WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JAMES J. LOGAN, M.D., RESPONDENT.	:	0003341

Division of Legal Services and Compliance Case No. 13 MED 260

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

James J. Logan, M.D.
Mile Bluff Clinic
1040 Division Street
Mauston, WI 53948-1931

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

Wisconsin Medical Examining Board
Department of Safety and Professional Services
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 disposition of this matter, subject to the approval of the Medical Examining Board (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, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent James J. Logan, M.D., (dob December 02, 1952) is licensed in the State of Wisconsin to practice medicine and surgery, having license number 24202-20, first issued on October 23, 1981, with registration current through October 31, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is Mile Bluff Clinic, 1040 Division Street, Mauston, Wisconsin 53948-1931.

2. Respondent had been treating Patient A at Mile Bluff Clinic in Mauston (MBC) since early 2008. Between October 29, 2010 and December 28, 2012, Patient A was prescribed

various controlled substances including opioid medications, benzodiazepines, and anti-depressants.

3. As of December 28, 2012, Patient A was being prescribed the following controlled substances: clonazepam 1 mg; fentanyl 75 mcg/hr patch; OxyContin 80 mg; Prozac 40 mg; and Seroquel XR 150 mg. Patient A received refills on January 28, 2013 and February 27, 2013.

4. On March 28, 2013, Patient A was transported to Mile Bluff ER (MBER) after being found unresponsive, bleeding, and seizing. He required intubation and helicopter transport to UW Hospital in Madison, where he was admitted to the ICU. CT studies showed no acute hemorrhage and no major injuries. Suspected etiology included benzodiazepine withdrawal.

5. On April 5, 2013, Patient A was discharged from UW Hospital to a Juneau County nursing home for rehabilitative care. Patient A was transferred back to UW Hospital on April 15, 2013 with altered mental state and recent fall.

6. On April 18, 2013, Patient A was seen by an addiction specialist at UW Hospital, who recommended increased gabapentin, outpatient psychiatric care, an AODA assessment, non-opioid medications for pain control, and close monitoring for substance use.

7. On April 23, 2013, Patient A was seen by another provider at MBER complaining of increased confusion, agitation and argumentative behavior towards the nursing home staff. The provider contacted Respondent, who indicated that Patient A's "wife may be smuggling him (patient) narcotics medications in the nursing home."

8. The nursing home discharged Patient A with instructions to follow up with Respondent, and sent Respondent a letter indicating that Patient A's wife "was supplying him with meds. Now he is becoming belligerent, loud, demanding, throwing items at staff – withdrawal?"

9. On April 25, 2013, Patient A was seen by another provider at MBER for anxiety, tremors, sore throat, and fever. He reported hallucinations and claimed "he can turn his seizures on and off at will." Patient A was diagnosed with anxiety with psychotic features. Lorazepam was administered and prescription medications restarted. The provider discharged Patient A to home, and contacted Respondent who said he would follow up with the patient in the morning.

10. On April 26, 2013, Patient A saw Respondent who prescribed: Keppra; alprazolam 1 mg; clonazepam 0.5 mg; clonazepam 1 mg; fentanyl 12 mcg patches; Prozac 80 mg; and Seroquel XR 150 mg.

11. On April 29, 2013, a home health nurse performed a patient "observation & assessment." Her notes indicate that:

> [B]oth patient and wife demonstrate questionable ability to follow MD plan of care with medication administration. Unclear if they are answering questions reliably...patient and wife cannot locate medications...include fentanyl patches, clonazepam, and lorazepam. [Respondent's] office called...to notify him of this information.

12. A May 2, 2013 home health note indicates:

> [P]atient reports tried to kill himself last night because the pain was so bad...it's my lizard pain, [Respondent] knows all about it...I asked him if he were using his fentanyl patches, to which he replies, I can't find them...and states I want some morphine and some OxyContin...he verbalized he would attempt to kill his [*sic*] self tonight...I contacted [Respondent]...JCSD...ER to offer a report.

13. Also on May 2, 2013, Patient A was seen by another provider at MBER for overdose. Patient A indicated that he had taken 30 pills in a suicide attempt. Patient A was interviewed by a crisis counselor and social services, and was discharged home.

14. On May 3, 2013, Respondent signed a "Home Health Certification and Plan of Care" which stated that Patient A was to receive home health care with goals to be free from seizures and in medication compliance by May 29, 2013.

15. On May 7, 2013, a home health nurse indicated that Patient A and his wife failed a medication check. An empty box for fentanyl patches was observed. Patient A reported 0/10 pain.

