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
MAZIN ELLIAS, M.D., RESPONDENT.	:	0003559

Division of Legal Services and Compliance (Division) Case Nos.
12 MED 403 and 14 MED 189

The parties to these actions for the purpose of Wis. Stat. § 227.53 are:

Mazin Ellias, M.D.
3022 Warm Spring Drive,
Green Bay, WI, 54311

Wisconsin 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 this 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 Mazin Ellias, M.D., (dob March 11, 1956), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 40486-20, first issued on October 9, 1998, 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 703 N. 12th Ave., Wausau, WI 54401. However, Respondent reports his current address as 3022 Warm Spring Drive, Green Bay, WI 54311.

2. At all times relevant to these matters, Respondent was a pain management specialist employed by Advanced Pain Management (APM) in both the Wausau, WI and Stevens Point, WI clinics.

12 MED 403

3. On or about October 24, 2012, Respondent was scheduled to perform a radiofrequency ablation at levels L3-S1 on Patient A. Upon Patient A's presentation for the procedure, it was learned that he had over-medicated himself with valium. The patient was hypotensive (blood pressure was 70/36) and difficult to arouse.

4. Nursing staff recommended that Patient A be given a fluid bolus prior to commencement of the procedure. Respondent insisted on proceeding as scheduled and instead, administering IV fluids during the procedure. Clinic management became involved and directed that the bolus be administered in the preoperative area before proceeding with surgery.

5. By attempting to perform a surgical procedure on Patient A before administering the fluid bolus, Respondent's judgment compromised patient care, which fell below the standard of minimal competence and created the unacceptable risk that Patient A would suffer adverse health consequences.

6. On an unspecified date in September or October, 2012, Radiology Technician S.B. was assisting Respondent who was scheduled to perform a radiofrequency ablation (RFA) procedure on Patient B. This was S.B.'s first time running the RFA machine. S.B. had difficulty operating the machine, which caused the procedure to take longer than normal.

7. Respondent became frustrated with the situation. To avoid taking his frustration out on staff, Respondent left the patient in the operating room, with S.B. in charge of the RFA machine, for 3-5 minutes.

8. It was outside the standard of care for Respondent to leave Patient B in the operating room under the circumstances described above. By doing so, Respondent compromised patient care and demonstrated judgment that fell below the standard of minimal competence, and created an unreasonable risk of harm to patient safety.

9. Respondent acknowledges that difficulty in communications between himself and healthcare staff may have contributed to misunderstandings that led to the filing of the complaint in this matter.

10. Respondent took proactive measures to address the issue by completing the *Intensive Course in Managing Difficult Communications in Medical Practice* sponsored by Case Western Reserve University School of Medicine from November 13-15, 2013, earning 20.75 AMA PRA category 1 continuing medical education credits.

14 MED 189

11. On May 9, 2013, Patient C gave written consent to have Respondent perform a radiofrequency neurolysis medial/dorsal procedure on her left side L2,3,4,5 S1vertebrae. Contrary to the consent, Respondent performed the procedure on Patient C's right side.

12. By performing the wrong procedure on Patient C, Respondent's care of Patient C fell below the standard of minimal competence and created an unreasonable risk of harm that Patient C's actual medical condition would go untreated and/or Patient C might suffer other or additional adverse health consequences.

13. On October 24, 2013, Patient D gave written consent to have Respondent perform a Bilateral Facet injection of L4/5, L5/S1 and MBB L3,4,5, S1. Respondent performed a Bilateral Hypogastric Plexus Block. Respondent subsequently identified the issue, and performed the facet injection the same day at Patient D's request.

14. By performing the wrong procedure on Patient D, Respondent's care of Patient D fell below the standard of minimal competence and created an unreasonable risk of harm that Patient D's actual medical condition would go untreated and/or Patient D might suffer other or additional adverse health consequences.

15. On February 8, 2014, Respondent was scheduled to perform a RFA on Patient E's Patient E right L2,3,4,5 and S1. During the procedure, Patient E experienced an episode of apnea and became cyanotic. Nursing staff called "code blue" and asked Respondent to abort the procedure so that Patient E could be placed on her back for administration of an "Ambu" bag with high flow oxygen. Respondent initially refused in order to save time, instead attempting to administer the oxygen with Patient E still lying on her stomach. The procedure was subsequently aborted until Patient E's condition was stabilized, after which Respondent restarted the procedure.

