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Before the
State Of Wisconsin
Medical Examining Board

In the Matter of the Disciplinary Proceedings
Against Siamak B. Arassi, M.D., Respondent.

FINAL DECISION AND ORDER

Order No. ORDER 000840

Division of Legal Services and Compliance Case No. 20 MED 375 and 21 MED 284

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated at Madison, Wisconsin on the 15th day of February, 2023.

Member
Medical Examining Board

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Siamak B. Arassi, M.D., Respondent.	DHA Case No. SPS-22-0031 DLSC Case Nos. 20 MED 375 and 21 MED 284

PROPOSED DECISION AND ORDER

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

Siamak B. Arassi, M.D.
19115 W. Capital Drive, Suite 117
Brookfield, WI 53045

Wisconsin Medical Examining Board
P.O. Box 8366
Madison, WI 53707-8366

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

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

PROCEDURAL HISTORY

On April 28, 2022, the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division) served the Notice of Hearing and the Complaint in this matter on Siamak B. Arassi, M.D. (Respondent), by both certified and regular mail, consistent with Wis. Admin. Code § SPS 2.08. The Respondent filed an Answer to the Complaint on May 18, 2022.

On June 8, 2022, Administrative Law Judge Angela Chaput Foy (ALJ) held a prehearing conference with the parties. The Respondent appeared by his counsel, Attorney Diane Welsh and Attorney Awais Khaleel. The ALJ ordered that any amended complaint be filed no later than

October 6, 2022, and that an answer to an amended complaint would be due 20 days after service, pursuant to Wis. Admin. Code § SPS 2.09(4). An adjourned prehearing conference was scheduled for October 31, 2022 at 9:30 a.m. A prehearing conference report and notice of adjourned prehearing conference was sent to both parties.

On August 31, 2022, the attorneys for the Respondent notified the ALJ by email that their representation of the Respondent had terminated.

On September 8, 2022, the Division filed an Amended Complaint and served the Respondent by email, regular mail, and certified mail. The Respondent failed to file an answer to the Amended Complaint. On October 13, 2022, the Division filed a Motion for Default Judgment. The Respondent did not file a response to the motion.

An adjourned telephone prehearing conference was held on October 31, 2022, at 9:30 a.m. The Respondent failed to appear. The Division moved for default based on the Respondent's failure to file an answer to the Amended Complaint and failure to appear for the adjourned prehearing conference, pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c).

On November 8, 2022, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file a recommended proposed decision and order no later than December 7, 2022.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-22 are taken from the Amended Complaint filed against the Respondent in this matter.

1. Siamak B. Arassi, M.D. (Respondent) (Year of Birth 1963) is licensed in the state of Wisconsin to practice medicine and surgery, having license number 41661-20, first issued on September 24, 1999, with registration current through October 31, 2023.

2. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services is 19115 W. Capital Drive, Suite 117, Brookfield, Wisconsin 53045.

Prior Discipline

3. On August 19, 2015, the Medical Examining Board (Board) reprimanded Respondent and ordered that for six (6) months, he retain a professional mentor to review case files. The Board found that Respondent prescribed opioids without reviewing prior treatment records, without conducting or charting an appropriate physical examination, without ordering appropriate testing, without making or charting objective findings supporting the given diagnosis(es) and his prescribing, without discussing and/or ordering alternate non-opioid

treatments, without implementing adequate precautions against prescription drug abuse and/or diversion, without recognizing and acting on commonly recognized red flags for potential prescription drug abuse and/or diversion, and by prescribing opioids and benzodiazepines in combination without having a discussion of the potential dangers. *See* Board Order 0004202.

Current Cases

4. At all times relevant to these proceedings, Respondent practiced as a physician and Medical Director providing substance abuse prevention and treatment services at a clinic located in Brookfield, Wisconsin (Clinic).

5. From at least 2012 through 2014-15, Respondent was the sole owner of the Clinic. Since 2014-15, Respondent's wife became the sole owner of the Clinic. Throughout the Clinic's existence, Respondent has maintained complete control over the Clinic, is responsible for the day to day operations of the Clinic, and is responsible for ensuring that the Clinic and its personnel comply with applicable statutes and codes enforced by the Wisconsin Department of Health Services (DHS). Respondent acts as signatory for all documentation submitted to the DHS and/or delegates to individuals to sign on his behalf or the Clinic's behalf.