16. Also on May 7, 2013, Respondent again signed a "Home Health Certification and Plan of Care" which stated that Patient A was to receive home health care with goals to be free from seizures and in medication compliance by June 1, 2013.

17. On May 8, 2013, Patient A saw Respondent for chronic back pain and depression, and was prescribed: alprazolam 1 mg; fentanyl 12 mcg/hr patches; Prozac 80 mg; and Seroquel XR 150 mg.

18. A May 13, 2013 home health note indicates that "both [Patient A] and his wife have such mental problems they both need mental evaluation." Patient A was discharged from home health services without complying with Respondent's goals.

19. On May 22, 2013, Patient A saw Respondent who prescribed: clindamycin 150 mg for toothache/infection; fentanyl 12mcg/hr patches; Prozac 80 mg; and Seroquel XR 150 mg. Patient A was also advised to take 600 mg of ibuprofen and 325 mg of aspirin.

20. On June 20, 2013, Patient A saw Respondent who prescribed: alprazolam 0.05 mg; clonazepam 1 mg; Prozac 80 mg; and Seroquel 25 mg. Patient A was also advised to take 600 mg of ibuprofen every 4 hours and 325 mg of aspirin daily.

21. On July 8, 2013, Patient A called MBC requesting refills of clonazepam, alprazolam and fentanyl because he reportedly lost his medications. The request was denied.

22. On July 19, 2013, Patient A saw Respondent who prescribed: alprazolam 0.05 mg; clonazepam 1 mg; fentanyl 12 mcg/hr patches; and Seroquel 25 mg. Prozac was discontinued. Respondent advised Patient A to stop ibuprofen, but continue 325 mg aspirin.

23. On July 25, 2013:

a. **0930**: Patient A saw Respondent for worsening headaches and arthalgias. Respondent also diagnosed agitation, stating that Patient A "demands more pain clinic and hs [*sic*] had problems with pain medication usage." Respondent ordered a CT scan, which was performed after the appointment.

b. **1023**: Patient A's wife called MBC stating patient wants a referral to Pain Management in La Crosse. Referral documents faxed to pain program at 1123.

c. **1127**: Patient A called MBC stating that he was just leaving from the CT scan and "forget it, he is going to off himself & he's sick and tired of going thru this pain."

24. On July 26, 2013, Patient A saw Respondent to discuss the July 25th CT results, which were negative for stroke. Respondent attributed Patient A's slurred speech to his pain medication, and prescribed lidocaine patches for back pain.

25. On August 5, 2013:

a. **1411**: Patient A called MBC requesting OxyContin, clonazepam, fentanyl, and Xanax; all immediately or he would "freak out." Patient A told receptionist that "he knows the pain patch is driving him literally insane, almost to the point of killing other people." The receptionist reported the call to Respondent who was working in the MBER that day.

b. **1416**: Respondent indicated that he could not refill medications from the MBER.

c. **1605**: Patient A again called MBC requesting medication refills and alleging that "if he didn't get those meds, he would not make it."

d. **1612**: Respondent spoke to an MBC clinic employee per telephone and stated that he would refill "a small amount and he will deal with it in more detail when he gets back to the office." Patient A called MBC stating "he is very suicidal and he keeps saying we are running out of time…You need to get my meds refilled so I can make it through tomorrow…pt hung up."

e. **1704**: Patient A was notified that nobody at MBC could fill his medications, but that Respondent would see him in the MBER. Patient A subsequently presented to Respondent in the MBER for chronic back pain.

26. Respondent's August 5, 2013 MBER notes indicate that Patient A had been taking "significant amount of both fentanyl and also OxyContin…had multiple seizures down in Madison, was taken off the medication because of seizures, had to be intubated in the emergency room and it was thought there might have been some taking of medications inappropriately."

27. Respondent's August 5, 2013 diagnosis was back pain and agitation, and he prescribed: fentanyl patches 25 mcg; alprazolam 1 mg; clonazepam 1 mg; and oxycodone 15 mg (#60). Respondent noted that "to ensure that [Patient A] is being compliant and not taking too much, we will ask his wife, [name redacted] to help in control of his medications so he does not take the medications inappropriately." Respondent scheduled a follow-up visit for August 18, 2013.

28. On August 8, 2013, Patient A's cousin called MBC to express concern about Patient A's drug abuse and erratic behavior. The cousin reported having visited Patient A on August 4, 2013, and that he had found Patient A to have "at least 10 fentanyl patches on his body and had been eating the inside of the patches to get high." Respondent notified human services that Patient A was abusing his prescription.

