WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."

  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca

- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact DSPS@wisconsin.gov

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	
	:	0004603

Division of Legal Services and Compliance Case Nos. 14 MED 300, 14 MED 302 and 15 MED 002

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

David J. Houlihan, M.D.
W5119 Knobloch Road
La Crosse, WI 54601

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 David J. Houlihan, M.D. (DOB February 4, 1964), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 35991-20, first issued on September 23, 1994, with registration current through October 31, 2017.

2. Respondent is not licensed to practice medicine in any other jurisdiction.

3. The most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) for Respondent is W5119 Knobloch Road, La Crosse, Wisconsin 54601.

4. On August 13, 2014, the Department's Division of Legal Services and Compliance (DLSC) opened Case No. 14 MED 302 to investigate allegations that Respondent had engaged in unprofessional conduct in his care and treatment of patients at the United States Veterans Affairs Medical Center located in Tomah, Wisconsin (Tomah VA).

5. On January 20, 2015, DLSC opened Case No. 15 MED 002 to investigate additional allegations that Respondent had engaged in unprofessional conduct in his care and treatment of patients at Tomah VA.

6. On March 16, 2016, the Board approved a formal Complaint against Respondent in DLSC Case No. 15 MED 002. It was filed with the Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) on March 23, 2016, thereby initiating SPS-16-0030. A true and correct copy of the Complaint as filed is attached hereto as Exhibit A.

7. On April 4, 2016, Respondent filed an Answer to the Complaint in 15 MED 002/SPS-16-0030, denying all allegations of unprofessional conduct against him.

8. On June 16, 2016, Respondent was added as a party to then-pending DLSC Case No. 14 MED 300, to investigate allegations that Respondent engaged in unprofessional conduct in his care and treatment and/or in his supervision of the care and treatment of patients at Tomah VA.

9. On July 20, 2016, the Board approved a formal Complaint against Respondent in DLSC Case No. 14 MED 302. It was filed with DHA on the same date, thereby initiating SPS-16-0050. A true and correct copy of the Complaint as filed is attached hereto as Exhibit B.

10. On August 3, 2016, Respondent filed an Answer to the Complaint in 14 MED 302/SPS-16-0050, denying all allegations of unprofessional conduct against him.

11. On September 1, 2016, Administrative Law Judge Jennifer Nashold (ALJ Nashold) issued an order consolidating 15 MED 002/SPS-16-0030 with 14 MED 302/SPS-16-0050.

12. On October 3, 2016, ALJ Nashold issued an order setting the consolidated matters for hearing on March 13-17 and March 20-24, 2017, with deadlines for amended pleadings, dispositive motions, the disclosure of witnesses and exhibits, the close of discovery, and motions *in limine*.

13. On October 19, 2016, the Board approved an Amended Complaint in 15 MED 002/SPS-16-0030. It was filed with DHA on the same date. A true and correct copy of the Amended Complaint as filed is attached hereto as Exhibit C.

14. On October 31, 2016, Respondent filed an Answer to the Amended Complaint in 15 MED 002/SPS-16-0030, denying all allegations of unprofessional conduct against him.

15. On November 11, 2016, DLSC filed a Motion For Partial Summary Judgment as to Count 22 of the Amended Complaint in 15 MED 002/SPS-16-0030. On November 23, 2016,

Respondent filed a response opposing DLSC's motion, and DLSC filed a reply on December 2, 2016.

16. On December 19, 2016, ALJ Nashold issued a Summary Judgment Order granting summary judgment on Count 22 of the Amended Complaint in 15 MED 002/SPS-16-0030. A copy of the order is attached hereto as Exhibit D.

17. On December 20, 2016, the Board approved a formal Complaint against Respondent in 14 MED 300. It has not been filed with DHA as of the date of this order.

18. As to all the remaining counts pled against him in 15 MED 002/SPS-16-0030 and 14 MED 302/SPS-16-0050, and in the approved but not filed Complaint in 14 MED 300, Respondent denies any unprofessional conduct.

19. DLSC and Respondent agree to fully and finally resolve 15 MED 002/SPS-16-0030, 14 MED 302/SPS-16-0050, and 14 MED 300 by entry of the following Conclusions of Law and Order.

20. DLSC agrees to not pursue costs, including attorney fees, pursuant to Wis. Stat. § 440.22.

21. Respondent agrees he will never apply for any credential issued by the Department or any regulatory board affiliated with the Department which in any way involves the provision of medical care and treatment, or other medical or health care services.

22. Respondent agrees he will not accept any new patients as of the effective date of this 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. Pursuant to the Summary Judgment Order described in Finding of Fact 16, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(c).

ORDER

1. The attached Stipulation is accepted.

2. The PERMANENT SURRENDER by Respondent David J. Houlihan, M.D. of his license and registration to practice medicine and surgery in the State of Wisconsin (license no. 35991-20) and the appurtenant right to renew that registration is hereby accepted, and shall become effective thirty (30) days from the date of this Order so that Respondent can discharge his current patients in accordance with Wis. Admin. Code § Med 10.03(2)(o).

3. This surrender constitutes Respondent's permanent relinquishment of his right to practice medicine and surgery in the State of Wisconsin. The Board will not at any time in the future, process or otherwise consider an application or attempt at renewal by Respondent of credentials necessary to practice medicine and surgery in the State of Wisconsin.

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

WISCONSIN MEDICAL EXAMINING BOARD

by: Kenneth B. Simon, MD 1/18/17

A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	0004603

Division of Legal Services and Compliance Case Nos. 14 MED 300, 14 MED 302 and 15 MED 002

Respondent David J. Houlihan, 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 in the course of the above-described matters pending before the Wisconsin Department of Administration, Division of Hearings and Appeals, and the Division of Legal Services and Compliance. Respondent consents to the resolution of these matters 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 Attorney Frank M. Doherty.

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 Wisconsin Department of Administration, Division of Hearings and Appeals, and 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 these matters 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.

11/10/2017
Date

David L. Houlihan, M.D.
W5119 Knobloch Road
La Crosse, WI 54601
License no. 35991-20

1/11/17
Date

Frank M. Doherty, Attorney for Respondent #1035832
Hale Skemp Hanson Skemp & Sleik
505 King Street, Suite 300
La Crosse, WI 54601

1/18/17
Date

Yolanda McGowan, Prosecuting Attorney
Joost Kap, Prosecuting Attorney
Colleen Meloy, Prosecuting Attorney
Sarah Norberg, Prosecuting Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

EXHIBIT
A

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	COMPLAINT
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	

Division of Legal Services and Compliance Case No. 15 MED 002

Yolanda Y. McGowan, an Attorney for the State of Wisconsin, Department of Safety and Professional Services, Division of Legal Services and Compliance, Post Office Box 7190, Madison, Wisconsin 53707-7190, upon information and belief, alleges that:

1. Respondent David J. Houlihan, M.D. (DOB February 4, 1964), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 35991-20, first issued on September 23, 1994, with registration current through October 31, 2017.

2. The most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) for Respondent is W5119 Knobloch Road, La Crosse, Wisconsin 54601.

3. At all times pertinent to this matter, Respondent practiced medicine at the Veterans Administration Medical Center located in Tomah, Wisconsin (Tomah VA).

4. Respondent's practice specialty is psychiatry.

5. Respondent's medical practice at Tomah VA began in 2002 as an outpatient psychiatrist.

6. Respondent continued to serve as an outpatient psychiatrist while assuming various management roles at Tomah VA, including Clinical Director of Mental Health, Acting Chief of Staff, Chief of Staff, and Acting Medical Center Director.

7. In his role as Chief of Staff, Respondent provided and/or directed or supervised the provision of healthcare services to veterans of the United States Military.

8. Effective January 16, 2015, Respondent's clinical privileges at Tomah VA were summarily suspended.

9. The reported basis for the suspension was the conclusion that Respondent's clinical practice did not meet the accepted standards of practice and potentially constituted an imminent threat to patient welfare.

10. Effective November 9, 2015, Respondent's employment at Tomah VA was terminated and his clinical privileges were revoked.

11. The reported basis for Respondent's termination and the revocation of his clinical privileges was the determination that:

a. Respondent failed to provide appropriate medical care to at least 22 patients between 2005 and 2014, and

b. Respondent engaged in professional misconduct involving eight reported incidents of abuse of authority occurring between 2008 and 2013.

COUNT 1

12. Respondent provided and/or directed and supervised the provision of healthcare services to Patient A[1] (a male born in 1978) at various times from 2005 until August 2014.

13. In or around 2003, Patient A presented to Tomah VA to establish care.

14. Patient A returned to Tomah VA in 2005 requesting treatment for addiction; he reported opioid dependence and abuse/addiction to controlled substances, including benzodiazepines.

15. From 2005 through 2014, Patient A was seen intermittently at Tomah VA for mental health diagnoses including posttraumatic stress disorder (PTSD), generalized anxiety disorder, attention deficit hyperactivity disorder (ADHD), and Bi-polar I Disorder.

16. On August 10, 2014, Patient A was admitted to Tomah VA following reports of suicidal thoughts, feeling out of control, and complaints of low back pain.[2]

17. On August 22, 2014, while Patient A was still receiving inpatient care at Tomah VA, Respondent saw Patient A for "Pharmacy Management" and "Further Evaluation" at an outpatient appointment.[3]

18. Following the August 22, 2014 appointment, Respondent neither made, nor caused to be made, any changes to the list of prescription medications Patient A was receiving.

19. Prior to August 28, 2014, Patient A's Tomah VA healthcare records reflected a reported history of:

a. frequently adjusting and/or discontinuing medications on his own;

b. taking medications that were not prescribed for him;

[1] In order to respect the patient's privacy, he will be referenced in all pleadings as "Patient A." Patient A's identity is being disclosed to Respondent in a separate communication.
[2] Patient A's admission to the inpatient treatment unit continued until August 30, 2014.
[3] Respondent anticipated assuming Patient A's care upon his expected discharge from inpatient treatment.

c. taking excessive amounts of benzodiazepines and other medicines;

d. obtaining controlled substances illegally, and

e. a potentially severe allergic reaction to Suboxone®.

20. On August 28, 2014, in consultation with another Tomah VA psychiatrist, Respondent agreed to start Patient A on Suboxone® at a dosage of 8 mg twice daily.

21. Suboxone®, the brand name for buprenorphine, is a Schedule III narcotic under the federal Controlled Substances Act and Wis. Stat. § 961.18(5m)(a).

22. On and prior to August 28, 2014, Suboxone® was approved by the United States Food and Drug Administration to treat patients with opioid dependence.

23. On and prior to August 28, 2014, Patient A was not dependent on opioids.

24. On August 29, 2014, Respondent prescribed Patient A 8 mg of Suboxone® to be administered twice daily.

25. When Respondent prescribed Suboxone® for Patient A, he did not adjust or cause to be adjusted, any of the medications Patient A was receiving at the time, which included atomoxetine, diazepam, diphenhydramine HCL, duloxetine, hydroxyzine pamoate, quetiapine fumarate, temazepam, and tramadol.

26. On the morning of August 29, 2014, Patient A was administered the first of three doses of Suboxone® in a 24 hour period.

27. On August 30, 2014, Patient A died in his room on the Tomah VA inpatient treatment unit.

28. Patient A's autopsy report noted the cause of death as mixed-drug toxicity (tramadol, diazepam, diphenhydramine, and buprenorphine). It further noted a finding of pulmonary edema with evidence of terminal aspiration.[4]

29. Respondent was one of Patient A's treating and/or supervising physicians immediately prior, and up to the time of Patient A's demise.

30. During the course of his care and treatment of Patient A, Respondent knew or should have known that Patient A:

a. frequently adjusted and/or discontinued medications on his own;

b. reported taking medications that were not prescribed for him;

[4]Aspiration may occur when a person is unconscious or under the effects of a general anesthetic; it can result from delayed respiratory depression.

c. misused certain of his medications, including benzodiazepines, by taking excessive amounts;

d. obtained controlled substances illegally, and

e. a potentially severe allergic reaction to Suboxone®.

