patient's father agreed to monitor the patient's lockbox and her daily dose of Suboxone.

19. On September 19, 2007, Respondent increased Patient B.H.'s dose of Klonopin (a benzodiazepine). Respondent notes that he had a lengthy telephone conversation on this date about the patient's state of anxiety, panic, and opioid withdrawal. He states that her medication was adjusted to treat these issues.

20. On October 29, 2007, Patient B.H. reported to Respondent that she had stopped taking Clonazepam and Klonopin. Respondent started her on Phenobarbital for benzodiazepine withdrawal seizures.

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

22. One year later, on October 21, 2008, Patient B.H presented to the St. Mary's Hospital Emergency Room in Superior with a complaint of somnolence. The ER doctor noted that Patient B.H. had been in the ER in May and August of 2008 requesting narcotics for neck and back pain. Patient B.H. reported that she took Clonazepam from a family member. A drug screen was positive for the presence of benzodiazepines and amphetamines. The assessment was somnolence, possibly from Klonopin overuse, narcotic addiction, benzodiazepine addiction and possible diversion of Klonopin. Respondent notes that he spoke by telephone with the physician in the Emergency Department and requested that the patient not be given Suboxone unless the urine drug screen was negative for non-prescribed drugs.

23. On October 27, 2009, Patient B.H. presented to Respondent reporting taking an Adderal that she obtained off the street. A drug screen on that date was positive for amphetamines. Respondent prescribed a ten-day supply of Suboxone on that date.

24. Dilaudid (hydromorphone hydrochloride) is a potent Schedule II controlled opioids agonist. It has the highest potential for abuse and risk of producing respiratory depression. It is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential.

25. On November 16, 2009, Patient B.H. telephoned Respondent and advised that she had called a pharmacist and pretended to be a doctor's office requesting Methadone. Two weeks later, Respondent prescribed Suboxone and Gabapentin.

26. On December 9, 2009, Respondent advised Patient B.H. that his office would no longer prescribe schedule 2 and 4 medications to her.

27. Respondent's conduct in his treatment of Patient B.H. was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of chronic pain in her neck or back; the diagnoses do not justify the prescription of medications for chronic pain in her neck or back; and he inappropriately continued to prescribe certain medications to Patient B.H. without adequate documentation in the presence of potential relative contraindications to their use in that he was aware that at certain times she self-escalated her doses of medication, that she used ahead on her Methadone at certain times, that she altered her prescription in 2007 and 2009, that she abused marijuana and alcohol at certain times, that she used methamphetamine and non-prescribed amphetamines at certain times, that in October 2009 she obtained Adderal of the street, that in 2008 she stole Clonazepam from a family member and had a drug screen positive for amphetamines.

ALLEGATIONS RELATING TO PATIENT J.M.

28. On August 3, 1993, Respondent initially evaluated and treated Patient J.M. at L.E. Phillips Libertas Center ("L.E. Phillips") in Chippewa Falls. This Treatment Center is affiliated with St. Joseph's Hospital but is a separate rehab and detox unit for treating patients with chemical dependency. On August 3, 1993 the patient's primary complaint was of nausea and vomiting and the inability to hold down her Methadone. Patient J.M.'s reported history included opioid dependence with Methadone maintenance for approximately 12 years. Respondent's impression included acute gastritis and opioid dependency with Methadone maintenance. His plan of treatment was to admit her to the hospital and have her undergo addiction assessment. The assessment showed alcohol dependence, cannabis dependence, sedative barbiturate dependence, tranquilizer dependence, amphetamine dependence, opioid dependence on heroin and hallucinogen abuse. Upon her discharge on August 31, 1993, the plan included treating regularly with Respondent for Methadone maintenance.

29. Patient J.M. treated with Respondent from 1993 to 2008 for opioid dependence, thyroid problems, mood disorders and other general health problems. During this time the patient was evaluated by a psychiatrist who diagnosed the prescribed treatment for certain psychiatric disorders.

30. On February 12, 2007, Patient J.M. presented to Respondent at which time she reported no chronic pain. Respondent did not perform or document a physical examination and did not indicate an 'assessment. He noted that mental health counseling was recommended but did not specify any mood or mental health issues on that date. The patient had previously been evaluated and diagnosed by a psychiatrist. Respondent prescribed Methadone, Buproprion, Effexor and Opana.

31. Bupropion is an antidepressant used for treating depression and seasonal affective disorder (SAD).

32. Effexor is a serotonin and norepinephrine reuptake inhibitor (SNRI) used to treat

depression.

33. Opana is a narcotic pain medicine used to treat moderate to severe pain and is a Schedule II Controlled Substance pursuant to Wis. Stat. § 961.16(2)(a)7, and has habit-forming potential. Respondent states that Opana is also used in the addiction field to treat breakthrough withdrawal pain.