6. As a result of providing substance abuse prevention and treatment services, as well as accepting Medicaid funds, Respondent and the Clinic applied for and received one or more certifications from the DHS. Certification by the DHS requires that the Clinic and Respondent abide by various statutes and codes enforced by the DHS.

7. In May 2019, the DHS completed an onsite recertification inspection (2019 Survey) of the Clinic and found that the Clinic and/or its providers (including Respondent) were in violation of various statute and code provisions. In July 2020, the DHS completed a desk-review complaint investigation involving Respondent and the Clinic and found that both were in violation of various statute and code provisions. The violations involved subject areas, including but not limited to, prompt and adequate patient treatment, staff qualifications, required patient record documentation, and licensing requirements for staff.

8. In 2017, the Clinic and Respondent applied for and received certification from the DHS to offer an "Ambulatory Detoxification Service" pursuant to Wis. Admin. Code. § DHS 75.08. A requirement of this certification is that a registered nurse be available on a 24-hour basis. On multiple occasions following certification, the Clinic did not comply with this requirement, yet Respondent advertised that the clinic was certified to provide such services on the Clinic's website and referenced the provision of such services in patient medical records.

9. According to the 2019 Survey, on multiple occasions in 2017 through 2019, Respondent prescribed medication to Clinic patients whose patient records did not contain a medication consent form.

10. According to the 2019 Survey, Respondent hired and directed Peer Support G to provide day treatment substance abuse treatment to Clinic patients.

11. Peer Support G was a patient of the Clinic and Respondent through November 2018 receiving substance abuse treatment. Peer Support G began her employment with the Clinic providing day treatment substance abuse treatment to Clinic patients in early November 2018.

12. Peer Support G is not and has never been credentialed by the Department as a substance abuse counselor or mental health professional. Peer Support G does not hold any credential allowing Peer Support G to provide day treatment substance abuse treatment.

13. On multiple occasions in 2018 and 2019, Clinic patient records did not contain a treatment plan signed by the Medical Director.

14. On multiple occasions in 2017 through 2019, Clinic patient records did not contain a discharge summary, and/or contained an incomplete discharge summary.

15. Wisconsin Admin. Code § DHS 94.09(4) requires prior informed consent by Clinic patients prior to the prescription or administration of medication by Respondent, absent specific circumstances.

16. Wisconsin Admin. Code § DHS 75.03(4)(d) requires all staff who provide substance abuse counseling, except physicians knowledgeable in the practice of addiction medicine and psychologists knowledgeable in psychopharmacology and addiction treatment, to be substance abuse counselors.

17. Wisconsin Admin. Code § DHS 75.03(13)(a) requires Clinic patient records to contain a treatment plan signed by the consulting physician.

18. Wisconsin Admin. Code § DHS 75.03(17) requires Clinic patient records to contain a complete discharge summary, including the signature of the consulting physician.

19. On August 30, 2022, Respondent's attorney emailed the Division and the ALJ in this matter advising that the attorney and her firm are no longer representing Respondent and that Respondent "no longer wishes to pursue this administrative review of the DSPS com[p]laints."

20. On August 30, 2022, Respondent emailed the Division, copying the ALJ in this matter, as follows:

> What part of it you don't understand you vindictive person you fucked my life you fucked my professional life you guys can go fuck yourself I left that country because of people like you go to fucking hell how's that for a response to you you don't deserve my professional services
> You can't touch me so go fuck yourself I was a good doctor I provided life-saving services to my patients and you motherfuckers don't deserve it you don't deserve good people like me

21. Shortly after sending the email described in paragraph 20, Respondent sent another email to the Division, copying the ALJ in this matter, as follows:

> Do not dare to contact me again ever go do whatever damage you think you can do to me you're sorry ass you and your organizations that you represent they all can go fuck themselves.

22. On August 30, 2022, the Clinic's website contained the following message:

> I got sick and tired of the vindictive department of justice department, department of health and family services in Madison, medical Board of Wisconsin, and department of quality assurance they a bunch of gangsters all working under the same roof and the same building in Madison and they're not there to help you they're there to make sure that you fail they only help their own bodies it is an exclusive club shame on them for treating me so badly.