31. During the course of the care and treatment of Patient A, Respondent prescribed or caused to be prescribed to Patient A, multiple controlled and non-controlled medications with the potential for respiratory depression.

32. When prescribing Suboxone® to Patient A, Respondent did not inquire into, or otherwise assess whether Patient A was at increased risk of harm for a potentially severe allergic reaction to receiving 8 mg of Suboxone®.

33. When prescribing Suboxone® to Patient A, Respondent did not in any way document the prescription order, including the amount and frequency to be administered, the clinical justification for the prescription order itself; the clinical justification for the prescription order in combination with the other controlled substances Patient A was receiving, or the assessment of risks and benefits to the patient in light of his reported medical history as reflected in the Tomah VA patient records.

34. When prescribing Suboxone® to Patient A, Respondent did not inform Patient A of the risks and benefits of treatment with Suboxone®, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments;

35. During the course of the care and treatment provided to Patient A, Respondent prescribed and/or caused to be prescribed to Patient A significant amounts of controlled substances without adequate or any medical support.

36. During the course of the care and treatment of Patient A, Respondent prescribed and/or caused to be prescribed to Patient A a combination of controlled substances, including benzodiazepines and opioids, for which there was no adequate clinical or evidence-based support.

37. A minimally competent and reasonable physician would have:

a. recognized that a patient with Patient A's health history and mental condition was at high risk for abusing and/or misusing controlled substances, including benzodiazepines, and reduced, discontinued or otherwise modified Patient A's controlled substance medications to reduce the unacceptable risk of adverse health consequences to the patient;

b. recognized that the multiple and varied combination of controlled substances being prescribed to Patient A could unnecessarily increase the patient's risk of adverse consequences due to over-sedation, increased respiratory depression, mixed-drug toxicity, and/or death, and taken action to protect against this risk;

c. assessed the risks and benefits, and evaluated the appropriateness of prescribing 8 mg of Suboxone® twice daily to a patient with Patient A's health history, as reflected in the Tomah VA records;

d. would not have added an additional controlled substance with sedative properties (Suboxone®) to the medications the patient was already receiving;

e. utilized extreme caution and careful monitoring of the patient to protect against an unacceptable risk of harm due to increased respiratory depression and other risks of adverse health consequences created by the concurrent administration of multiple benzodiazepines and opioids;

f. informed Patient A of the potential for complications regarding treatment with Suboxone® alone, and in combination with the other controlled substance medications Patient A was receiving;

g. obtained informed consent for the mode and method of treatment to be rendered to Patient A, and

h. indicated on Patient A's healthcare chart that risks and benefits of the treatment plan (including pharmacological management), as well as reasonable alternate modes of treatment, had been communicated to Patient A.

38. Respondent's care and treatment, and/or supervision of the care and treatment provided to Patient A, including prescriptive practices regarding Patient A, fell below the standard of minimal competence, and created the unacceptable risk that Patient A would experience adverse health consequences, up to, and including death.

39. Respondent David J. Houlihan, M.D., by the conduct previously described herein was negligent.

40. Respondent David J. Houlihan, M.D., departed from or failed to conform to the standard of minimally competent medical practice, creating the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(b)[5].

41. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence, created the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(c).

[5] All references to the Wisconsin Administrative Code are to the Code in effect at the time of the alleged conduct: November 2002 for conduct occurring prior to October 1, 2013, and October 2013 for conduct occurring on and after October 1, 2013.

42. Respondent David J. Houlihan, M.D., by providing care and treatment to Patient A without informing him about the risks and benefits of treatment, and about the availability of other alternate medical modes of treatment and the risks and benefits of those treatments, created the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(j).

43. Respondent David J. Houlihan, M.D., by failing, to establish and maintain timely patient health care records consistent with the requirements of Wis. Admin. Code ch. Med 21, engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(e).

COUNT 2

44. On or about February 12, 2015, the United States Veterans Administration (VA) commenced a focused review of Respondent's clinical practices at Tomah VA.

a. The review was conducted by a five-member panel.

b. The panel included three psychiatrists (Reviewers) who actively practiced in VA facilities outside the Tomah, Wisconsin region.

c. The Reviewers were provided access to patient charts of 27 patients to whom Respondent had prescribed opioids and/or Suboxone® in 2014.

45. In their review, the Reviewers raised the following issues and concerns related to Respondent's clinical practice:

a. inappropriate care;

b. prescriptive practices (including inappropriate or unsafe prescribing);

c. acting beyond the scope of practice of general psychiatry;

d. inadequate documentation, and

e. failure to discuss risks and benefits of treatment.

46. In the course of his clinical practices at Tomah VA, Respondent routinely provided care outside the scope of a general psychiatric practice.

47. In the course of his clinical practices at Tomah VA, when treating patients presenting with chronic pain complaints, Respondent:

a. routinely prescribed opioids in doses that greatly exceeded the recommended maximum daily amount;

b. did not refer these patients to primary care, pain management, or other providers;

c. did not consult with any specialists in treating patients with chronic pain complaints;

d. routinely prescribed opioids without sufficient supporting documentation, and/or

e. routinely prescribed opioids in direct contradiction of written recommendations by other, more qualified providers.

48. A minimally competent and reasonable mental health provider practicing in a mental health clinic would not treat patients with chronic pain complaints with chronic opioid medications, but would refer patients to a pain management program, involve a pain management specialist, or would otherwise utilize a collaborative, interdisciplinary care approach to chronic pain management.

49. A minimally competent and reasonable physician would have informed patients of the risks and benefits of treating chronic pain complaints with high doses of opioid medications, and of other available alternate, viable modes of non-pharmacological based medical treatment for chronic pain management, interdisciplinary chronic pain management options, and about the benefits and risks of these treatments.

50. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician by practicing outside the scope of general psychiatry in his treatment of patients presenting with complaints of chronic pain.

51. Respondent David J. Houlihan, M.D., by the conduct previously described herein:

a. departed from or failed to conform to the standard of minimally competent medical practice;

b. practiced medicine when unable or unwilling to do so with reasonable skill and safety;

c. prescribed, dispensed, administered or caused to be prescribed, dispensed, or administered, prescription medications in a manner that is inconsistent with the standard of minimal competence;

d. practiced medicine beyond the scope of his medical specialty and training;

e. performed medical acts without required informed consent, and

f. failed to maintain patient health care records consistent with the requirements of Wis. Admin. Code ch. Med 21.

thereby creating the unacceptable risk that patients would suffer adverse health consequences from lack of appropriate chronic pain management, including risk of injury or death due to over-sedation, substance abuse, inadequate treatment of chronic pain, and adverse side effects of medications used alone or in combination with others. By said conduct, Respondent engaged in

unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h), (i), (j), (p), (u) and (za) and Wis. Admin. Code §§ Med 10.03(2)(a), (b), (c), (j) and (3)(e).

COUNT 3

52. In early 2015, the VA Administrative Board of Investigation (ABI) investigated allegations that Respondent, while acting as the Tomah VA Chief of Staff, abused his authority by treating pharmacy and other staff adversely when they raised concerns regarding Respondent's prescriptive practices, particularly overmedication and drug diversion.

53. On July 23, 2015, the ABI issued a report finding that on multiple occasions spanning several years, Respondent engaged in inappropriate, unfair, and intimidating actions which fostered an environment in which Tomah VA staff felt unable to openly communicate concerns about potentially unsafe prescribing practices.

54. The ABI report concluded that Respondent's inappropriate conduct was sufficiently egregious to constitute an abuse of his authority as Chief of Staff.

55. Respondent, in his role as Tomah VA Chief of Staff, on multiple occasions between 2005 and 2014, engaged in conduct that was disruptive, threatening, or harsh, or otherwise negatively impacted members of the Tomah VA staff in the performance of their duties.

56. Between 2005 and 2014, due to the hostile and disruptive work environment created by Respondent, Tomah VA staff deliberately refrained from communicating with or consulting with Respondent about patient care issues to avoid hostility and confrontation.

57. A minimally competent and reasonable physician would not engage in repeated or significant disruptive behavior or interaction with medical facility personnel that could reasonably be expected to adversely impact the quality of health care rendered.

58. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician in his interactions with medical facility personnel and abuse of his authority as Tomah VA Chief of Staff.

59. Respondent David J. Houlihan, M.D., by engaging in repeated or significant disruptive behavior or interactions with Tomah VA personnel, or otherwise abusing his authority as Tomah VA Chief of Staff, created an unacceptable risk that the quality of patient care at Tomah VA would be adversely impacted.

60. Respondent's above-described conduct tends to constitute a danger to the health, welfare, or safety of patient or public, and constitutes unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h) and § 10.03(2)(h).

61. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

The Division of Legal Services and Compliance demands that the Medical Examining Board hear evidence relevant to the matters alleged in this complaint, determine and impose the discipline warranted, and assess the costs against Respondent David J. Houlihan, M.D.

Dated 23rd of March, 2016.

Yolanda Y. McGowan, Attorney
State Bar No. 1021905
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190
(608) 266-3679
Yolanda.McGowan@wisconsin.gov

EXHIBIT
B

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	COMPLAINT
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	

Division of Legal Services and Compliance Case No. 14 MED 302

Yolanda Y. McGowan and Joost Kap, Attorneys for the State of Wisconsin, Department of Safety and Professional Services, Division of Legal Services and Compliance, Post Office Box 7190, Madison, Wisconsin 53707-7190, upon information and belief, allege that:

1. Respondent David J. Houlihan, M.D. (DOB February 4, 1964), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 35991-20, first issued on September 23, 1994, with registration current through October 31, 2017.

2. The most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) for Respondent is W5119 Knobloch Road, La Crosse, Wisconsin 54601.

3. Respondent currently practices psychiatry at a clinic located in La Crosse, Wisconsin.

4. At all times pertinent to this matter, Respondent practiced medicine at the Veterans Affairs Medical Center located in Tomah, Wisconsin (Tomah VA).

5. Respondent's medical practice at Tomah VA began in 2002 as an outpatient psychiatrist.

6. Respondent continued to serve as an outpatient psychiatrist while assuming various management roles at Tomah VA, including Clinical Director of Mental Health, Acting Chief of Staff, Chief of Staff, and Acting Medical Center Director.

7. In his roles at Tomah VA, Respondent provided, directed, and/or supervised the provision of healthcare services to veterans of the United States Military.

8. Effective January 16, 2015, Respondent's clinical privileges at Tomah VA were summarily suspended.

9. Effective November 9, 2015, Respondent's employment at Tomah VA was terminated and his clinical privileges were revoked.

COUNT 1 - PATIENT B[1]

10. On more than one occasion between 2006 and 2015, Patient B (a female veteran born in 1984) received healthcare services at Tomah VA.

11. On August 29, 2006, Patient B presented to Tomah VA's urgent care center with complaints of shoulder pain. Patient B's healthcare record for that visit includes health history as follows: Patient B suffered a shoulder injury during basic training in 2002; in or around 2005, Patient B began experiencing neck pain believed to be secondary to her shoulder injury; and Patient B, having been previously hospitalized for depression, was seeking service-connected disability for depression.

12. During the August 29, 2006 visit, Patient B reported Tylenol® and ibuprofen as her current medications; reported her most prior medication regimen as including hydromorphone and oxycodone; reported that she did not want to be "put on a bunch of experimental meds," and requested that her pain medication regimen be closely monitored.

13. Between 2006 and 2015, Patient B was seen intermittently at Tomah VA by Respondent and other Tomah VA healthcare providers for various physical and/or mental health conditions including substance abuse, non-compliance with prescribed medications, suicidal ideations, detoxification, shoulder pain, and panic/anxiety attacks.

14. Between 2006 and 2015, Patient B's Tomah VA healthcare chart reflects references to diagnoses of Bipolar Disorder, Alcohol Abuse, Depression, Attention Deficit/Hyperactivity Disorder, and Psychalgia.

15. On May 24, 2007, Patient B was admitted to Tomah VA for the first of seven in-patient admissions to the psychiatric unit for substance abuse-related conditions between then and December 2007.

16. On June 8, 2007, Respondent first saw Patient B while she was still receiving care on the inpatient psychiatric unit at Tomah VA. Respondent doubled the dosages of several controlled substance medications Patient B was receiving, including Prozac®, Valium® and risperidone.