34. Respondent continued to prescribe Methadone to Patient J.M. in 2007. Records from January and February describe chronic cholecystic disease and the diagnosis on January 16, 2007 was recurrent biliary pain. On September 10, 2007, Patient J.M. presented to Respondent in follow up regarding her Methadone treatment. On that date there is no indication in the records that she complained of any pain issues. Respondent did not perform or document a physical examination.

35. In April of 2008, Respondent's clinic ceased serving as a Methadone clinic.

36. On April 9, 2008, Patient J.M. presented to Respondent and complained of stress and anxiety related to the transition to a different Methadone clinic. She also reported receiving a "drug driving" charge and of taking more Ativan than prescribed. Respondent diagnosed her with polysubstance dependence, probably bipolar, situation anxiety and stress. Respondent states he refused to give her Methadone and a regular amount of Ativan because of hypomanic and probable bipolar behavior. He prescribed Ativan and Seroquel. Respondent states he provided Ativan in a very small amount.

37. Ativan is a benzodiazepine used to relieve anxiety and cause drowsiness before certain medical procedures, and is a Schedule IV Controlled Substance pursuant to Wis. Stat. § 961.20(2)(m).

38. Seroquel is an atypical antipsychotic used to treat schizophrenia or bipolar disorder. It is also used to treat depression.

39. On June 10, 2008, Patient J.M. presented to Respondent advising that she wanted to stop taking Methadone which she was receiving from a Methadone clinic. Respondent did not perform or document a physical examination on that date. He diagnosed Patient J.M. with opioid dependency and chronic pain. Two days later, on June 12, 2008, Respondent prescribed Fentanyl, Hydromorphone and Suboxone for Patient J.M. after she had taken the last of her Methadone. He also prescribed Wellbutrin, Klonopin and Effexor on that date. Respondent states that the Wellbutrin and Effexor prescriptions were not new. Rather, these had previously been prescribed by a psychiatrist and Respondent was continuing them for symptoms commonly experienced during withdrawal. Respondent also states that the patient's history includes chronic pain in the GI tract.

40. Wellbutrin is an antidepressant used to treat depression.

41. Effexor is a serotonin and norepinephrine reuptake inhibitor (SNRI) used to treat depression.

42. On June 21, 2008, Patient J.M. spoke to Respondent on the telephone and advised that she was under investigation for prescription fraud. Respondent refused to refill her prescriptions on that date. Patient J.M. did not return for further treatment from Respondent.

43. Respondent's conduct in his treatment of Patient J.M. was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of chronic pain; the diagnoses do not justify the prescriptions of medication for chronic pain; he prescribed mood disorder medications without documenting the basis and rationale; and there was no documented justification for the concurrent use of Methadone and narcotic analgesics or the concurrent use of multiple anti-depressants/anti-anxiety medications and benzodiazepines.

CONCLUSIONS OF LAW

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

2. Respondent, by engaging in any practice or conduct that tends to constitute a danger to the health, welfare, or safety of the patient or public, 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).

ORDER

IT IS HEREBY ORDERED THAT

1. The attached Stipulation of the parties is accepted.

2. Clifford T. Bowe, M.D., is hereby REPRIMANDED for the above conduct.

3. The license of Clifford T. Bowe, M.D., is hereby LIMITED with the following terms and conditions:

   a. Within nine months from the date of this Order, Respondent shall provide proof sufficient to the Board, or its designee, of Respondent's satisfactory completion of the 10th Annual Comprehensive Pain Board Review Symposium offered by the University of Wisconsin School of Medicine and Public Health.

   b. Within 30 days after the course identified above has concluded, Dr. Bowe shall provide proof sufficient to the Board, or its designee, of satisfactory completion of the course.

   c. Dr. Bowe shall not apply any of the hours of education completed to satisfy the terms of this Order toward the biennial training required under Wis. Stat. § 448.13.

d. All costs of the educational program shall be the responsibility of Dr. Bowe.

IT IS FURTHER ORDERED THAT

4 Respondent shall, within 90 days of this Order, pay costs of this proceeding in the amount of ONE THOUSAND FOUR HUNDRED ($1,400.00) DOLLARS. Payment shall be made to the Wisconsin Department of Safety and Professional Services, and mailed to:

Department Monitor
Department of Safety and Professional Services
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Telephone: (608) 267-3817
Fax: (608) 266-2264

5. Violation of any terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs or fails to comply with the ordered continuing education as ordered, the Respondent's license (No. 13372-20) 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 and completion of the continuing education.

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

Wisconsin Medical Examining Board

By: _____ 2/15/12
A Member of the Board Date