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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	**FINAL DECISION AND ORDER**
AVERY D. ALEXANDER, M.D., RESPONDENT.	:	**0003558**

Division of Legal Services and Compliance Case Numbers:
12 MED 156, 13 MED 084 and 13 MED 123

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

Avery D. Alexander, M.D.
Alexander Eye Institute
250 N. Metro Drive
Appleton, WI 54913

Medical Examining Board
P.O. Box 8366
Madison, WI 53708-8366

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

The parties in these matters agree to the terms and conditions of the attached Stipulation as the final disposition of these matters, subject to the approval of the Medical Examining Board (Board). The Board has reviewed the Stipulation and considers it acceptable.

Accordingly, the Board in these matters adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Avery D. Alexander, M.D. (born February 6, 1959), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 30180-20, first issued on May 24, 1989, and current through October 31, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 250 N. Metro Dr., Appleton, WI 54913. Respondent is certified in Ophthalmology by the American Board of Ophthalmology.

2. At all times pertinent to this matter, Respondent performed refractive eye surgeries, including LASIK and PermaClear® lens procedures at Alexander Eye Institute in Appleton, Wisconsin.

3. Respondent was previously reprimanded by the Board on August 17, 2011 in case number 09 MED 383 for allegedly failing to record specific intraocular pressures for a patient with pre-existing glaucoma following refractive surgery. He successfully completed four hours of continuing medical education in the postsurgical care of patients with glaucoma and his unrestricted license was restored on November 16, 2011.

CASE NO. 12 MED 156

4. On June 9, 2010, Patient A, a then 49 year-old woman, visited Respondent's clinic for a consultation. She reported problems with night vision, reading road signs and reading without glasses. She was considering bifocals, but wanted to improve her vision without a lens procedure. She had already undergone LASIK and had enhancements with other eye surgeons. Respondent examined Patient A's eyes, after which he offered her several treatment options, including PermaClear®. Patient A was provided promotional literature about PermaClear® which enumerated the benefits, but none of the risks, of the procedure. Patient A was specifically cautioned that her cell growth under the left eye flap from a prior LASIK procedure may limit her best corrected vision. Patient A agreed to a surgical work up for the PermaClear® procedure.

5. Patient A returned on June 15, 2010 for a surgical workup. According to Respondent's chart note, Respondent discussed the different lens options available (TECNIS® and ReSTOR®) and the limitations of each; the probable need for additional procedures based upon Patient A's prior LASIK history and the risks of halos and need for light at near vision. The chart note also includes the following: "patient understands risks, including loss of best corrected visual acuity, persistent need for glasses or contact lenses, inability to promise perfect vision and need for reading glasses. Patient understands and is willing to proceed with surgery."

6. Patient A asserts that Respondent told her only of the benefits, not the risks of the recommended procedure. She specifically denies that the representations noted in the Respondent's June 15, 2010 note were shared with her prior to the date of the procedure.

7. Included in the patient record is a PermaClear® Sight Restoration Checklist dated June 15, 2010 which references, among other things, review of a written consent form and review and signature of "PermaClear® 'Tips for Success.'" A copy of the referenced "PermaClear® 'Tips for Success document signed by Patient A on that date is also in the record. Patient A was presented with the consent form (a typed six page, single-spaced document which enumerated a number of possible complications, and contained a statement that no results were guaranteed), which she signed. However, only the signature page was placed in Patient A's chart.

8. On June 22, 2010, Respondent performed the PermaClear® procedure on Patient A's left eye. On June 24, 2010, this process was repeated, and the procedure was performed on Patient A's right eye. Again, only the signature page was placed in Patient A's chart.

9. Respondent indicates that recommendations were made to retain only the signature page in the electronic medical records system due to issues with its capacity, and to maintain copies of the complete informed consent documents in paper form.

CASE NO. 13 MED 084

10. On January 26, 2011, Respondent saw Patient B, a then 59 year-old female who had been told by her optometrist that she had developed cataracts. She complained of light sensitivity and worsening near vision. Respondent confirmed that she had the start of cataracts and explained some of the treatment options, including glasses or an elective PermaClear® procedure. She received a new eyeglass prescription and was asked to return for a complete eye exam in one year.