17. On more than one occasion between 2007 and 2015, including, but not limited to dates in May 2010, October 2011, June 2012, March 2013, and November 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient B in amounts and/or combinations with insufficient or no medical support, creating an unreasonable risk that Patient B may suffer adverse health effects, up to, and including death.

18. On more than one occasion between 2007 and 2015, including, but not limited to dates in May 2010, October 2011, June 2012, March 2013, and November 2014, Respondent

[1] To respect privacy, patients will be referenced in all pleadings as Patients B, C, D, E and F. Each patient's identity has been disclosed to Respondent in a separate communication.

prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient B without informing Patient B of available alternate modes of medical treatment and the risks/benefits of said treatments.

19. On more than one occasion between 2007 and 2015, including, but not limited to dates in May 2010, October 2011, June 2012, March 2013, and November 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient B with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

20. On more than one occasion between 2007 and 2015, including, but not limited to dates in May 2010, October 2011, June 2012, March 2013, and November 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient B without adequate safeguards and consequences to prevent diversion and abuse of the prescribed medications, thereby creating unreasonable risk of harm to Patient B and the public.

21. On more than one occasion between 2007 and 2015, including, but not limited to dates in May 2010, October 2011, June 2012, March 2013, and November 2014, Respondent failed to refer Patient B to other providers and/or work in collaboration with other providers to ensure that Patient B's physical and mental health conditions were appropriately treated.

22. On more than one occasion between 2007 and 2015, Respondent met with Patient B at locations outside Tomah VA, during which he shared intimate, personal details of his life, and engaged in other non-professional communications with Patient B.

23. On more than one occasion between 2007 and 2015, Patient B had direct access to Respondent via his personal cell phone, and used such to engage in telephone conversations and text messaging with Respondent, including during periods of time in which Respondent was on administrative leave and/or suspension from his employment with Tomah VA.

24. On more than one occasion between 2007 and 2015, Patient B was disruptive toward and made demands of Tomah VA healthcare providers related to medications Respondent prescribed to Patient B, with threats of retribution against the providers by Respondent if the demands were not met.

25. Patient B's disruptive, demanding and/or threatening behavior interfered with patient care and/or could reasonably be expected to adversely impact the quality of care rendered.

26. On more than one occasion between 2007 and 2015, Respondent aided and abetted Patient B's disruptive, demanding, and/or threatening behavior toward other healthcare providers and staff at Tomah VA, thereby creating an unreasonable risk of harm to Patient B, other Tomah VA patients, and the public.

COUNT 2 - PATIENT C

27. On more than one occasion between 2005 and 2015, Patient C (a male veteran born in 1961) received healthcare services at Tomah VA.

28. Between 2005 and 2015, Patient C was seen intermittently at Tomah VA by Respondent and other Tomah VA healthcare providers for various physical and/or mental health conditions including depression, substance abuse (alcohol and cocaine), and joint pain.

29. Between 2005 and 2015, Patient C's Tomah VA healthcare chart reflects references to diagnoses of Severe Depression without psychosis; Post Traumatic Stress Disorder (PTSD), Drug Dependence, Diabetes, Headache, Arthralgia, and non-compliance with medication.

30. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2011, April 2012, August 2013, and September 2014, Respondent prescribed opioids in increasing amounts, multiple benzodiazepines, and other controlled and non-controlled substances to Patient C.

31. On more than one occasion between 2007 and 2014, Patient C repeatedly relapsed into alcohol and other drug use, often resulting in criminal convictions and extended periods of incarceration. After being released from incarceration, Patient C would return to Tomah VA and Respondent would resume prescribing opioids in increasing amounts, multiple benzodiazepines, and other controlled and non-controlled substance medications to Patient C.

32. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2011, April 2012, August 2013, and September 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient C without adequate assessments, safeguards and consequences to prevent diversion and abuse of the prescribed medications, thereby creating an unreasonable risk of harm to Patient C and the public.

33. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2011, April 2012, August 2013, and September 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient C in amounts and/or combinations with insufficient or no medical support, creating an unreasonable risk that Patient C may suffer adverse health effects, up to, and including death.

34. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2011, April 2012, August 2013, and September 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient C without informing Patient C of available alternate modes of medical treatment and the risks/benefits of said treatments.

35. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2011, April 2012, August 2013, and September 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient C with

medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

COUNT 3 - PATIENT D

36. On more than one occasion between 2011 and 2014, Patient D (a female veteran born in 1983) received healthcare services at Tomah VA.

37. In May 2011, Patient D presented to Tomah VA for a compensation and pension examination, subsequent to a September 2010 basic training accident requiring right hip surgery.

38. As part of the May 2011 examination, Patient D denied any physical conditions except the right hip injury.

39. As part of the May 2011 examination, Patient D denied any psychiatric conditions, including depression, anxiety, panic attacks and substance abuse.

40. Patient D was next seen at Tomah VA in September 2012 with complaints of increased hip pain. An urgent care provider prescribed Vicodin®, but Patient D reported it caused nausea, headache, and vomiting.

41. Between September 2012 and December 2012, Patient D began reporting symptoms of depression, a history of substance abuse, began requesting Percocet®, claimed back and groin pain, and subsequently failed to present for scheduled physical therapy and mental health appointments.

42. Between 2012 and 2014, Patient D's Tomah VA healthcare chart reflects references to diagnosis of Major Depressive Disorder, Panic Disorder, and Opioid Dependence.

43. On December 21, 2012, Patient D first saw Respondent. Patient D's Tomah VA healthcare chart from that visit references Percocet® as Patient D's drug of choice for abuse.

44. On more than one occasion between 2012 and 2014, including, but not limited to dates in February, April, May, and November 2013, Respondent prescribed opioids including Percocet®, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient D without adequate safeguards or consequences to prevent diversion and abuse of the prescribed medications, thereby creating an unreasonable risk of harm to Patient D and the public.

45. On more than one occasion between 2012 and 2014, including, but not limited to dates in April, May, and November 2013, Respondent prescribed opioids including Percocet®, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient D in amounts and/or combinations with insufficient or no medical support, creating an unreasonable risk that Patient D may suffer adverse health effects, up to, and including death.

46. On more than one occasion between 2012 and 2014, including, but not limited to dates in April 2013 and January 2014, Respondent prescribed opioids including Percocet®,

stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient D without informing Patient D of available alternate modes of medical treatment and the risks/benefits of said treatments.

47. On more than one occasion between 2012 and 2014, including, but not limited to dates in March and April 2013, Respondent prescribed opioids including Percocet®, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient D with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

48. On more than one occasion between 2012 and 2014, Respondent failed to refer Patient D to other providers and/or work in collaboration with other providers to ensure that Patient D's physical and mental health conditions were appropriately treated.

COUNT 4 - PATIENT E

49. On more than one occasion between 2002 and 2014, Patient E (a male veteran born in 1963) received healthcare services at Tomah VA.

50. In July 2002, Patient E presented to Tomah VA for admission to a mental health and substance abuse program, with a history of alcohol abuse, polysubstance abuse, and bipolar disorder, among other history and presentation.

51. In 2002 and 2003, Patient E was treated by Respondent and other Tomah VA healthcare providers for mental health and substance abuse conditions; during that time Patient E was known to engage in deceptive behavior for obtaining controlled substances.

52. Patient E returned to Respondent's care at Tomah VA in December 2007 upon reporting a recent out-of-state hospitalization for suicidal ideation. Patient E's Tomah VA healthcare chart from that visit reflects references to diagnoses of severe depression and substance abuse.

53. On more than one occasion between 2007 and 2014, including, but not limited to dates in January 2008, December 2010, April 2011, March 2013, and January 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient E without adequate safeguards and consequences to prevent diversion and abuse of the prescribed medications, thereby creating an unreasonable risk of harm to Patient E and the public.

54. On more than one occasion between 2007 and 2014, including, but not limited to dates in January 2008, April 2011, July 2012, and January 2013, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient E in amounts and/or combinations with insufficient or no medical support, creating an unreasonable risk that Patient E may suffer adverse health effects, up to, and including death.

55. On more than one occasion between 2007 and 2014, including, but not limited to dates in January 2008 and July 2012, Respondent prescribed opioids, stimulants,

benzodiazepines, and other controlled and non-controlled substances to Patient E without informing Patient E of available alternate modes of medical treatment and the risks/benefits of said treatments.

56. On more than one occasion between 2007 and 2014, including, but not limited to dates in January 2008, December 2010, December 2012, January 2013, and January 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient E with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

57. On more than one occasion between 2011 and 2014, Respondent failed to refer Patient E to other providers and/or work in collaboration with other providers to ensure that Patient E's physical and mental health conditions were appropriately treated.

58. On more than one occasion between 2011 and 2014, Patient E, based upon his relationship with Respondent, was disruptive toward and made demands of Tomah VA healthcare providers related to medications Respondent prescribed to Patient E, with threats of retribution against the providers by Respondent if the demands were not met.

59. Patient E's disruptive, demanding and/or threatening behavior interfered with patient care and/or could reasonably be expected to adversely impact the quality of care rendered.

60. On more than one occasion between 2011 and 2014, Respondent aided and abetted Patient E's disruptive, demanding, and/or threating behavior toward other healthcare providers and staff at Tomah VA, thereby creating an unreasonable risk of harm to Patient E, other Tomah VA patients, and the public.

COUNT 5 - PATIENT F

61. On more than one occasion between 2004 and 2014, Patient F (a female veteran born in 1957) received healthcare services at Tomah VA.

62. In January 2004, Patient F presented to Tomah VA requesting to be treated because she was not satisfied with the private health system where she previously received care, in part because providers there refused to see her.

63. Patient F presented to Tomah VA with no prior medical records, a large bag of various medications, and a self-reported history which included chronic back pain, chronic headaches, depression/anxiety, psychotic disorder, various surgeries, among other history and presentation.

64. Between 2004 and 2007, Patient F treated with Tomah VA providers, other than Respondent, who at various times refused Patient F's requests for opioids and benzodiazepines because of her history, her demonstrated inability to take medications as prescribed and/or follow other treatment as ordered, and due to concerns about Patient F's diversion and abuse of prescribed medications.

65. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2007, August 2010, June 2011, February 2012, February 2013, and January 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient F without adequate safeguards and consequences to prevent diversion and abuse of the prescribed medications, thereby creating an unreasonable risk of harm to Patient F and the public.

66. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2007, June 2011, February 2012, February 2013, and January 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient F in amounts and/or combinations with insufficient or no medical support, creating an unreasonable risk that Patient F may suffer adverse health effects, up to, and including death.

67. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2007, August 2010, July 2011, April 2013, and January 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient F without informing Patient F of available alternate modes of medical treatment and the risks/benefits of said treatments.

68. On more than one occasion between 2007 and 2014, including, but not limited to dates in October 2007, March 2008, May 2010, June 2011, November 2012, February 2013, and January 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient F with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

69. On February 5, 2014, the Tomah Police Department responded to a call about Patient F's well-being. Officers forced entry into Patient F's residence and found Patient F deceased. In addition to documenting a significant amount of prescription medications in Patient F's home, investigating officers observed a 100mcg/h Fentanyl patch on Patient F's body, which Respondent had prescribed to her. The law enforcement report indicates the investigating officer had "rarely seen that large of a dosage of Fentanyl outside of the hospital setting or terminal cancer patients on hospice or at home in anticipation of death."

70. On more than one occasion between 2007 and 2014, Respondent failed to refer Patient F to other providers and/or work in collaboration with other providers to ensure that Patient F's physical and mental health conditions were appropriately treated.

AS TO ALL COUNTS

71. During the course of the care and treatment of Patients B - F, Respondent prescribed and/or caused to be prescribed to Patients B - F multiple and varied controlled and non-controlled substance medications, including benzodiazepines and opioids, in significant amounts, for which there was no adequate clinical or evidence-based support.

72. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients B - F, Respondent did not inform Patients B - F of the risks and benefits of treatment with each of the multiple and varied controlled and

non-controlled substance medications prescribed, alone or in combination, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments.

73. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients B - F, Respondent did not adequately or fully document the clinical justification for his prescribing practices or the assessment of risks and benefits to the patient.

74. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients B - F, Respondent did not employ adequate safeguards against diversion and/or abuse of the prescribed medications.

75. During the course of the care and treatment of Patients B - F, Respondent did not ensure that the patients' physical and mental health needs were timely and adequately addressed.

76. During the course of the care and treatment of Patients B - F, Respondent did not consistently maintain healthcare records that were timely, accurate, complete, or otherwise sufficient to ensure patient safety.

77. A minimally competent and reasonable physician treating Patients B - F would have, *inter alia*:

a. recognized that patients with Patients B - F's health histories and mental health diagnoses would be at high risk for abusing and/or misusing controlled substances, and as such, reduced, discontinued or otherwise modified the patient's controlled and non-controlled substance medications to reduce the unreasonable risk of adverse health consequences to the patient;

b. recognized that the multiple and varied combinations of controlled and non-controlled substances being prescribed to Patients B - F could unnecessarily increase the patient's risks of adverse consequences due to a myriad of side effects, and taken action to protect against these risks;

c. assessed the risks and benefits to the patients of the prescribing practices, and evaluated the appropriateness of the amounts and combinations of controlled and non-controlled medications prescribed to the patients;

d. utilized sufficient caution and monitoring to protect Patients B - F from unreasonable risk of harm due to increased respiratory depression and other risks of adverse health consequences created by the concurrent administration of multiple controlled and non-controlled substance medications (including benzodiazepines, stimulants and opioids);

e. informed Patients B - F of the potential for complications regarding concurrent treatment with benzodiazepines, stimulants, and opioids alone, and in combination with each other, and other controlled substance medications and/or alcohol or other illicit substances;

f. obtained informed consent for the mode and method of treatment to be rendered to Patients B - F;

g. indicated in Patients B - F's healthcare charts that risks and benefits of the treatment plan (including pharmacological management), as well as reasonable alternate modes of treatment, had been communicated to Patients B - F prior to administration of treatment;

h. exercised reasonable judgment to ensure that all of Patients B - F's physical and mental health care needs were timely and adequately addressed, including referrals to and/or working collaboratively with other healthcare providers;

i. maintained timely, accurate, and complete patient healthcare charts for all patients; and

j. acted with reasonable judgment, competence, and respect for patient boundaries.

78. The medical practice of Respondent David J. Houlihan, M.D., when providing, directing, and/or supervising the care and treatment of Patients B - F, including his prescriptive practices regarding Patients B - F, fell below the standard of minimal competence, and created the unreasonable risk that Patients B - F would experience adverse health consequences.

79. Respondent David J. Houlihan, M.D., by his overall practices regarding the care and treatment of Patients B - F, including his failure to act with honesty, respect for the law, reasonable judgment, competence and respect for patient boundaries, departed from or failed to conform to the standard of minimally competent medical practice, creating the unreasonable risk that Patients B - F would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002) and Wis. Admin. Code § Med 10.03(2)(b) (Oct. 2013).[2]

80. Respondent David J. Houlihan, M.D., by administering, dispensing, prescribing, supplying, or obtaining controlled substances otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law, created the unreasonable risk that Patients B - F would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(p) (Nov. 2002).

81. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence, created the unreasonable risk that Patients B - F would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.03(2)(c) (Oct. 2013).

[2] All references to the Wisconsin Administrative Code are to the Code in effect at the time of the alleged conduct: November 2002 for conduct occurring prior to October 1, 2013, and October 2013 for conduct occurring on and after October 1, 2013.

82. Respondent David J. Houlihan, M.D., by providing care and treatment to Patients B - F without informing the patient of the risks and benefits of treatment, and about the availability of other alternate medical modes of treatment and the risks and benefits of those treatments, created the unreasonable risk that Patients B - F would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(u) (Nov. 2002) and Wis. Admin. Code § Med 10.03(2)(j) (Oct. 2013).

83. Respondent David J. Houlihan, M.D., by failing to establish and maintain timely patient health care records consistent with the requirements of Wis. Admin. Code ch. Med 21, engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(za) (Nov. 2002) and Wis. Admin. Code § Med 10.03(3)(e) (Oct. 2013).

84. Respondent David J. Houlihan, M.D., by aiding and abetting patients' repeated or significant disruptive behavior or interaction with other healthcare providers, engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.03(2)(h) (Oct. 2013).

85. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

The Division of Legal Services and Compliance demands that the Medical Examining Board hear evidence relevant to the matters alleged in this complaint, determine and impose the discipline warranted, and assess the costs against Respondent David J. Houlihan, M.D.

Dated 7th of July, 2016.

Yolanda Y. McGowan, Attorney
State Bar No. 1021905
Joost Kap, Attorney
State Bar No. 1055878
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190
(608) 266-3679

EXHIBIT
C

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	DHA Case No. SPS-16-0030
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	DLSC Case No. 15 MED 002

AMENDED COMPLAINT

Yolanda Y. McGowan, an Attorney for the State of Wisconsin, Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), Post Office Box 7190, Madison, Wisconsin 53707-7190, upon information and belief, alleges that:

1. Respondent David J. Houlihan, M.D. (DOB February 4, 1964), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 35991-20, first issued on September 23, 1994, with registration current through October 31, 2017.

2. The most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) for Respondent is W5119 Knobloch Road, La Crosse, Wisconsin 54601.

3. Respondent currently practices psychiatry at a clinic located in La Crosse, Wisconsin.

4. From 2002 to 2015, Respondent practiced medicine at the Veterans Affairs Medical Center located in Tomah, Wisconsin (Tomah VA).

5. Respondent's medical practice at Tomah VA began in 2002 as an outpatient psychiatrist.

6. Respondent continued to serve as an outpatient psychiatrist while assuming various management roles at Tomah VA, including Clinical Director of Mental Health, Acting Chief of Staff, Chief of Staff, and Acting Medical Center Director.

7. In his roles at Tomah VA, Respondent provided and/or directed or supervised the provision of health care services to veterans of the United States Military.

COUNT 6 - PATIENT A[1] (CRP[2] 27)

[1] To respect privacy, patients will be referenced in all pleadings as Patients A, and G - T. Each patient's identity is being disclosed to Respondent in a separate communication.
[2] Tomah VA Clinical Review Patient

8. The Division re-alleges and incorporates by reference, Count 1 of its Complaint dated and filed in this action on March 23, 2016.

COUNT 7 - PATIENT G (CRP 1)

9. On more than one occasion between 2002 and 2014, Patient G (a male veteran born in 1950) received health care services at Tomah VA from Respondent and other health care providers.

10. Between 2002 and 2014, Patient G's Tomah VA health care record references diagnoses of and/or active problems including post-traumatic stress disorder (PTSD), major depressive disorder, alcohol abuse disorder, psychalgia, borderline personality disorder, and complaints of pain.

11. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient G in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient G may suffer adverse health effects.

12. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient G without informing Patient G of available alternate modes of medical treatment and the risks and benefits of said treatments.

13. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient G with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

14. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient G without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient G or the public.

15. On more than one occasion between 2002 and 2014, Respondent failed to refer Patient G to other providers and/or work in collaboration with other providers to ensure that Patient G's physical and mental health conditions were appropriately treated.

COUNT 8 - PATIENT H (CRP 2)

16. On more than one occasion between 2003 and 2014, Patient H (a male veteran born in 1949) received health care services at Tomah VA from Respondent and other healthcare providers.

17. Between 2003 and 2014, Patient H's Tomah VA health care record references diagnoses of and/or active problems including generalized anxiety disorder, depression, various complaints of pain, alcohol or other drug use, and PTSD.

18. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient H in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient H may suffer adverse health effects.

19. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient H without informing Patient H of available alternate modes of medical treatment and the risks and benefits of said treatments.

20. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient H with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

21. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient H without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient H or the public.

22. On more than one occasion between 2003 and 2014, Respondent failed to refer Patient H to other providers and/or work in collaboration with other providers to ensure that Patient H's physical and mental health conditions were appropriately treated.

COUNT 9 - PATIENT I (CRP 4)

23. On more than one occasion between 2007 and 2014, Patient I (a male veteran born in 1974), received health care services at Tomah VA from Respondent and other healthcare providers.

24. Between 2007 and 2014, Patient I's Tomah VA health care record references diagnoses of and/or active problems including PTSD, schizoid personality disorder, pain in joint involving pelvic region and thigh, and alcohol or other drug use.

25. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient I in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient I may suffer adverse health effects.

26. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to

Patient I without informing Patient I of available alternate modes of medical treatment and the risks and benefits of said treatments.

27. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient I with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

28. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient I without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient I or the public.

29. On more than one occasion between 2007 and 2014, Respondent failed to refer Patient I to other providers and/or work in collaboration with other providers to ensure that Patient I's physical and mental health conditions were appropriately treated.

COUNT 10 - PATIENT J (CRP 8)

30. On more than one occasion between 2003 and 2014, Patient J (a male veteran born in 1946), received health care services at Tomah VA from Respondent and other health care providers.

31. Between 2003 and 2014, Patient J's Tomah VA health care record references diagnoses of and/or active problems including a history of disruptive, assaultive behavior, PTSD, narcissistic personality disorder, psychalgia, headache, and tremor secondary to multiple concussions.

32. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient J in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient J may suffer adverse health effects.

33. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient J without informing Patient J of available alternate modes of medical treatment and the risks and benefits of said treatments.

34. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient J with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

35. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to

Patient J without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient J or the public.

36. On more than one occasion between 2003 and 2014, Respondent failed to refer Patient J to other providers and/or work in collaboration with other providers to ensure that Patient J's physical and mental health conditions were appropriately treated.

COUNT 11 - PATIENT K (CRP 9)

37. On more than one occasion between 2011 and 2014, Patient K (a male veteran born in 1953) received health care services at Tomah VA from Respondent and other health care providers.

38. Between 2011 and 2014, Patient K's Tomah VA health care record references diagnoses of and/or active problems including schizoaffective disorder, psychalgia, opioid dependence, borderline personality disorder, attempted suicide, poly substance abuse disorder, and complaints of pain.

39. On more than one occasion between 2011 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient K in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient K may suffer adverse health effects.

40. On more than one occasion between 2011 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient K without informing Patient K of available alternate modes of medical treatment and the risks and benefits of said treatments.

41. On more than one occasion between 2011 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient K with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

42. On more than one occasion between 2011 and 2014, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient K without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient K or the public.

43. On more than one occasion between 2011 and 2014, Respondent failed to refer Patient K to other providers and/or work in collaboration with other providers to ensure that Patient K's physical and mental health conditions were appropriately treated.

COUNT 12 - PATIENT L (CRP 10)

44. On more than one occasion between 2006 and 2015, Patient L (a male veteran born in 1956) received health care services at Tomah VA from Respondent and other health care providers.

45. Between 2006 and 2015, Patient L's Tomah VA health care record references diagnoses of and/or active problems including major depressive disorder, non-compliant behavior, and bipolar disorder. Patient L's health care record also references a history of alcohol dependence and treatment for seizures related to alcohol withdrawal.

46. On more than one occasion between 2006 and 2015, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient L in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient L may suffer adverse health effects.

47. On more than one occasion between 2006 and 2015, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient L without informing Patient L of available alternate modes of medical treatment and the risks and benefits of said treatments.

48. On more than one occasion between 2006 and 2015, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient L with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

49. On more than one occasion between 2006 and 2015, Respondent prescribed opioids, benzodiazepines, and other controlled and non-controlled substances to Patient L without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient L or the public.

50. On more than one occasion between 2006 and 2015, Respondent failed to refer Patient L to other providers and/or work in collaboration with other providers to ensure that Patient L's physical and mental health conditions were appropriately treated.

COUNT 13 - PATIENT M (CRP 13)

51. On more than one occasion between 2012 and 2014, Patient M (a male veteran born in 1981) received health care services at Tomah VA from Respondent and other health care providers.