16. Upon the "code blue" being called, Respondent should have immediately aborted the procedure to ensure patient safety. By failing to do so, Respondent jeopardized Patient E's safety and unnecessarily increased the risk that Patient E might suffer adverse health consequences as a result of being deprived of oxygen. This conduct fell below the standard of minimal competence.

17. Respondent failed to inform Patient E of this event, and further failed to document it in Patient E's medical chart.

18. On July 15, 2014, Respondent was scheduled to perform a surgical procedure on Patient F's left side. Nursing staff conducted a "time-out" immediately before beginning the procedure in order to confirm the procedure to be performed, and on which side of Patient F's body.

19. Notwithstanding the above, in preparing for the procedure, Respondent began numbing the wrong side of Patient E's body. Alert healthcare staff realized the error, thereby averting a wrong-site surgery.

20. By attempting to perform a wrong-site surgery, Respondent's care of Patient F fell below the standard of minimal competence and created an unreasonable risk of harm that Patient F's actual medical condition would go untreated and/or Patient F might suffer other or additional adverse health consequences.

21. Case number 14 MED 189 was opened for investigation based upon a variety of allegations relating to quality of care, communication, record-keeping and scheduling issues.

22. Given the nature and extent of the allegations, many of which were acknowledged by Respondent, the Division asked Respondent to voluntarily submit to a fitness to practice evaluation and to cease practicing medicine and surgery until such time as the investigation of these matters could be concluded.

23. Respondent has not practiced medicine since July 28, 2014 and has agreed to not resume practicing medicine pending informal resolution of these matters.

24. The fitness to practice evaluation was conducted on August 29, 2014, by a provider approved by the board's liaison, who authored a report of the evaluation, dated September 29, 2014 (Report).

25. The Report concluded that there was "no evidence to suggest that [Respondent] had a major psychiatric illness causing problems with [his] work or that would interfere with [his] capacity to work." The evaluator recommended that Respondent further work on the manner in which he interacts with patients and staff, that he limit the number of procedures he performs, and that he adjust his work schedule to limit the number of nights per week he is on call.

26. Respondent agrees to follow the recommendations outlined in the Report, and 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 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).

2. By the conduct described in the Findings of Fact in 12 MED 403 and 14 MED 189, Respondent Mazin Ellias, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code §§ Med 10.02(2)(h) [1] and 10.03(2)(b) by departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public, and § Med 10.02(2)(z) by performing an act constituting the practice of medicine and surgery without required informed consent under Wis. Stat. §448.30.

[1] Note: all references to Wis. Admin. Code § Med 10.02 refer to the Code as it existed before October 1, 2013.

3. By the conduct described in the Findings of Fact in 14 MED 189:

a. Respondent Mazin Ellias, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.03(2)(h) by engaging in repeated or significant disruptive behavior or interaction with hospital personnel, patients or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered.

b. Respondent Mazin Ellias, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code §§ Med 10.03(2)(d) and 10.03(2)(j) by performing or attempting to perform any surgical or invasive procedure on the wrong patient, or at the wrong anatomical site, or performing the wrong procedure on any patient and by performing an act constituting the practice of medicine and surgery without required informed consent under Wis. Stat. §448.30.

4. As a result of the above conduct, Mazin Ellias, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. Respondent Mazin Ellias, M.D., is REPRIMANDED.

3. The Board recognizes and accepts the continuing medical education credits described in Finding of Fact No.11 as the equivalent of the education the Board would have otherwise required.

4. With respect to the license to practice medicine and surgery issued to Mazin Ellias, M.D., (license number 40486-20) it is hereby ordered as follows:

Practice

a. Within seven (7) days of the date of this Order, or the date on which Respondent resumes practicing medicine and surgery in the state of Wisconsin, whichever occurs first, Respondent shall provide his employer with a copy of this Final Decision and Order and all other subsequent orders.

b. For a period of one year, Respondent shall refrain from being on "night call" more frequently than one night every other third night. After one year, this restriction may be modified at the recommendation of Respondent's counselor.