11. On January 31, 2012, Patient B returned for an eye exam and noted continuing complaints with her near vision, together with "dimming," problems with light and problems with night driving. She could no longer sew after dusk and could not thread a needle with proper light. Patient B was offered the option of cataract removal with an upgrade to a multifocal IOL. She chose to come back for a surgical work-up to explore that procedure.

12. On February 22, 2012, Patient B underwent the surgical work-up for cataract removal with a multifocal lens. According to Respondent's chart note, Respondent discussed the different lens options available (TECNIS® and ReSTOR®) and the limitations of each, as well as the possible need for enhancement by LASIK in the future. The chart note also includes the following: "patient understands risks, including loss of best corrected visual acuity, persistent need for glasses or contact lenses, inability to promise perfect vision and need for reading glasses. Patient understands and is willing to proceed with surgery." A written consent form was provided to, and signed by Patient B on that date.

13. On February 28, 2012 (left eye) and March 1, 2012 (right eye), Respondent removed the bilateral cataracts and placed TECNIS® multifocal lenses in Patient B's eyes.

14. Approximately seven months later, because of complaints of continuing blurry or "hazy" vision, a LASIK enhancement procedure was planned for both eyes, at no further cost to the patient. A written consent form was provided to, and signed by Patient B for the bilateral procedure on August 13, 2012; the procedure was scheduled for September 13, 2012.

15. On September 13, 2012, after commencing the procedure, Respondent determined that LASIK could not be performed, so another procedure, PRK, was performed on Patient B's left eye. No procedure was ever performed on her right eye.

16. The LASIK informed consent document signed by Patient B authorized Respondent to perform a different procedure if deemed appropriate. As such, no further consent document was necessary.

17. Only the signature pages from the various consent forms signed by Patient B were placed in the electronic medical record. Respondent indicates that recommendations were made

to retain only the signature page in the electronic medical records system due to issues with its capacity, and to maintain copies of the complete informed consent documents in paper form.

CASE NO. 13 MED 123

18. On October 13, 2008, Patient C, a then 56 year-old woman, presented to Alexander Eye Institute for an initial consultation and met with a technician and with Dr. Alexander. Patient C was seeking better distance and near vision without glasses (which she had been in since 3rd grade). Respondent presented PermaClear® as her best option, and a PermaClear® work-up was scheduled for December 22, 2008.

19. On December 22, 2008, Patient C returned for the surgical work-up. She was again examined by Dr. Alexander and was provided with a PermaClear® folder which included, inter alia, post-operative instructions and information. Respondent's chart note from that visit includes the following: "patient understands risks, including loss of best corrected visual acuity, persistent need for glasses or contact lenses, inability to promise perfect vision and need for reading glasses. Patient understands and is willing to proceed with surgery."

20. Included in the patient record is a PermaClear® Sight Restoration Checklist dated December 22, 2010 which references, among other things, review of a written consent form and review and signature of "PermaClear® Tips for Success.'" A copy of the referenced "PermaClear® Tips for Success document signed by Patient C on that date is also in the record. Patient C was presented with the consent form (a typed six page, single-spaced document which enumerated a number of possible complications, and contained a statement that no results were guaranteed), which she signed. However, only the signature page was placed in Patient C's chart.

21. On January 6, 2009, Respondent performed the PermaClear® procedure (inserting a ReSTOR® lens) on Patient C's left eye. Two days later, on January 8, 2009, Respondent performed the PermaClear® procedure on Patient C's right eye.

22. Over the next several months, Patient C's vision improved but there were continued complaints of cloudiness, along with glare and light sensitivity. On September 16, 2009, she reported that her distance vision was "worsening." Respondent examined her eyes on September 30, 2009 and offered to perform a LASIK enhancement at no additional charge. Patient C was informed of possible risk of LASIK enhancements and given a folder of information, including a written consent form, which was signed for the left eye on October 9, 2009. Respondent performed the left eye LASIK enhancement on October 15, 2009.