52. Between 2012 and 2014, Patient M's Tomah VA health care record references diagnoses of and/or active problems including PTSD, noncompliance with medication regimen, agoraphobia with panic disorder, primary insomnia, polysubstance dependence, substance abuse, arthralgia, and complaints of pain.

53. On more than one occasion between 2012 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient M in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient M may suffer adverse health effects.

54. On more than one occasion between 2012 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient M without informing Patient M of available alternate modes of medical treatment and the risks and benefits of said treatments.

55. On more than one occasion between 2012 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient M with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

56. On more than one occasion between 2012 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient M without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient M or the public.

57. On more than one occasion between 2012 and 2014, Respondent failed to refer Patient M to other providers and/or work in collaboration with other providers to ensure that Patient M's physical and mental health conditions were appropriately treated.

COUNT 14 - PATIENT N (CRP 16)

58. On more than one occasion between 2006 and 2015, Patient N (a male veteran born in 1981) received health care services at Tomah VA from Respondent and other health care providers.

59. Between 2007 and 2015, Patient N's Tomah VA health care record references diagnoses of and/or active problems including panic disorder with agoraphobia, generalized anxiety disorder, major depressive disorder, psychalgia, schizoaffective disorder, and attention deficit disorder. Patient N's Tomah VA health care record documents Patient N's difficulty with treatment compliance and history of substance use disorder.

60. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient N in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient N may suffer adverse health effects.

61. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient N without informing Patient N of available alternate modes of medical treatment and the risks and benefits of said treatments.

62. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient N with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

63. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient N without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating an unacceptable risk of harm to Patient N or the public.

64. On more than one occasion between 2007 and 2014, Respondent failed to refer Patient N to other providers and/or work in collaboration with other providers to ensure that Patient N's physical and mental health conditions were appropriately treated.

COUNT 15 - PATIENT O (CRP 18)

65. On more than one occasion between 2002 and 2014, Patient O (a male veteran born in 1949) received health care services at Tomah VA from Respondent and other health care providers.

66. Between 2002 and 2014, Patient O's Tomah VA health care record references diagnoses of and/or active problems including schizoaffective disorder, herniated disc, and complaints of pain.

67. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient O in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient O may suffer adverse health effects.

68. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient O without informing Patient O of available alternate modes of medical treatment and the risks and benefits of said treatments.

69. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient O with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

70. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient O without adequate safeguards and consequences to prevent diversion or abuse of the prescribed medications, thereby creating unacceptable risk of harm to Patient O or the public.

71. On more than one occasion between 2002 and 2014, Respondent failed to refer Patient O to other providers and/or work in collaboration with other providers to ensure that Patient O's physical and mental health conditions were appropriately treated.

COUNT 16 - PATIENT P (CRP 19)

72. On more than one occasion between 2003 and 2014, Patient P (a male veteran born in 1957) received health care services at Tomah VA from Respondent and other health care providers.

73. Between 2003 and 2014, Patient P's Tomah VA health care record references diagnoses of and/or active problems including opioid abuse, complaints of pain, chronic obstructive pulmonary disease (COPD), sleep apnea, and PTSD.

74. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient P, in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient may suffer adverse health effects.

75. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient P without informing Patient P of available alternate modes of medical treatment and the risks and benefits of said treatments.

76. On more than one occasion between 2003 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient P with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure proper patient safety.

77. On more than one occasion between 2003 and 2014, Respondent prescribed opioids stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient P without adequate safeguards and consequences to prevent diversion or abuse of prescribed medications, thereby creating unacceptable risk of harm to Patient P or the public.

78. On more than one occasion between 2003 and 2014, Respondent failed to refer Patient P to other providers and/or work in collaboration with other providers to ensure that Patient P's physical and mental health conditions were appropriately treated.

COUNT 17 - PATIENT Q (CRP 20)

79. On more than one occasion between 2002 and 2014, Patient Q (A female veteran born in 1950) received health care services at Tomah VA from Respondent and other health care providers.

80. Between 2002 and 2014, Patient Q's Tomah VA health care record references diagnoses of and/or active problems including depressive disorder, generalized anxiety disorder, polysubstance dependence, PTSD, and complaints of pain.

81. On more than one occasion between 2004 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient Q in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient Q may suffer adverse health effects.

82. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient Q without informing Patient Q of available alternate modes of medical treatment and the risks and benefits of said treatments.

83. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient Q with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure proper patient safety.

84. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient Q without adequate safeguards and consequences to prevent diversion or abuse of prescribed medications, thereby creating unacceptable risk of harm to Patient Q or the public.

85. On more than one occasion between 2002 and 2014, Respondent failed to refer Patient Q to other providers and/or work in collaboration with other providers to ensure that Patient Q's physical and mental health conditions were appropriately treated.

COUNT 18 - PATIENT R (CRP 23)

86. On more than one occasion between 2002 and 2014, Patient R (a male veteran born in 1952) received health care services at Tomah VA from Respondent and other health care providers.

87. Between 2002 and 2014, Patient R's Tomah VA health care record references diagnoses of and/or active problems including PTSD, psychalgia, osteoarthritis, substance abuse, and alcohol abuse.

88. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient R in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient R may suffer adverse health effects.

89. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to

Patient R without informing Patient R of available alternate modes of medical treatment and the risks and benefits of said treatments.

90. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient R with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

91. On more than one occasion between 2002 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient R without adequate safeguards and consequences to prevent diversion or abuse of prescribed medications, thereby creating unacceptable risk of harm to Patient R or the public.

92. On more than one occasion between 2002 and 2014, Respondent failed to refer Patient R to other providers and/or work in collaboration with other providers to ensure that Patient R's physical and mental health conditions were appropriately treated.

COUNT 19 - PATIENT S (CRP 24)

93. On more than one occasion between 2007 and 2014, Patient S (a male veteran born in 1957) received health care services at Tomah VA from Respondent and other health care providers.

94. Between 2007 and 2014, Patient S's Tomah VA health care record references diagnoses of and/or active problems including schizophrenia, major depressive disorder, alcohol dependence, and COPD.

95. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient S in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient S may suffer adverse health effects.

96. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient S without informing Patient S of available alternate modes of medical treatment and the risks and benefits of said treatments.

97. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient S with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

98. On more than one occasion between 2007 and 2014, Respondent prescribed opioids, stimulants, benzodiazepines, and other controlled and non-controlled substances to Patient S without adequate safeguards and consequences to prevent diversion or abuse of prescribed medications, thereby creating unacceptable risk of harm to Patient S or the public.

99. On more than one occasion between 2007 and 2014, Respondent failed to refer Patient S to other providers and/or work in collaboration with other providers to ensure that Patient S's physical and mental health conditions were appropriately treated.

COUNT 20 - PATIENT T (CRP 26)

100. On more than one occasion between 2007 and 2015, Patient T (a male veteran born in 1987) received health care services at Tomah VA from Respondent and other health care providers.

101. Between 2007 and 2015, Patient T's Tomah VA health care record references diagnoses of and/or active problems including bipolar affective disorder, migraine headaches, and history of a fall.

102. On more than one occasion between 2007 and 2015, Respondent prescribed opioids, benzodiazepines, barbiturates and other controlled and non-controlled substances to Patient T in amounts and/or combinations with insufficient or no medical support, creating an unacceptable risk that Patient T may suffer adverse health effects.

103. On more than one occasion between 2007 and 2015, Respondent prescribed opioids, benzodiazepines, barbiturates, and other controlled and non-controlled substances to Patient T without informing Patient T of available alternate modes of medical treatment and the risks and benefits of said treatments.

104. On more than one occasion between 2007 and 2015, Respondent prescribed opioids, benzodiazepines, barbiturates and other controlled and non-controlled substances to Patient T with medical record documentation which was inaccurate, incomplete, or otherwise insufficient to ensure patient safety.

105. On more than one occasion between 2007 and 2015, Respondent prescribed opioids, benzodiazepines, barbiturates, and other controlled and non-controlled substances to Patient T without adequate safeguards and consequences to prevent diversion or abuse of prescribed medications, thereby creating unacceptable risk of harm to Patient T or the public.

106. On more than one occasion between 2007 and 2015, Respondent failed to refer Patient T to other providers and/or work in collaboration with other providers to ensure that Patient T's physical and mental health conditions were appropriately treated.

AS TO COUNTS 7 – 20

107. During the course of the care and treatment of Patients G - T, Respondent prescribed and/or caused to be prescribed to Patients G - T multiple and varied controlled and non-controlled substance medications, including benzodiazepines, stimulants, and opioids, in significant amounts, for which there was no adequate clinical or evidence-based support.

108. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients G - T, Respondent did not inform Patients G - T of the risks and benefits of treatment with each of the multiple and varied controlled and non-controlled substance medications prescribed, alone or in combination, and of other available alternate, viable modes of treatment and about the risks and benefits of these treatments.

109. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients G - T, Respondent did not adequately or fully document the clinical justification for his prescribing practices or the assessment of risks and benefits to the patient.

110. When prescribing and/or increasing the dosages of multiple and varied controlled and non-controlled substance medications to Patients G - T, Respondent did not employ adequate safeguards against diversion and/or abuse of the prescribed medications.

111. During the course of the care and treatment of Patients G - T, Respondent did not ensure that the patients' physical and mental health needs were timely and adequately addressed.

112. During the course of the care and treatment of Patients G - T, Respondent did not consistently maintain health care records that were timely, accurate, complete, or otherwise sufficient to ensure patient safety.

113. A minimally competent and reasonable physician treating Patients G - T would have, *inter alia*:

a. recognized that patients with Patients G - T's health histories and mental health diagnoses would be at high risk for abusing and/or misusing controlled substances, and as such, reduced, discontinued or otherwise modified the patient's controlled and non-controlled substance medications to reduce the unacceptable risk of adverse health consequences to the patient;

b. recognized that the multiple and varied combinations of controlled and non-controlled substances being prescribed to Patients G - T could unnecessarily increase the patient's risks of adverse consequences due to a myriad of side effects, and taken action to protect against these risks;

c. assessed the risks and benefits to the patients of the prescribing practices, and evaluated the appropriateness of the amounts and combinations of controlled and non-controlled medications prescribed to the patients;

d. utilized sufficient caution and monitoring to protect Patients G - T from unacceptable risk of harm due to increased respiratory depression and other risks of adverse health consequences created by the concurrent administration of multiple controlled and non-controlled substance medications;

e. informed Patients G - T of the potential for complications regarding concurrent treatment with benzodiazepines, stimulants, and opioids alone, and in combination

with each other, and other controlled substance medications and/or alcohol or other illicit substances;

f. obtained informed consent for the mode and method of treatment to be rendered to Patients G - T;

g. indicated in Patients G - T's health care records that risks and benefits of the treatment plan (including pharmacological management), as well as reasonable alternate modes of treatment, had been communicated to Patients G - T prior to administration of treatment;

h. exercised reasonable judgment to ensure that all of Patients G - T's physical and mental health care needs were timely and adequately addressed, including referrals to and/or working collaboratively with other health care providers;

i. maintained timely, accurate, and complete patient health care records for all patients; and

j. acted with reasonable judgment, competence, and respect for patient boundaries.

114. The medical practice of Respondent David J. Houlihan, M.D., when providing, directing, and/or supervising the care and treatment of Patients G - T, including his prescriptive practices regarding Patients G - T, fell below the standard of minimal competence, and created the unacceptable risk that Patients G - T would experience adverse health consequences.

115. Respondent David J. Houlihan, M.D., by his overall practices regarding the care and treatment of Patients G - T, including his failure to act with honesty, respect for the law, reasonable judgment, competence and respect for patient boundaries, departed from or failed to conform to the standard of minimally competent medical practice, creating the unacceptable risk that Patients G - T would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002) and Wis. Admin. Code § Med 10.03(2)(b) (Oct. 2013).[3]

116. Respondent David J. Houlihan, M.D., by administering, dispensing, prescribing, supplying, or obtaining controlled substances otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law, created the unacceptable risk that Patients G - T would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(p) (Nov. 2002).

117. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence, created the unacceptable risk that Patients G - T would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.03(2)(c) (Oct. 2013).

[3] All references to the Wisconsin Administrative Code are to the Code in effect at the time of the alleged conduct: November 2002 for conduct occurring prior to October 1, 2013, and October 2013 for conduct occurring on and after October 1, 2013.

118. Respondent David J. Houlihan, M.D., by providing care and treatment to Patients G - T without informing the patient of the risks and benefits of treatment, and about the availability of other alternate medical modes of treatment and the risks and benefits of those treatments, created the unacceptable risk that Patients G - T would suffer adverse health consequences. By said conduct, Respondent engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(u) (Nov. 2002) and Wis. Admin. Code § Med 10.03(2)(j) (Oct. 2013).

119. Respondent David J. Houlihan, M.D., by failing to establish and maintain timely patient health care records consistent with the requirements of Wis. Admin. Code ch. Med 21, engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.02(2)(za) (Nov. 2002) and Wis. Admin. Code § Med 10.03(3)(e) (Oct. 2013).

COUNT 21

120. The Division re-alleges and incorporates by reference, Count 3 of its Complaint dated and filed in this action on March 23, 2016.

COUNT 22 - ADVERSE DETERMINATION

121. Effective January 16, 2015, Respondent's clinical privileges at Tomah VA were summarily suspended.

122. Effective November 9, 2015, Respondent's clinical privileges at Tomah VA were revoked, and his employment was terminated.

123. Respondent appealed Tomah VA's decision to suspend and revoke his clinical privileges, and terminate his employment.

124. On April 11-15, 2016, Respondent's appeal was heard by a Veterans Affairs Administration (VA) Disciplinary Appeals Board (DAB) consisting of three physicians from VA facilities in Michigan, Nevada, and Kansas, and a Human Resources Consultant from a VA facility in Arkansas. The VA and Respondent were represented by counsel.

125. At the April 2016 DAB hearing, Respondent and other witnesses, including three psychiatrists, testified and were cross-examined under oath, and the parties and DAB jointly presented 155 exhibits including patient medical records, transcripts of sworn testimony, Office of Inspector General memoranda, and other documents.

126. On or about August 29, 2016, a final decision affirming the suspension and revocation of Respondent's VA clinical privileges, and the termination of Respondent's VA employment was issued.

127. The August 2016 decision sustained 20 charges of Respondent's failure to provide appropriate medical care to 20 different patients, 13 of which are the subject of this Amended Complaint.

128. The August 2016 decision sustained the one charge of professional misconduct based on Respondent's abuse of authority.

129. Respondent, David J. Houlihan, M.D., by having any act constituting the practice of medicine and surgery become subject to adverse determination by a federal agency or authority, engaged in unprofessional conduct. See Wis. Admin. Code § Med 10.03(3)(c) (Oct. 2013).

130. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

The Division of Legal Services and Compliance demands that the Medical Examining Board hear evidence relevant to the matters alleged in this Amended Complaint, determine and impose the discipline warranted, and assess the costs against Respondent David J. Houlihan, M.D.

Dated 7th of October, 2016.

Yolanda Y. McGowan
State Bar No. 1021905
Colleen L. Meloy
State Bar No. 1029855
Joost Kap
State Bar No. 1055878
Sarah E. Norberg
State Bar No. 1041826
Attorneys for Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190
(608) 266-3679
Yolanda.McGowan@wisconsin.gov

EXHIBIT

D

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against
David J. Houlihan, M.D., Respondent

DHA Case Nos. SPS-16-0050
SPS-16-0030
DLSC Case Nos. 14 MED 302
15 MED 002

SUMMARY JUDGMENT ORDER

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

David J. Houlihan, M.D., by:

Attorney Francis M. Doherty
Hale, Skemp, Hanson, Skemp & Sleik
505 King Street, Suite 300
P.O. Box 1927
La Crosse, WI 54602-1927

Department of Safety and Professional Services, Division of Legal Services and Compliance, by

Attorney Joost Kap, Attorney Sarah Norberg,
Attorney Colleen Meloy, Attorney Yolanda McGowan
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708-8935

The above-captioned matter is before this tribunal on a motion for partial summary judgment filed by the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division). A hearing is currently set in this matter for March 13-17 and March 20-24, 2017. For the reasons set forth below, the request for partial summary judgment is granted in part and denied in part.

UNDISPUTED MATERIAL FACTS

1. The United States Department of Veterans Affairs (VA) is a cabinet level federal agency which, among other things, provides medical care and treatment to veterans and active service members of the United States military. *See* www.va.gov; www.whitehouse.gov.

2. The VA has authority over the medical professionals it employs to provide medical care and treatment at VA facilities. (*Id.*)

3. Between 2002 and 2015, Respondent provided healthcare services while employed as psychiatrist at the VA Medical Center in Tomah, Wisconsin (Tomah VA). (Amended Complaint (Complaint), ¶¶ 4-6; Answer to Amended Complaint (Answer), ¶ 1)

4. Effective January 16, 2015, Respondent's clinical privileges at the Tomah VA were summarily suspended. (Complaint, ¶ 121; Answer, ¶ 36)

5. On September 17, 2015, Respondent received a Proposed Removal and Revocation signed by the acting Tomah VA medical director and listing 23 separate allegations against Respondent, of which 22 alleged his failure to provide appropriate medical care to Tomah VA patients. (Affidavit of Joost Kap (Kap Aff.), Exhibit (Ex.) A, p. 1)

6. Respondent filed a written response to the charges, but on November 9, 2015, his Tomah VA clinical privileges were revoked and his VA employment terminated based on his failure to provide appropriate medical care to 20 Tomah VA patients. (Complaint, ¶ 122; Answer, ¶ 37; Kap Aff., Ex. A, Attachment (Att.) A, p. 1)

7. Respondent appealed the VA's decision to suspend and revoke his clinical privileges and terminate his employment. (Kap Aff., Ex. A, p. 1)

8. On April 11-15, 2016, the appeal hearing took place before a VA Disciplinary Appeals Board (DAB) consisting of three physicians from VA facilities in Michigan, Nevada and Kansas, and a Human Resources Consultant from a VA facility in Arkansas. (Complaint, ¶ 124; Answer, ¶ 39; Kap Aff., Ex. A, Att. A, p. 1)

9. The VA and Respondent were represented by counsel at the hearing. Respondent and witnesses testified and were cross-examined under oath, including three expert VA psychiatrists who reviewed Respondent's care and treatment of the patients at issue. The parties and DAB jointly presented 155 exhibits, including patient medical records, transcripts of sworn testimony, Office of Inspector General memoranda, and other documents. (Complaint, ¶¶ 124-125; Answer, ¶¶ 39-41; Kap Aff., Ex. A, Att. A, p. 7)

10. The burden of proof applied at the DAB hearing was the same as applies in this matter: preponderance of the evidence. (Kap Aff., Ex. A, Att. A)

11. On June 20, 2016, the DAB issued a decision (DAB Decision) sustaining the suspension and revocation of Respondent's VA clinical privileges and terminating his employment with the VA. (Kap. Aff., Ex. A)

12. On August 29, 2016, the VA, by Principal Deputy Undersecretary for Health, Richard A. Stone, M.D., issued a "final administrative action" affirming and executing the DAB Decision. (Kap Aff., Ex. B)

13. The DAB Decision sustained 20 charges of Respondent's failure to provide appropriate medical care to 20 different patients. (Complaint, ¶ 127; Answer, ¶ 42; Kap Aff., Ex. A, Att. A)

14. As part of his appeal, Respondent raised the following defenses: (1) the charges against him were unfounded, unsupported by substantial evidence, the result of an abuse of discretion, not in accordance with applicable laws, standards, rules and regulations, and the result of failure to provide due process and failure to provide information; (2) the charges against him were politically motivated; (3) the charges against him had been previously reviewed by the Office of Inspector General and found to be unsubstantiated; and (4) the charges against him had not been raised during prior peer review processes. (Kap Aff., Ex. A, Att. A, p. 4)

15. The DAB decision addressed Respondent's defenses and found them all to be "without merit." (Kap Aff., Ex. A, Att. A, pp. 4-5)

16. The DAB Decision explicitly states it is "a major adverse action" against Respondent. (Kap Aff., Ex. A, Att. A, p. 2)

17. The DAB Decision explicitly states it involves Respondent's "**direct patient care** and/or **clinical competence.**" (*Id.*) (emphasis in original)

18. The DAB "**concluded the sustained charges . . . represent substandard care, professional incompetence or professional misconduct**" and that the resulting revocation of Respondent's "clinical privileges is reportable to the National Practitioner Data Bank." The DAB also sustained Respondent's termination from the Tomah VA. (Kap Aff., Ex. A, Att. A, pp. 95-96) (emphasis in original)

19. Of the 20 patients to whom Respondent was found to have provided substandard or incompetent medical care, 13 of them are pled in the Division's Amended Complaint as Patients A, G, H, I, K, L, M, N, P, Q, R, S and T.[1] (Kap Aff., Ex. A, Att. A; Complaint)

20. The DAB Decision addressed each patient individually and for each one cited substantial medical evidence of Respondent's substandard or incompetent medical care. The DAB Decision is incorporated into this summary judgment order and its most relevant conclusions are set forth in findings 21-33, below. (Kap Aff., Ex. A, Att. A)

[1] These patients are identified in the DAB Decision as 27, 1, 2, 4, 9, 10, 13, 16, 19, 20, 23, 24 and 26, respectively. This order uses the alphabetical designations used in the Division's Amended Complaint.

21. The DAB made the following findings regarding Patient A:

Charge XXII: Failure to provide appropriate medical care to Patient [A] (2 specifications)

Specification 1: *On August 28, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) for Patient [A], which was added to an existing combination of sedating medications including benzodiazepine (diazepam), benzodiazepine (temazepam), antipsychotic (quetiapine), antihistamine (diphenhydramine), antihistamine (hydroxyzine), and opioid (tramadol). The suboxone was initiated on August 29, 2014. Adding suboxone to this combination of medications did not meet the standard of care.*
Board Findings for Specification I: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *On August 28, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) for Patient [A] without discussing the risks and benefits of the medication with the patient and obtaining informed consent. Your failure to discuss the risks and benefits and obtain the patient's informed consent did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XXII: **Charge XXII is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [A] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 77-80) (emphasis in original)

22. The DAB made the following findings regarding Patient G:

Charge I. Failure to provide appropriate medical care to Patient [G] (4 specifications)

Specification 1: *Between July 29, 2005 and November 12, 2010, you prescribed two benzodiazepines (lorazepam and temazepam) in combination with an opioid (oxycodone or oxycodone/acetaminophen) to Patient [G], who had substance*

abuse in the history, increasing the potential for adverse effects. The medication combination in this patient did not meet the standard of care.