Counseling

c. Within thirty (30) days of the date of this Order, or the date on which Respondent resumes practicing medicine and surgery in the state of

Wisconsin, whichever occurs first, Respondent shall obtain the services of a licensed psychologist ("Counselor") who shall be pre-approved by the Board or its designee.

d. Respondent shall participate in, cooperate with, and follow all treatment recommended by Counselor for a minimum of one year, meeting weekly for at least six months, and then bi-monthly thereafter. After one year, Respondent and Counselor, in conjunction with Respondent's employer, can determine if counseling should continue, and if so, how frequently.

e. Respondent shall immediately provide Counselor with a copy of this Final Decision and Order and all other subsequent orders.

f. Counselor shall have no relationship that could reasonably be expected to compromise the ability of the Counselor to render fair and unbiased reports to the Department.

g. Respondent's counselor shall immediately report to the Department Monitor any knowledge of work related incidents or other written complaints involving or related to Respondent's care and treatment of patients or adverse interaction with colleagues.

Releases

h. Respondent shall provide and keep current releases complying with state and federal laws on file with Counselor. The releases shall allow the Board, its designee, and any employee of the Department of Safety and Professional Services, Division of Legal Services and Compliance to: (a) obtain patient health care and treatment records and reports, including mental health care records, and (b) discuss the progress of Respondent's counseling with Counselor. Copies of these releases shall immediately be filed with the Department Monitor.

Reporting

i. Respondent is responsible for compliance with all of the terms and conditions of this Order, including the timely submission of reports by others. Respondent shall promptly notify the Department Monitor of any violations of any of the terms and conditions of this Order by Respondent.

j. Respondent shall arrange for the Counselor to submit formal written reports every other month evaluating the nature and extent of the Respondent's progress and performance in counseling. The reports should be sent to the Department Monitor, Department of Safety and Professional Services, Division of Legal Services and Compliance, P.O. Box 7190, Madison, Wisconsin 53707-7190, or as otherwise directed by the Department Monitor.

k. Respondent shall submit monthly reports to the Department Monitor indicating whether Respondent has practiced in compliance with the terms and conditions of this Order. Said reports shall include a self-assessment and evaluation of the nature and extent of Respondent's practice and performance,

and shall specifically identify any action or inaction by the Respondent which may constitute unprofessional conduct—including engaging in repeated or significant disruptive behavior or interaction with physicians, hospital personnel, patients or their family members, or others; any violation of this Order, or any other action or inaction which may cause danger to the public or patient.

l. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order.

m. Respondent shall report to the Department Monitor any change of employment status, residence, address or telephone number within five (5) days of the date of a change.

Petitions for Modification for Limitations or Termination of Order

n. Respondent may petition the Board for modification of the terms of this Order after one year. Any petition for modification shall be accompanied by a written recommendation from Respondent's Counselor expressly supporting the specific modifications sought. Denial of a petition in whole or in part shall not be considered a denial of a license within the meaning of Wis. Stat. § 227.01(3)(a), and Respondent shall not have a right to any further hearings or proceedings on the denial.

o. Any requests, petitions, reports and other information required by this Order shall be mailed, e-mailed, faxed or delivered to the Department Monitor utilizing the contact information listed in paragraph 6, below.

Cost of Compliance

p. Respondent shall be responsible for all costs and expenses incurred in conjunction with the monitoring, screening, supervision and any other expenses associated with compliance with the terms of this Order.

5. Within ninety (90) days from the date of this Order, Mazin Ellias, M.D., shall pay the combined COSTS of these matters in the amount of $6, 227.55.

6. Payment of costs shall be made payable to the Wisconsin Department of Safety and Professional Services and sent 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

7. 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 (40486-20) 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.

8. 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 THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
MAZIN ELLIAS, M.D., RESPONDENT.	:	0003559

Division of Legal Services and Compliance Case Nos. 12 MED 403 and 14 MED 189

Respondent Mazin S. Ellias, 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 pending investigations by the Division of Legal Services and Compliance. Respondent consents to the resolution of these investigations 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 is represented by Attorney Michael P. Crooks.

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 matters 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.

Mazin S. Ellias, M.D., Respondent
3022 Warm Spring Drive,
Green Bay, WI, 54311
License No. 40486-20

10-30-2014
Date

Michael P. Crooks, Attorney
Peterson, Johnson & Murray, S.C.
3 S. Pinckney St., Ninth Fl.
Madison, WI 53703

10/31/14
Date

Yolanda McGowan, Attorney
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

11/3/14
Date