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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
BRADLEY T. BODNER, P.A., RESPONDENT.	:	ORDER 0001560

Division of Enforcement Case No. 09MED198

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

Bradley T. Bodner, P.A.
2800 Westhill Drive, Suite 200
Wausau, WI 54401

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

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

PROCEDURAL HISTORY

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

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

FINDINGS OF FACT

1. Bradley T. Bodner, P.A., Respondent, date of birth July 22, 1970, is licensed by the Wisconsin Medical Examining Board to practice as a physician assistant in the State of Wisconsin, pursuant to license number 1312-23. This license was granted on January 9, 2001.

2. The Respondent's last address reported to the Department of Regulation and Licensing is 2800 Westhill Drive, Suite 200, Wausau, Wisconsin 54401.

3. At the time of the events set forth below, the Respondent was employed as a physician's assistant at Spine Care Specialists of Wisconsin S.C., 3200 Westhill Drive, Suite 102, Wausau, Wisconsin 54401, to work exclusively with Dr. J.

4. On July 8, 2003 at approximately 1200 hours, Patient A, a 51 year old male, presented himself to the Wausau Hospital emergency room with right-sided low back pain radiating down his right leg progressively worsening in intensity, as well as questionable symptoms of episodic saddle anesthesia. An MRI of the patient's lumbar spine showed L4 to L5 disc herniation causing central canal stenosis. Serial neurological examinations showed no saddle anesthesia and showed no focal neurologic deficits. The Emergency Department obtained a consultation with a neurosurgeon, Dr. J., who diagnosed lumbar disc. herniation with severe central canal stenosis and recommended surgery for discectomy, which was refused by the patient. The patient instead opted for an epidural steroid injection for treatment of the patient's condition. Dr. J listed Patient A's condition as "guarded" at this time.

5. Following the injection, at 1707 hours, "Patient A stated to radiology that his pain was resolved from 5/10 pre-procedure to 0/10 post-procedure with movement on a stretcher. The patient reported post-procedure right lower extremity numbness in the usual location of his pain, resulting from the local anesthetic".

6. At 1715 hours, Patient A ambulated with assistance and his pain increased in the right hip and leg during ambulation.

7. At 1725 hours, Emergency Department records indicate Patient A "expresses wish to stay in hospital overnight" as he had concerns about activities of daily life (ADL) at home and he was admitted. The patient was admitted by Hospitalist TB. The hospitalist wrote admission orders which included the following:

a) Bladder scan tonight and tomorrow; call with abnormal.
b) Neuro checks every shift x 3; call with abnormal.

Nurse LB, who worked the 3:00 p.m. to 11 p.m. shift on July 9, 2003, understood that the above orders required her to call hospitalist TB with any abnormal results.

Admitting Hospitalist TB noted in the history and physical examination report that Patient A had been experiencing some trouble with urination prior to his hospital admission.

8. The Emergency Department medical record reflected that Patient A was experiencing low back pain when lying in bed with increasing pain on movement of right hip and leg.

9. On the morning of July 9, 2003, Respondent saw Patient A for the first time as part of his morning rounds for his supervising physician, Dr. J. Although Patient A was admitted

by Hospitalist TB and no formal consult was requested of Dr. J., Patient A appeared on Respondent's hospital inpatient list. Respondent's visit with Patient A was reflected in the Physician's Progress Notes and included the following:

"Pt relates RLE numbness buttock to ® post thigh"
"Expresses desire to avoid surgery if possible"
"Pt has PCA but has not used it"

Patient A told Respondent that the patient had undergone an epidural steroid injection which produced complete relief of this pain. Patient A told Respondent that his complete pain relief persisted at the time of Respondent's morning hospital rounds.

10. At approximately 0940 hours on July 9, 2003, Hospitalist GL rounded on Patient A. The records reflect the patient's low back pain had improved. The patient had made little or no use of his PCA pump, so the hospitalist discontinued that device and replaced it with an order for Vicodin p.r.n. On examination the patient did have decreased sensation in his right leg. The hospitalist ordered that the patient increase his activities. The hospitalist ordered the nurses to walk the patient at least three time per day.

11. At approximately 1100 hours on July 9, 2003, while seeing patients in the clinic with Dr. J., Respondent advised Dr. J that Patient A was in the hospital. Dr J. indicated that he knew the patient from his encounter with him at the emergency department the day before.

12. At approximately 1600 hours, Respondent returned to reassess Patient A. Respondent's visit with the patient was reflected in the Physician's Progress Notes as:

"Pt related ↑ numbness Bilat LE"
"CBP continues when up ØCBP when laying flat"
"Relates injection provided Ø relief"
"Currently unable to void/ defecate per pt"
"Attempted ambulation c PT but short trip due to fear of loss of bowel/ bladder/ LE styths"
"Discussed possible OR for discectomy"
"Pt wishes to attempt ambulation c PT in AM
"Family c many questions. Answered to best of my ability
"Will reassess in AM"

It is Respondent's position that the above subjective findings are typical for any patient with a large disc herniation. Respondent further believes that the working diagnosis of large disc herniation with severe central canal stenosis was addressed with the recommendation for discectomy by surgery. The patient again refused surgery and responded that he would walk in the morning.