29. By certified mail dated August 8, 2013, Mile Bluff Medical Center Clinics administration discharged Patient A "due to [his] threatening and disrespectful behavior towards staff." Patient A was offered emergency medical care for 30 days, and Respondent enclosed 2 more prescriptions for pain medication.

30. Also on August 8, 2013, Patient A was found dead in his home with two fentanyl 25 mcg patches on his body. The coroner's September 4, 2013 report referenced "the fact that [Patient A] was prescribed 60 Oxycodone on August 5, 2013 and none were found" and the toxicology results, which reflected "Oxycodone 1036ng/mL, therapeutic range 10-200."

31. These findings along with Patient A's "prior history of prescription drug abuse and multiple overdoses" led the coroner to rule Patient A's death a "Suicide as a result of Oxycodone Toxicity/Overdose, interval-hours with contributing factors of Bipolar Disorder, Chronic Drug Abuse, and History of Suicidal Ideation."

32. Respondent has provided proof satisfactory to the Department that between March 29, 2014 and April 9, 2014, he successfully completed 10.75 credits of continuing medical education on the topics of pain management and responsible prescribing of opioid medication.

33. The standard of minimal competence for prescribing controlled substance requires the prescriber to, inter alia, assess and document the patient's risk for noncompliance, to prescribe the minimum amount of substance necessary to address the condition, and to objectively monitor compliance through toxicology screening, pill counts, observation of symptoms, etc.

34. Respondent's care of Patient A fell below the standard of minimal competence when Respondent:

a. Prescribed and continued to prescribe controlled substances to Patient A despite a well-documented history and ongoing instances of drug-seeking behaviors, prescription drug abuse requiring hospitalization, suicide

gestures and attempts, and other mental health disturbances related to prescription drug abuse;

b. On August 5, 2013, by prescribing opioid medications to Patient A despite Patient A's drug seeking behavior, and having prescribed a full monthly refill of Patient A's opioid medications just 17 days prior; and/or

c. On August 5, 2013, by relying on Patient A's wife to ensure that Patient A would be compliant in taking his medications as prescribed, despite well-documented concerns voiced by Respondent and other health care providers about her role in enabling Patient A's prescription drug abuse.

35. By the conduct set forth above Respondent's care of Patient A created the unacceptable risk that Patient A would accidentally or intentionally overdose.

36. Respondent contends that at all times he exercised reasonable care and attempted to prescribe in Patient A's best interest. However, Respondent recognizes the concerns of the Board and the Department of Safety and Professional Services and has amended his prescribing practice accordingly.

37. Respondent consents to entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

Note: All references to Wis. Admin. Code § Med 10.02(2) refer to the Code as it existed before October 1, 2013.

2. By the conduct described in the Findings of Fact, Respondent James J. Logan, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.02(2)(h) by engaging in tends to endanger the health, welfare or safety of patients or the public.

3. As a result of the above conduct, James J. Logan, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. Respondent James J. Logan, M.D., is REPRIMANDED.

3. The Board recognizes that Respondent has completed 10.75 credits of remedial medical education on the topics of pain management and responsible opioid prescribing, and accepts those credits in lieu of the remedial education which the Board would have otherwise ordered.

4. Within 90 days from the date of this Order, James J. Logan, M.D., shall pay COSTS of this matter in the amount of $1,915.71.

5. Payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

6. 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 full payment of costs as ordered, Respondent's license (no. 24202-20) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with full payment of the costs.

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

WISCONSIN MEDICAL EXAMINING BOARD

by:  8/20/14
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
JAMES J. LOGAN, M.D., RESPONDENT.	:	0003341

Division of Legal Services and Compliance Case No. 13 MED 260

Respondent James J. Logan, M.D., and the Division of Legal Services and Compliance, Department of Safety and Professional Services stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and he has retained Attorney Lori Gendelman before signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Medical Examining Board (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division

of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

James J. Logan, M.D., Respondent — Date 7/25/14
Mile Bluff Clinic
1040 Division Street
Mauston, WI 53948-1931
License no. 24202-20

Lori Gendelman, Attorney for Respondent — Date 8/1/14
Otjen, Gendelman, Zetzer, Johnson & Weir, S.C.
20935 Swenson Drive, Suite 310
Waukesha, Wisconsin 53186

Joost Kap, Attorney — Date 8/1/14
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