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Before The
State Of Wisconsin
Medical Examining Board

In the Matter of the Disciplinary Proceedings
Against **GRAHAM R. CASE, M.D.**, Respondent

FINAL DECISION AND ORDER
WITH VARIANCE
ORDER NO ORDER 0002373

Division of Legal Services and Compliance[1] Case No. 08 MED 249

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

Graham R. Case, M.D., by:

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Gutglass, Erickson, Bonville & Larson, S.C.
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Department of Safety and Professional Services, Division of Legal Services and Compliance, by

Attorney Arthur Thexton
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PROCEDURAL HISTORY

These proceedings were initiated when the Department of Safety and Professional Services, Division of Legal Services and Compliance (the Division), filed a formal complaint on April 6, 2011, against Respondent Graham R. Case, M.D. The complaint alleged that Dr. Case

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

engaged in conduct which tends to constitute a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h), and that his license was therefore subject to disciplinary action pursuant to Wis. Stat. § 448.02. Dr. Case, through counsel, filed an Answer on May 3, 2011. Following several prehearing and status conferences and attempts by the parties to resolve the case, at a final status conference held on February 28, 2012, the parties indicated that the matter had not been resolved and that it should be set for hearing. As a result, a hearing was set for October 24-26, 2012.

Prior to hearing, however, the Division filed a motion on March 20, 2012, requesting that this tribunal issue "an order finding that appropriate discipline may be imposed by the Board without the need for expert testimony, in that a court has found that Respondent has acted negligently in treating a patient; and modifying the scheduling order accordingly." The Division further requested that the hearing scheduled for October 24-26, 2012 be reduced to a one-day hearing which would be solely on the issue of discipline. A briefing order was issued, followed by a revised briefing order at the request of Dr. Case's counsel.

Following the April 23, 2012 filing of Dr. Case's response brief in opposition to the Division's motion, on April 25, 2012, the Division filed an Amended Complaint and Amended Notice of Hearing, which alleged negligence in treatment in addition to the alleged violation contained in the original complaint. The Division filed its reply brief on April 30, 2012.

On August 3, 2012, Dr. Case filed a Notice of Motion, Motion to Dismiss Amended Complaint and Brief in Support. After being given the opportunity to respond to Dr. Case's motion, the Division's attorney indicated that he did not believe further response was necessary and would therefore not file a response to Dr. Case's motion to dismiss the amended complaint.

On August 10, 2012, the Administrative Law Judge (ALJ) issued an Order Granting Partial Summary Judgment in favor of the Division, in which the ALJ concluded that there were no issues of material fact and that the Division was entitled to judgment as a matter of law on the

issue of whether Dr. Case's conduct constituted negligence in treatment, in violation of Wis. Stat. § 448.02(3). The ALJ determined that, pursuant to Wis. Stat. § 448.02(3)(b), the Milwaukee County Circuit Court's Order of Judgment based on the jury's Special Verdict finding Mr. Case ten percent negligent for the same conduct giving rise to this disciplinary proceeding was "conclusive evidence" that Dr. Case is guilty of negligence in treatment under Wis. Stat. § 448.02(3). In so holding, the ALJ also rejected Dr. Case's assertion that the Division was barred from filing an amended complaint which alleged negligence in treatment in the alternative to the original alleged violation that Dr. Case engaged in conduct constituting a danger to the health, welfare, or safety of a patient. Thus, the ALJ implicitly denied Dr. Case's motion to dismiss the amended complaint.

A hearing was held on the issue of discipline on October 24, 2012, at which counsel for Dr. Case reiterated that he was not waiving his right to challenge the ALJ's finding of negligence in treatment. Also at the hearing, the Division's attorney offered 7 exhibits into evidence which had been provided to Dr. Case's counsel at approximately 3:30 p.m. on October 23, 2012, the afternoon before the October 24, 2012 hearing. Dr. Case's attorney objected to exhibits 2 through 7 and the ALJ reserved a ruling on the issue, indicating that this decision would address the admissibility of the documents.