23. After several visits, Patient C returned in November of 2009 with complaints of continued "fog" over the left eye. During the early months of 2010, a new lens became available from TECNIS®. This new lens, and its limitations, were discussed and offered as an option to Patient C at a cost that would cover only the expenses of the lenses themselves and the surgery center expenses.

24. Patient C signed written consent forms, and on May 11, 2010, the left eye lens exchange took place. The right eye lens exchange was performed on January 6, 2011.

25. Patient C reported improved vision, but halos continued to be a problem and she continued to complain that her intermediate vision was not acceptable. She also complained of a "cloud" in the eyes on April 27, 2011. Respondent recommended a bilateral LASIK enhancement, and on May 5, 2011, Respondent lifted the flap on the left eye and performed a full LASIK enhancement on the right eye.

26. On September 22, 2011, Respondent performed Lasik on Patient C's left eye. A pre-operative note from September 22, 2011 indicates a plan to perform LASIK enhancement on Patient C's left eye, but a September 12, 2011 note refers to a plan to perform a LASIK enhancement on the right eye. A written consent form signed and dated by Patient C on September 22, 2011 for LASIK has "Right" written in the blank preceding the word "eye," which has a line drawn through it, and the word "left" is written in and circled next to it. That notation appears to be initialed with the letters "DW," one of Respondent's staff members.

27. Only the signature pages from the various consent forms signed by Patient C were placed in the electronic medical record. Respondent indicates that recommendations were made to retain only the signature page in the electronic medical records system due to issues with its capacity, and to maintain copies of the complete informed consent documents in paper form.

28. Pending the investigation of this matter, Respondent successfully completed the following continuing medical education: Case Western Reserve University – Intensive Course in Medical Record Keeping with Individual Preceptorships (attended November 6-7, 2014 for 14.5 AMA PRA Category 1 credits).

29. In resolution of these matters, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in these matters pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. §§ 227.44(5) and 448.02(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 Avery D. Alexander, M.D., violated Wis. Admin. Code § Med 10.02(2)(za) by failing to maintain a complete copy of the written consent document in the patient health care records consistent with the requirements of Wis. Admin. Code Ch. Med 21.

3. As a result of the above violation, Respondent Avery D. Alexander is subject to discipline pursuant to Wis. Stat. § 448.02.

ORDER

1. The attached Stipulation is accepted.

2. Respondent Avery D. Alexander, M.D., is REPRIMANDED.

3. The Board recognizes and accepts the CME credits referenced in the Findings of Fact as the equivalent of the education the Board would have otherwise required of Respondent. None of the education completed pursuant to this requirement may be used to satisfy any other continuing education requirements that have been or may be instituted by the Board or Department.

4. Within 90 days from the date of this Order, Respondent Avery D. Alexander shall pay COSTS of this matter in the amount of ($4,100.00) dollars.

5. Payment of costs shall be made payable to the Wisconsin Department of Safety and Professional Services and 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 payment of costs as ordered Respondent's license (no. 30180-20) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied.

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

WISCONSIN MEDICAL EXAMINING BOARD

by: _____ Nov. 19, 2014
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST

AVERY D. ALEXANDER, M.D.,
RESPONDENT.

STIPULATION

0003558

Division of Legal Services and Compliance[1] Case No. 12 MED 156, 13 MED 084, 13 MED 123

Respondent Avery D. Alexander, 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 has been provided an opportunity to obtain legal counsel before signing this Stipulation. Respondent is represented by Nash, Spindler, Grimstad & McCracken, LLP.

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.

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

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 or Respondent's attorney, 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.

Avery D. Alexander, M.D., Respondent
Alexander Eye Institute
250 N. Metro Drive
Appleton, WI 54913
License no. 20-30180

Nov 4th 2014
Date

Jeremy T. Gill, Attorney for Respondent
Nash, Spindler, Grimstad & McCracken, LLP
1425 Memorial Dr.
Manitowoc, WI 54220

11-4-14
Date

Yolanda Y. McGowan (BNC)
Yolanda Y. McGowan, Compliance Attorney
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53708-8935

11-5-14
Date