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between July 29, 2005 and November 12, 2010, you prescribed two benzodiazepines (lorazepam and temazepam) in combination with an opioid (oxycodone or oxycodone/acetaminophen) to Patient [G]. Your documentation was insufficient to support the medications used in the treatment of this patient. The clinical history, response to treatment, discussion of side effects and treatment plan were not adequately documented. You failed to provide adequate justification for your treatment regimen. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *Between June 4, 2012 and December 22, 2014, you prescribed 30 mg tablets of oxycodone (opioid) to Patient [G] with dosing of up to 240 mgs per day. The dosage prescribed exceeded the standard of care. Your treatment did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *Between June 4, 2012 and December 22, 2014, you prescribed 30 mg tablets of oxycodone (opioid) to Patient [G] with dosing of up to 240 mgs per day. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE I: **Charge I is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all the elements and specifications of this charge were sustained by a preponderance of

the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [G] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 9-13) (emphasis in original)

23. The DAB made the following findings regarding Patient H:

Charge II. Failure to provide appropriate medical care to Patient [H] (5 specifications)

Specification I: *Between November 25, 2011 and October 6, 2014, you prescribed a benzodiazepine (clonazepam) in combination with an opioid (oxycodone) to Patient [H], who had a documented history of substance abuse with alcohol and marijuana. The opioid dosage (oxycodone) was high, creating risk for adverse events. The medication combination did not meet the standard of care.*

Board Findings for Specification I: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between November 25, 2011 and October 6, 2014, you prescribed a benzodiazepine (clonazepam) in combination with an opioid (oxycodone) to Patient [H]. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *On December 16, 2013 and January 13, 2014, you prescribed methylphenidate (stimulant) to Patient [H]. Patient [H] was also prescribed a benzodiazepine (clonazepam) and an opioid (oxycodone) during the same timeframe. The medication combination did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *On December 16, 2013 and January 13, 2014, you prescribed methylphenidate (stimulant) to Patient [H]. Patient [H] was also prescribed a*

benzodiazepine (clonazepam) and an opioid (oxycodone) during the same timeframe. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 6: *Between April 3, 2009 and August 15, 2011, you prescribed a benzodiazepine (clonazepam) in combination with an opioid (oxycodone) and an additional narcotic (hydrocodone/acetaminophen) to Patient [H]. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 6: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE II: **Charge II is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications with this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [H] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 13-19) (emphasis in original)

24. The DAB made the following findings regarding Patient I:

Charge III. Failure to provide appropriate medical care to Patient [I] (1 specification)

Specification: *On January 30, 2009, you prescribed methylphenidate (stimulant) to Patient [I]. You continued Patient [I] on methylphenidate or another form of stimulant (dextroamphetamine) through January 8, 2015. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

***BOARD FINDING AS TO CHARGE III*: Charge III is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that the elements and the sole specification with this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [I] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 19-20) (emphasis in original)

25. The DAB made the following findings regarding Patient K:

Charge VII: Failure to provide appropriate medical care to Patient [K] (2 specifications)

Specification I: *Between February 27, 2012 and August 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [K] in combination with benzodiazepine (diazepam). The medication combination in this patient with substance abuse and suicide risk histories did not meet the standard of care.*

***Board Finding for Specification 1:* The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between February 27, 2012 and August 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [K] in combination with benzodiazepine (diazepam). Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

***Board Finding for Specification 2:* The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

***BOARD FINDING AS TO CHARGE VII:* Charge VII is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [K] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 23-26) (emphasis in original)

26. The DAB made the following findings regarding Patient L:

Charge VIII: Failure to provide appropriate medical care to Patient [L] (2 specifications)

Specification 3: *On May 12, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [L]. The suboxone: buprenorphine/naloxone (opioid/narcotic) was prescribed in combination with a benzodiazepine (clonazepam) on May 12, 2014. The medication combination in this patient with alcohol dependence and suicide risk histories did not meet the standard of care.*

Board Finding for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *On May 12, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [L]. The suboxone: buprenorphine/naloxone (opioid/narcotic) was prescribed in combination with a benzodiazepine (clonazepam) on May 12, 2014. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Finding for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE VIII: **Charge VIII is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all specifications with this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [L] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 26-29) (emphasis in original)

27. The DAB made the following findings regarding Patient M:

Charge XI: Failure to provide appropriate medical care to Patient [M] (3 specifications)

Specification 1: *Between August 28, 2012 and November 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [M] in combination with the following benzodiazepines: diazepam between October 3,*

2012 and March 22, 2013, and temazepam between November 30, 2012 and March 15, 2013. The medication combination did not meet the standard of care.

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between August 28, 2012 and November 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient [M] in combination with the following benzodiazepines: diazepam between October 3, 2012 and March 22, 2013 and temazepam between November 30, 2012 and March 15, 2013. You added mirtazapine (noradrenergic and specific serotonergic antidepressant (NaSSA)) between October 15, 2012 and November 4, 2013, to the combination of suboxone: buprenorphine/naloxone and benzodiazepines above. The medication was added without documented assessment of the impact with existing medication regimen. You failed to provide adequate justification for your treatment regimen. Your treatment did not meet standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is NOT supported by a preponderance of the evidence.**

. . .

Specification 3: *On January 27, 2014, you prescribed methylphenidate (stimulant) to Patient [M]. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XI: **Charge XI is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [M] as identified in the sustained specifications of this charge. Additionally, although specification 2 is not supported by a preponderance of the evidence, the remaining specifications are supported by a preponderance of the evidence; sustaining even just one specification would justify sustaining the charge in whole. With this finding for this charge, after reviewing the specifications that are supported by a preponderance of the evidence, the Board has determined that the agency proved

the essence of the charge in whole in that Appellant failed to provide appropriate medical care to Patient [M].

(Kap Aff., Exh. A, Att. A, pp. 34-38) (emphasis in original)

28. The DAB made the following findings regarding Patient N:

Charge XIII: Failure to provide appropriate medical care to Patient [N] (2 specifications)

Specification 1: *Between March 29, 2010 and May 16. 2014, you prescribed a benzodiazepine (diazepam) to Patient [N]. The benzodiazepine was prescribed in combination with oxycodone (opioid) between March 29, 2010 and June 10, 2011, and later morphine (opioid) between September 12, 2011 and December 20, 2012. The medication combination in this patient did not meet the standard of care.*

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between March 29, 2010 and January 6, 2015, you treated Patient [N] with multiple medications and combinations of medications including diazepam (benzodiazepine) between March 29, 2010 and May 16, 2014, oxycodone (opioid) between March 29, 2010 and June 10, 2011, morphine (opioid) between September 12, 2011 and December 20, 2012, methadone (opioid) between June 25, 2013 and August 14, 2014, suboxone: buprenorphine/naloxone (opioid/narcotic) between February 28, 2013 and January 6, 2015, trazodone (antidepressant) between March 29, 2010 and May 16, 2014, and tramadol (opioid) between April 30, 2010 and February 24, 2012. Your documentation and rationale was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XIII: **Charge XIII is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [N] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 42-45) (emphasis in original)

29. The DAB made the following findings regarding Patient P:

Charge XVI: Failure to provide appropriate medical care to Patient [P] (7 specifications)

Specification 1: *Between October 23, 2012 and January 12, 2015, you prescribed morphine (opioid) to Patient [P]. The dosage in some orders was 720 mg per day. The dosage prescribed exceeded the standard of care. Your treatment did not meet the standard of care.*

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between October 23, 2012 and January 12, 2015, you prescribed morphine (opioid) to Patient [P]. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient [P] in combination with morphine (opioid). The medication combination did not meet standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient [P] in combination with morphine (opioid). Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 5: *Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient [P] in combination with morphine (opioid). In addition, you prescribed dextroamphetamine (stimulant) to Patient [P] on February 24, 2014. The medication combination did not meet the standard of care.*

Board Findings for Specification 5: **The Board finds that this specification is NOT supported by a preponderance of the evidence.**

. . .

Specification 6: *Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient [P] in combination with morphine (opioid). In addition, you prescribed dextroamphetamine (stimulant) to Patient [P] on February 24, 2014. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 6: **The Board finds that this specification is NOT supported by a preponderance of the evidence.**

. . .

Specification 7: *On February 24, 2014, you prescribed dextroamphetamine (stimulant) to Patient [P]. Your documentation and rationale was insufficient to justify the medication used in the treatment of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 7: **The Board finds that this specification is NOT supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XVI: **Charge XVI is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements of this charge were sustained by a preponderance of the evidence. Additionally, although specifications 5, 6 and 7 were not supported by a preponderance of the evidence, the remaining specifications are supported by a preponderance of the evidence; sustaining even just one specification would justify sustaining the charge in whole. With this finding for this charge, after reviewing the specifications that are supported by a preponderance of the evidence, the Board has determined that the agency proved the essence of the charge in whole in that Appellant failed to provide appropriate medical care to Patient [P].

(Kap Aff., Ex. A, Att. A, pp. 47-54) (emphasis in original)

30. The DAB made the following findings regarding Patient Q:

Charge XVII: Failure to provide appropriate medical care to Patient [Q] (4 specifications)

Specification 1: *Between June 20, 2005 and December 18, 2014, you prescribed morphine (opioid) to Patient [Q]. Between January 20, 2006 and December 18, 2014, you prescribed oxycodone (opioid) to Patient [Q]. You prescribed these opioid medications in combination with lorazepam (benzodiazepine) between December 11, 2009 and November 7, 2014. The medication combination did not meet the standard of care.*

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between June 20, 2005 and December 18, 2014, you prescribed morphine (opioid) to Patient [Q]. Between January 20, 2006 and December 18, 2014, you prescribed oxycodone (opioid) to Patient [Q]. You prescribed these opioid medications in combination with lorazepam (benzodiazepine) between December 11, 2009 and November 7, 2014. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *Between January 16, 2004 and December 18, 2014, you prescribed methylphenidate (stimulant) to Patient [Q]. The medication was prescribed by you to treat PTSD. It is not standard care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *Between January 16, 2004 and December 18, 2014, you prescribed methylphenidate (stimulant) to Patient [Q]. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XVII: **Charge XVII is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [Q] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 54-58) (emphasis in original)

31. The DAB made the following findings regarding Patient R:

Charge XIX: Failure to provide appropriate medical care to Patient [R] (4 specifications)

Specification 1: *Between May I, 2009 and October 27, 2014, you prescribed amphetamine/dextroamphetamine (stimulant) to Patient [R]. The medication was prescribed by you to treat PTSD. It is not standard of care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.*

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between May 1, 2009 and October 27, 2014, you prescribed amphetamine/dextroamphetamine (stimulant) to Patient [R]. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *Between March 25, 2002 and July 28, 2014, you prescribed clonazepam (benzodiazepine) to Patient [R]. You continued the use of clonazepam (benzodiazepine) despite history of alcohol dependence. Your treatment did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *Between March 25, 2002 and July 28, 2014, you prescribed clonazepam (benzodiazepine) to Patient [R]. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XIX: **Charge XIX is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [R] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 67-71) (emphasis in original)

32. The DAB made the following findings regarding Patient S:

Charge XX: Failure to provide appropriate medical care to Patient [S] (1 specification)

Specification: *Between July 26, 2010 and January 6, 2014, you prescribed methylphenidate (stimulant) to Patient [S]. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of this patient who had a history of alcohol dependence and paranoid schizophrenia. Your treatment did not meet the standard of care.*

Board Findings for Specification: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

BOARD FINDING AS TO CHARGE XX: **Charge XX is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that the elements and sole specification with this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [S] as identified in the sustained specification of this charge.

(Kap Aff., Ex. A, Att. A, pp. 71-72) (emphasis in original)

33. The DAB made the following findings regarding Patient T:

Charge XXI: Failure to provide appropriate medical care to Patient [T] (4 specifications)

Specification 1: *Between July 13, 2007 and January 13, 2015, you prescribed the benzodiazepine (temazepam) to Patient [T]. Between March 7, 2008 and January 15, 2015 the benzodiazepine (diazepam) was prescribed to Patient [T]. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). The medication combination did not meet the standard of care.*

Board Findings for Specification 1: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 2: *Between July 13, 2007 and January 13, 2015, you prescribed the benzodiazepine (temazepam) to Patient [T]. Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient [T]. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). There is no documentation that risk of adverse effects of these medications was discussed with the patient. This was relevant since the patient dropped his daughter and she sustained injuries per documentation on March 24, 2014.*

Board Findings for Specification 2: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 3: *Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient [T]. Between July 2009 and June 10, 2014, you prescribed medication combining barbiturates (butalbital). Between July 13, 2007 and January 13, 2015, you prescribed another benzodiazepine (temazepam). Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.*

Board Findings for Specification 3: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

Specification 4: *Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient [T]. Between July 2009 and June 10, 2014,*

you prescribed medication containing barbiturates (butalbital). Between July 13, 2007 and January 13, 2015, you prescribed another benzodiazepine (temazepam). In addition, on December 17, 2012, you prescribed a sedating muscle relaxant (cyclobenzaprine). Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

Board Findings for Specification 4: **The Board finds that this specification is supported by a preponderance of the evidence.**

. . .

***BOARD FINDING AS TO CHARGE XXI*: Charge XXI is SUSTAINED IN WHOLE.** The Board sustained this charge in whole due to the fact that all elements and specifications of this charge were sustained by a preponderance of the evidence. The agency proved the charge as written and the Board finds that Appellant failed to provide appropriate medical care to Patient [T] as identified in the sustained specifications of this charge.