On February 20, 2013, the Medical Examining Board reviewed the Proposed Decision submitted by the ALJ. Upon considering the ALJ's proposed decision and disciplinary recommendations, and Respondent's Objections and Complainant's Response, the Wisconsin Medical Examining Board issues the final decision and order below.

FINDINGS OF FACT

Undisputed Material Facts as Found in the Order Granting Partial Summary Judgment

1. Respondent Graham R. Case, M.D. (D.O.B. 4/22/76) was granted a license to practice medicine and surgery in the State of Wisconsin (#48366-20) on July 7, 2005. Dr. Case's registration to practice under that license expired on October 31, 2009 and Dr. Case holds the right to renew this registration.

2. Dr. Case's address of record with the Wisconsin Medical Examining Board (the Board) is 1526 S. 169th St., New Berlin, Wisconsin 53151. Dr. Case is employed at Medford Radiological Group, 842 E. Main Street, Medford, Oregon 97504, where he practices with subspecialty training in Musculoskeletal Radiology.

3. On June 5, 2008, a Special Verdict was entered in Milwaukee County Circuit Court Case No. 07CV000296 which concluded that Dr. Case was negligent with respect to his care or treatment of the patient in question on February 20, 2006, and that Dr. Case's negligence was a cause of the patient's injuries. The jury attributed 10 percent of the total causal negligence to Dr. Case; 70 percent to St. Luke's Medical Center through its employees, representatives or agents other than Dr. Case; and 20 percent to Dr. George Zaleski.

4. Based on the Special Verdict, an Order for Judgment was entered by the Milwaukee County Circuit Court Judge on July 3, 2008.

5. On April 6, 2011, the Division filed a Notice of Hearing and Complaint with the Division of Hearing and Appeals alleging that, based on events which occurred on February 20, 2006 while Dr. Case was in his residency program at Aurora St. Luke's Medical Center in Milwaukee, Wisconsin, which resulted in the patient in question becoming a paraplegic, Dr. Case committed professional misconduct by engaging in conduct tending to constitute a danger to the health, welfare, or safety of a patient, in violation of Wis. Admin. Code § Med 10.02(2)(h).

6. On April 25, 2012, the Division filed an Amended Notice of Hearing and Amended Complaint with the Division of Hearings and Appeals based on the same conduct as that alleged in the original complaint, which stated that Dr. Case's conduct constituted unprofessional

conduct as alleged in the original complaint "or, in the alternative, constitutes negligence in treatment."

Additional Facts as Contained in the Special Verdict and Order of Judgment and as Admitted by Dr. Case's Answer to the Division's Amended Complaint

7. The incident for which Dr. Case was found negligent took place while Dr. Case was involved with a procedure in which the patient was undergoing a "baclofen challenge" for treatment of spasticity.

8. During this procedure, Dr. Case placed a needle in the intrathecal space and asked a radiology technician for contrast, to allow for confirmation of the needle placement.

9. The technician gave Dr. Case Renografin 60 contrast, which had been drawn up into a syringe.

10. Renografin 60 is contraindicated for intrathecal use because it can cause death, convulsions, cerebral hemorrhage, coma, paralysis, arachnoiditis, acute renal failure, cardiac arrest, seizures, rhabdomyolysis, hyperthermia, and brain edema.

11. When the supervising radiologist arrived, a small "puff" of Renografin 60 was used, which, upon fluoroscopy, confirmed that the needle was in the intrathecal space.

12. Dr. Case began to remove the tube from the needle but the supervising radiologist intervened and directed Dr. Case to unscrew the syringe from the tube and replace it with the syringe containing baclofen. As a result, the Renografin 60 contrast that remained in the tube was introduced into the spinal fluid, together with the baclofen.

13. The Milwaukee County Circuit Court's Order of Judgment entered judgment against defendants Dr. Case and Continental Casualty Company in the amount of $1 million and against the defendant Wisconsin Injured Patients and Families Compensation Fund in the amount of $8,084,981.88.