13. At the time of Respondent's patient visit at 1600 hours:

a) The patient relayed that he had not had pain relief from the epidural injection which is in contradiction to the patient's statement that morning that the patient had received pain relief from the injection.

b) Respondent was aware from the admitting history and physical examination that the patient had experienced urinary problems prior to admission.

c) Respondent knew that bladder and serial neurologic checks were being done by hospital personnel with orders to call any abnormal results to the hospitalists.

d) Respondent knew that a nurse's note at 1455 hours that day indicated that the patient had walked in the hall and to the commode and that the patient had increased pain following the activity.

e) At the time of Respondent's rounds at 1600 hours, Patient A did not have a Foley catheter in place.

14. Respondent did not notify his supervising physician of Patient A's change in subjective description of condition from the previous evaluation.

15. Respondent failed to document the examination he conducted of the patient on July 9, 2003, and the results of that examination in the patient's chart.

16. At 1900 hours on July 9, 2003, Nurse LB called Hospitalist TB regarding an abnormal bladder scan. At the time of the call, Nurse LB read Respondent's entire 1600 note to the hospitalist. The hospitalist ordered Nurse LB to place a Foley catheter in the patient. Nurse LB did not notify Dr. J or Respondent about the order for the Foley catheter or about the abnormal bladder scan and the records do not reflect a physician order to do so.

17. Nurse LB did neurological assessments of the patient on July 9, 2003 at 1650 hours and at 2030 hours. At 1650 hours, the dorsiflexion of the left ankle was weak. At 2030 hours, the dorsiflexion of the left ankle is entirely absent. There were also significant sensory abnormalities in both legs at 1650 and 2030 hours. Nurse LB did not notify Dr. J or Respondent about any of these neurological changes in the patient.

18. On July 10, 2003, at approximately 1000 hours, Respondent reassessed Patient A. When evaluating Patient A, Respondent found there was a change in Patient's A's condition. Respondent's visit with the patient was reflected in the Physician's Progress Notes as follows:

"A & O X 3 Relates cont Bilat LE numbness"
"Attempted to stand to urinate & is unable to perform due to weakness"
"Foley placed for inability to void. 700cc output"
"Pt c/o Back Pain only c SLR & Ambulation"
"Ø CBP while laying in Bed"
"PE – Bilat knee 5/5 6 flex/"
"Ankles Ø movement / toes Ø movement Bilaterally"
"Pt related Ø sensation in bottom of feet"
"Blunted response to toe pinch. Bilat."
"Plan - Discuss c Dr. J Eval today"

"Probably OR for Discectomy."

19. Respondent again recommended surgery to Patient A and contacted Dr. J., as Patient's condition had changed significantly from the previous encounter. Dr. J immediately examined Patient A, ordered an MRI, diagnosed cauda equina syndrome, and recommended immediate surgery. Patient A again refused surgery and wanted a second opinion.

20. Patient A requested a second opinion prior to surgery and the surgery was performed by another surgeon. After the surgery, Patient A still had numbness resulting in permanent bladder, bowel and problems with ambulation. Patient was diagnosed with cauda equina syndrome.

21. Respondent's conduct as set forth above, with regard to Patient A fell below the minimum standards of competence established in the profession when Respondent failed to report to his supervising physician the patient's complaints and his examination findings at 1600 hours.

22. Respondent failed to meet the minimum standards for health care records by failing to include in his examinations of Patient A pertinent objective findings related to examination and test results as well as an assessment or diagnosis.

CONCLUSIONS OF LAW

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

2. Respondent's conduct as set forth in paragraphs 14, 15 and 21 above, constitutes a violation of Wis. Admin. Code § Med 10.02(2) (h).

3. Respondent, by failing to document a patient's medical condition, engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 21.03(2).

ORDER

IT IS HEREBY ORDERED that the attached Stipulation of the parties is accepted.

IT IS FURTHER ORDERED that Bradley T. Bodner, P.A. is hereby REPRIMANDED.

IT IS FURTHER ORDERED that the license of Bradley T. Bodner, P.A. to practice medicine and surgery in the State of Wisconsin shall be LIMITED on the following terms and conditions:

1. Bradley T. Bodner, P.A. shall, within twelve (12) months of the date of this Order, obtain nine (9) hours of education in neurosurgical emergencies; and obtain three (3) hours of education in documentation.

a. The Board recognizes the course completed by Respondent from March 7 through 10, 2012, entitled "28th Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves presented by the American Association of Neurological Surgeons, as satisfaction of the requirement for education in neurosurgical emergencies. A copy of the course syllabus is attached as Exhibit A. Respondent shall file the certifications of completion as required by paragraph 1 d. below.

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

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

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

e. All costs of the educational programs shall be the responsibility of Respondent.

IT IS FURTHER ORDERED that:

2. Respondent shall within 90 days of this Order pay costs of this proceeding in the amount of nine hundred ($900.00). Payment shall be made to the Wisconsin Department of Regulation and Licensing, and mailed to:

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

3. Violation of any terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's

license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered or fails to comply with the ordered continuing education as set forth above, the Respondent's license (No. 1312-23) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

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

Wisconsin Medical Examining Board

By: _____ 5/16/12

A Member of the Board Date

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