(Kap Aff., Ex. A, Att. A, pp. 72-76) (emphasis in original)

34. A dissenting opinion was filed by the sole psychiatrist serving on the DAB, which is incorporated into this summary judgment order. (Kap Aff., Ex. A, Att. B)

DISCUSSION

Standards Governing Summary Judgment

"The summary judgment procedure as provided in s. 802.08, Stats., shall be available to the parties upon approval by the division or the administrative law judge." Wis. Admin. Code § HA 1.10(2).

Pursuant to Wis. Stat. § 802.08, summary judgment "shall be rendered if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Wis. Stat. § 802.08(2). "When a motion for summary judgment is made and supported as provided in this section [§ 802.08], an adverse party may not rest upon the mere allegations or denials of the pleadings but the adverse party's response, by affidavits or as otherwise provided in this section, must set forth specific facts showing that there is a genuine issue for trial." Wis. Stat. § 802.08(3). "If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against such party." *Id.* "[W]hen the facts are not in dispute and the legal issues are capable of resolution, summary judgment is mandatory." *Smith v. State Farm Fire & Cas. Co.*, 127 Wis. 2d 298, 301, 380 N.W.2d 372 (Ct. App. 1985).

"'A motion for summary judgment may be made on the basis of the pleadings or other portions of the record in the case or it may be supported by affidavits and a variety of outside material.'" *Tews v. NHI, LLC*, 2010 WI 137, ¶ 49, 330 Wis. 2d 389, 793 N.W.2d 860 (citation omitted). On a motion for summary judgment, the facts are construed in favor of the non-moving party. *DeHart v. Wis. Mut. Ins. Co.*, 2007 WI 91, ¶ 7, 302 Wis. 2d 564, 734 N.W.2d 394. "[I]f there are any material facts in dispute or any reasonable inferences that might be drawn from undisputed facts which point to a result contrary to the one sought by the movant, the motion must be denied." *Peninsular Carpets, Inc. v. Bradley Homes, Inc.*, 58 Wis. 2d 405, 410, 206 N.W.2d 408 (1973).

Unprofessional Conduct Pursuant to Wis Admin. Code § Med 10.03(3)(c)

The Wisconsin Medical Examining Board (Board) may discipline a physician if the physician has engaged in unprofessional conduct. Wis. Stat. § 448.02(3). The Division seeks summary judgment on Count 22 of its Amended Complaint in Case No. SPS-16-0030, which alleges that Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(c). Pursuant to this provision, unprofessional conduct is defined to include "[h]aving any credential pertaining to the practice of medicine and surgery or any act constituting the practice of medicine and surgery become subject to adverse determination by any agency of this or another state, or by any federal agency or authority." Wis. Admin. Code § Med 10.03(3)(c).

The undisputed facts establish as a matter of law that Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(c). First, the DAB Decision was issued by the United States Department of Veterans Affairs Disciplinary Appeals Board, a federal agency or authority, and was affirmed and executed as a final administrative action by Veterans Affairs Principal Deputy Undersecretary for Health, Richard A. Stone, M.D. Second, the DAB Decision was adverse to Respondent because it affirmed the suspension and revocation of his medical staff privileges at the Tomah VA, and the termination of his VA employment. Respondent concedes there is no dispute that the VA terminated him and revoked his clinical privileges. (Respondent's Brief at p. 3) The DAB explicitly states its decision is "a major adverse action" against Respondent.

Third, the DAB Decision relates to Respondent's acts constituting the practice of medicine and surgery. It affirmed 20 charges of Respondent's "failure to provide appropriate medical care" to his patients at the Tomah VA. The DAB Decision explicitly states it "involves ***direct patient care*** and/or ***clinical competence***" and sustains charges which "**represent substandard care, professional incompetence or professional misconduct.**" (Emphasis in original.) Respondent's conduct fits within the definition of "practice of medicine and surgery" contained in Wis. Stat. § 448.01(9), which states:

> (a) To examine into the fact, conduction or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.

(b) To apply principles or techniques of medical sciences in the diagnoses or prevention of any of the conditions described in par. (a) and in sub. (2).[2]

Because the elements of Wis. Admin. Code § Med 10.03(3)(c) are met, Respondent engaged in unprofessional conduct under that provision. Respondent's arguments to the contrary are unconvincing. Respondent states that Wis. Admin. Code § Med 10.03(3)(c) applies only to the actions of a "regulatory or licensing agency," not to a federal agency such as the VA. Respondent asserts that the purpose of Wis. Admin. Code § Med 10.03(3)(c) is to give reciprocity for adverse regulatory decisions affecting a physician's licensing in other jurisdictions so that if a physician's license in another jurisdiction is revoked or suspended, the Wisconsin Board may do the same. No authority is provided in support of this interpretation. Moreover, the plain language of Wis. Admin. Code § Med 10.03(3)(c) expressly negates such a narrow interpretation, in that it refers much more broadly to "any agency of this or another state, or by any federal agency or authority." Further, the provision refers to "[h]aving any credential pertaining to the practice of medicine and surgery *or* any act constituting the practice of medicine and surgery become subject to adverse determination . . . ." Wis. Admin. Code § Med 10.03(3)(c) (emphasis provided). It is clear from the language contained in these two alternative clauses that there are two scenarios under which unprofessional conduct may be found – when a credential becomes subject to an adverse determination *or* when "any act constituting the practice of medicine and surgery" becomes subject to an adverse determination. It is this second scenario which is at issue here. Respondent's interpretation of Wis. Admin. Code § Med 10.03(3)(c) ignores or gives no effect to the provision's second clause, contrary to well-established canons of statutory and administrative rule construction. *See e.g.*, *County of Columbia v. Bylewski*, 94 Wis. 2d 153, 164, 288 N.W.2d 129 (1980) ("(I)t is a basic rule of statutory construction that in construing statutes, effect is to be given, if possible, to each and every word, clause and sentence in a statute, and a construction that would result in any portion of a statute being superfluous should be avoided wherever possible."). Thus, Respondent misconstrues the law in contending the VA needs to be a regulatory or licensing agency to fall within the parameters of Wis. Admin. Code § Med 10.03(3)(c). The undisputed facts establish that the Tomah VA, a federal agency, made an adverse determination regarding Respondent's acts which constitute the practice of medicine and surgery. As a result, Respondent has engaged in unprofessional conduct as that phrase is defined by Wis. Admin. Code § Med 10.03(3)(c).

Respondent makes various other arguments as to why Wis. Admin. Code § Med 10.03(3)(c) does not apply here. He states that if the provision is read to include the Tomah VA's adverse determination, then one would expect to see numerous decisions involving physicians employed by UW Hospitals who were disciplined by the Board merely because UW Hospitals revoked the physician's privileges and terminated the physician based on practice concerns. He further argues that such an interpretation would deprive him of due process and a right to a hearing because the Tomah VA relied on an average physician standard rather than the Wisconsin standard of care. Respondent also asserts that the DAB Decision on which the Division relies was arbitrarily restricted in scope because it excluded Respondent's exhibits and is subject to further judicial review. None of Respondent's arguments address nor circumvent the plain language of Wis. Admin. Code § Med 10.03(3)(c), discussed above.

[2] Sub. (2) defines "disease" as "any pain, injury, deformity or physical or mental illness or departure from complete health or the proper condition of the human body or any of its parts." Wis. Stat. § 448.01(2).

Moreover, with respect to Respondent's due process argument, even if the DAB Decision uses a standard of care different from that required by the Board in disciplinary proceedings (an assertion which the Division disputes), Respondent's argument would be unavailing as the standard applied in the DAB proceeding is irrelevant to the question of whether Respondent engaged in unprofessional conduct as defined by Wis Admin. Code § Med 10.03(3)(c). The definition of unprofessional conduct in Wis. Admin. Code § Med 10.03(3)(c) does not require the federal agency or authority to apply the Board's standard in making its adverse determination. Moreover, to the extent Respondent's argument challenges the facial constitutionality of the rule itself, this tribunal is without authority to address it. *See e.g., Metz v. Veterinary Examining Board*, 2007 WI App 220, 305 Wis. 2d 788, 741 N.W. 2d 244. Even if this tribunal had authority to address the constitutionality of an administrative rule, however, Respondent has not established that Wis. Admin. Code § Med 10.03(3)(c) is unconstitutional, either facially or as applied.

Because the undisputed facts establish that a federal agency or authority made an adverse determination regarding Respondent's acts constituting the practice of medicine and surgery, as a matter of law, Respondent has engaged in "unprofessional conduct" as defined in Wis. Admin. Code § Med 10.03(3)(c). The Division is therefore entitled to summary judgment with respect to Count 22 of its Amended Complaint.

Discipline and Costs

The Division requests that as part of these summary judgment proceedings, Respondent's license to practice medicine be revoked and that he be required to pay the full costs of these proceedings pursuant to Wis. Stat. § 440.22(2). However, Respondent argues that summary judgment on the issue of discipline is inappropriate because there are factual issues regarding what discipline, if any, would be appropriate. He further states that due process requires that he be provided with the opportunity to conduct discovery, obtain experts, cross-examine the Division's witnesses and present evidence on this issue. Respondent does not expressly address the issue of costs.

The Board "has broad authority to discipline a licensee who has been found guilty of unprofessional conduct." *Galang v. Medical Examiming Board*, 168 Wis 2d 695, 484 N.W.2d 375 (Ct. App. 1992). 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 core purpose [of disciplinary proceedings] is not to punish the provider but to protect the public and to insure the performance of licensees meets the accepted standard of care." *Krahenbuhl v. Wisconsin Dentistry Examining Board*, 2004 WI App 147, ¶ 31, 275 Wis. 2d 626, 685 N.W.2d 591.

With respect to assessment of costs under Wis. Stat. § 440.22(2), the Board has previously considered the following factors: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the cooperation of the respondent; (5) any prior discipline; and (6) the fact that

the Department is a program revenue agency, funded by other licensees. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz*, Order No. LS0802183CHI (Aug. 14, 2008).

The Division has not provided any authority suggesting that summary judgment is appropriate for such discretionary determinations, nor has this tribunal uncovered such authority. Because of the discretionary nature of determining both discipline and costs, the exercise of which entails consideration of a wide variety of factors based on the evidence, and because no authority has been provided showing that such discretionary issues are appropriate for summary judgment, the Division has not met its burden of establishing that imposition of a particular discipline or percentage of costs is required "as a matter of law" under Wis. Stat. § 802.08.

Furthermore, this order only addresses one count of the Division's Amended Complaint in Case No. SPS-16-0030. The remaining counts of that Amended Complaint are still pending as are the counts alleged in the Complaint in Case No. SPS-16-0050. A hearing is set in these matters for March 13-17 and March 20-24, 2017. If the Division still wishes to pursue its remaining allegations, the issues of discipline and costs may be taken up at the conclusion of the evidence following hearing. If, based on this summary judgment order, the Division no longer wishes to pursue the remaining counts alleged, a hearing may be held on the issues of discipline and costs for the violation found in these summary judgment proceedings (or, if the parties agree, they may brief those issues in lieu of a hearing). Therefore, a telephone status conference will be held as set forth in the Order section below, at which the parties shall inform the undersigned administrative law judge whether a hearing will be held on the remaining alleged violations or whether the issues of discipline and costs should be determined based solely on the unprofessional conduct found in this Order. The parties may file written submissions prior to the status conference.

ORDER

For the reasons set forth above, IT IS ORDERED that:

1. The Division's motion for partial summary judgment is granted with respect to whether Respondent engaged in unprofessional conduct under Wis. Admin. Code § Med 10.03(3)(c) as alleged in Count 22 of the Division's Amended Complaint in Case No. SPS-16-0030.

2. The Division's motion for partial summary judgment is denied with respect to the issues of discipline and costs.

3. A telephone conference will be held on **January 10, 2017, at 11:00 a.m.** to address the issues set forth above.

Dated at Madison, Wisconsin on December 19, 2016.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: _____
Jennifer E. Nashold
Administrative Law Judge