DISCUSSION AND CONCLUSIONS OF LAW

Violation of Wis. Stat. § 448.02(3)

Wisconsin Stat. § 448.02(3)(b) states, in relevant part:

> A unanimous finding by a panel established under s. 655.02, 1983 stats., or a finding by a court that a physician has acted negligently in treating a patient is conclusive evidence that the physician is guilty of negligence in treatment. . . . A certified copy of the findings of fact, conclusions of law and order of the panel or the order of a court is presumptive evidence that the finding of negligence in treatment was made.

In the Order Granting Partial Summary Judgment, the ALJ concluded that, pursuant to Wis. Stat. § 448.02(3)(b), the Milwaukee County Circuit Court's Order of Judgment based on a jury's Special Verdict finding Dr. Case ten percent negligent was "conclusive evidence" that Dr. Case was negligent in treatment under Wis. Stat. § 448.02(3). The discussion and conclusions of law related to the finding of a violation are contained in the attached Order Granting Partial Summary Judgment and are incorporated into this decision.

Admissibility of the Division's Proposed Exhibits at the Hearing on Discipline

At the October 24, 2012 hearing on discipline in this matter, counsel for Dr. Case, Attorney Paul Erickson, objected to admission of the Division's proposed Exhibits 2-7 on grounds that the documents were only provided to him the afternoon before the hearing rather than by the July 16, 2012 deadline set forth in the February 28, 2012 scheduling order. The Division's proposed Exhibit 1 was the Milwaukee County Order for Judgment and the Special Verdict which had previously been provided by the Division as an attachment to its March 20, 2012 Motion and was therefore already part of the record.

Attorney Erickson also objected to each of these proposed exhibits on more specific grounds. With regard to proposed Exhibit 2, a document from Westlaw entitled, "West's Jury Verdicts," featuring as its "Case of the Month" for July 2009 a summary of the civil case involving Dr. Case and captioned, "Jury Awards Patient $10M for Post-procedure Brain Damage," counsel argued that the author was unknown and that there was no guarantee that the

summary of the case was accurate or authentic. Regarding proposed Exhibit 3, which is a set of certified medical records for the patient in question, Attorney Erickson argued that without foundation and testimony, the ALJ would be unable to interpret the records and could not accept the Division attorney's interpretation. With respect to proposed Exhibit 4, a July 6, 2007 deposition of Dr. Case in the underlying civil case brought against him and others, Attorney Erickson stated that there was no foundation for its introduction. He also accurately noted that the Division attorney had represented that he would not call any witnesses for the disciplinary hearing, and, based on that representation, Attorney Erickson did not hire an expert for the hearing and did not require the appearance of Dr. Case, who lives in Oregon. He further stated that the Division's attempt to enter the deposition into evidence was a backhanded way of attempting to introduce witness testimony. A similar objection was stated with regard to proposed Exhibit 5, which is an April 4, 2007 deposition of Joseph Guidone, who, according to the deposition, was the staff radiology technician at Aurora during the incident in question (attached to the deposition are several exhibits). Attorney Erickson also stated that there was no verification of the authenticity of proposed Exhibits 6 and 7, which are copies of "Flouro Procedures" conducted by Dr. Case and a "Summer Core Lecture Series" for first year residents from July and August of 2011, respectively.

In response, the Division stated that the original scheduling order was issued when the parties and ALJ were assuming there would be a hearing on all aspects of the case, including the alleged violation, and that had the case proceeded to hearing rather than to summary judgment proceedings, the Division would have named an expert. Counsel for the Division further stated that he believed the entirety of the scheduling order was suspended and that he believed there was no operative scheduling order as to when the exhibits would be provided. He also noted that it was not until the day before the disciplinary hearing that he learned that Dr. Case would not be attending the hearing either in person or by telephone.

However, as noted by Attorney Erickson, although on May 1, 2012, the ALJ sent an email granting the parties' request to postpone the deadline for filing preliminary witness lists, the email did not change any of the other deadlines. Further, although the August 10, 2012 Order Granting Partial Summary Judgment suspended the deadlines established in the February 28, 2012 scheduling order and stated that modifications to the February 28, 2012 scheduling order would be discussed at a subsequent status conference, the July 16, 2012 deadline for providing exhibit lists and exhibits had already passed at the time the August 10, 2012 Order was issued. Therefore, the language suspending the deadlines did not apply to the exhibit deadline and applied only to those deadlines which had not passed, namely, the discovery deadline of August 17, 2012 and the deadline for dispositive motions, August 31, 2012. Thus, the Division's exhibits were not filed or served in compliance with the deadline then in effect.

Although with certain limited exceptions, the rules of evidence do not strictly apply to administrative proceedings, *see* Wis. Stat. § 227.45, exclusion of proposed exhibits 2 through 7 is warranted under the circumstances here. The fact that the proposed exhibits, consisting of well over 100 pages, were provided to Attorney Erickson and the ALJ the afternoon prior to the disciplinary hearing rather than by the July 16, 2012 deadline contained in the scheduling order, combined with the evidentiary defects discussed above, make admission of these proposed exhibits fundamentally unfair to Dr. Case. Accordingly, in deciding what discipline, if any, is appropriate in this matter, the ALJ considered only those facts that were found in the summary judgment proceedings and contained in the Special Verdict and Order for Judgment, and those facts which are undisputed in Dr. Case's answer to the amended complaint. These facts are set forth in the Findings of Fact, above.

The ALJ's Recommendation for Discipline and Costs

As a result of Dr. Case's negligence in treatment, the recommendation by the ALJ was that the Respondent receive a reprimand and that fifty (50) per cent of the costs of the investigations and prosecution of this matter be imposed against Respondent.

EXPLANATION OF VARIANCE

As the regulatory authority and final decision-maker in this Class 2 proceeding, the Medical Examining Board may modify the ALJ's proposed decision. *See* Wis. Stat. § 227.46(2). The Board must provide reasons for any such modifications. *Id.* Here, the Board adopts as its own the findings of fact, conclusions of law, and discussion set forth in the proposed decision. However, the Board modifies the ALJ's recommendations with respect to the issues of discipline and costs.

The three purposes of discipline are: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976). The incident that led to the Milwaukee County Circuit Court's negligence finding against Dr. Case occurred in 2006 during his residency at a teaching hospital. Dr. Case completed the remainder of his residency without incident. He subsequently passed his radiology board certification examination, and has had a successful radiology practice since. The Division acknowledges that no additional education, remedial training, or practice limitations or supervision are indicated for Dr. Case.

Moreover, the jury in the court action attributed 90% of the negligence that resulted in the plantiff-patient's injury to the other defendants, assigning only 10% to Dr. Case. The Board

notes that Dr. Case was on directions from the supervising radiologist when the incident occurred.

The Board wishes to make clear its awareness that none of these considerations can mitigate the seriousness of the injury that resulted from the negligence. The consequences to the patient were profound and devastating. However, the Board's obligation is to serve the purposes of discipline, i.e., rehabilitating the Respondent and protecting the public from future such negligence through deterrence of Dr. Case and his fellow licensees. As stated, Dr. Case is not in need of rehabilitation, and any risk of him committing similar conduct in the future has been sufficiently reduced by his years of successful practice since the incident occurred. Likewise, the amount of time which has passed since the incident, considered with the other facts in this matter, moots any deterrent effect on others that imposing discipline upon Dr. Case might have had if it had been imposed contemporaneously.

Based on the totality of the circumstances in this matter, the Board determines that no discipline is necessary to protect the public, rehabilitate the licensee, or for purposes of deterrence.

ORDER

IT IS THEREFORE ORDERED for the reasons set forth above, that no discipline is necessary in this matter.

IT IF FURTHER ORDERED that no costs shall be imposed.

Dated this 2nd day of April, 2013.

By: Sheldon A. Wasserman, MD

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