Facts Related to Default

23. On April 28, 2022, the Department served the Notice of Hearing and the Complaint on the Respondent at his address of record with the Department, by both certified and regular mail.

24. On May 18, 2022, the Respondent filed an Answer to the Complaint.

25. On June 8, 2022, the ALJ held a prehearing conference with both parties. The Respondent appeared by his counsel, Attorney Diane Welsh and Attorney Awais Khaleel. The ALJ ordered that any amended complaint be filed no later than October 6, 2022, and an answer to an amended complaint was due 20 days after service of the amended complaint. An adjourned prehearing conference was scheduled for October 31, 2022, at 9:30 am.

26. On June 9, 2022, the ALJ mailed a prehearing conference report and the notice of the adjourned prehearing conference to both parties.

27. On August 30, 2022, the attorneys for the Respondent notified the Division and the ALJ by email that their representation of the Respondent had ended.

28. On August 30, 2022, the Respondent sent emails to the ALJ and the Division using vulgar language, indicating that he left the country, and implying that he would not be contesting any action that the Division would take on his license.

29. On September 8, 2022, the Division filed an Amended Complaint and served the Respondent by email, regular mail, and certified mail.

30. The Respondent failed to file an answer to the Amended Complaint.

31. On October 13, 2022, the Division filed a Motion for Default Judgment. The Respondent did not file a response to the Motion for Default Judgment.

32. At the adjourned prehearing conference held on October 31, 2022, the Respondent failed to appear. The ALJ attempted to reach the Respondent at the telephone number he had on file with the Division. The ALJ called the Respondent and left a voicemail following a recording that identified the line as the Respondent's at the Healing Corner. The ALJ also emailed the Respondent at the email address he had used to communicate with the ALJ and the Division. The ALJ left the line open for fifteen minutes. The Respondent did not call the ALJ or respond to the ALJ's email.

33. On October 31, 2022, the Division moved for default based on the Respondent's failure to answer the Amended Complaint, failure to respond to the Motion for Default Judgment, and failure to appear for the prehearing conference.

34. On November 8, 2022, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file and serve a recommended Proposed Decision and Order no later than December 7, 2022.

35. The Division timely filed its recommended Proposed Decision and Order.

DISCUSSION

Jurisdictional Authority

The Wisconsin Medical Examining Board (Board) has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3). Section 440.03(1) of the Wisconsin Statutes provides that the Department "may promulgate rules defining uniform procedures to be used by the department . . . and all examining boards and affiliated credentialing boards attached to the department or an examining board, for . . . conducting [disciplinary] hearings." These rules are codified in Chapter SPS 2 of the Wisconsin Administrative Code.

The Division of Hearings and Appeals has authority to preside over this disciplinary proceeding and issue this proposed decision and order pursuant to Wis. Stat. §§ 227.43(1m), 227.46(1) and Wis. Admin. Code § SPS 2.10(2).

Default

The Division properly served the Amended Complaint on the Respondent by mailing a copy to his address of record with the Department by both certified and regular mail. A copy of the Amended Complaint was also emailed to the Respondent at his email address of record with the Department. Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08.

The Division of Hearings and Appeals properly served the Respondent with its notices pursuant to Wis. Admin. Code § HA 1.03 (The division may serve decisions, orders, notices, and other documents by first class mail.).

An answer to a complaint must be filed within 20 days from the date of service of the Complaint. Wis. Admin. Code § SPS 2.09(4). If a respondent "fails to answer as required by s. SPS 2.09 or fails to appear at the hearing at the time fixed therefor, the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence." Wis. Admin. Code § 2.14.

For a telephone prehearing conference, the administrative law judge may find a failure to appear grounds for default if any of the following conditions exist for more than ten minutes after the scheduled time for prehearing conference: (1) the failure to provide a telephone number to the ALJ after it had been requested; (2) the failure to answer the telephone; (3) the failure to free the line for the proceeding; and (4) the failure to be ready to proceed with the prehearing conference as scheduled. Wis. Admin. Code § HA 1.07(3)(c).

Here, the Respondent failed to file an answer to the Amended Complaint, failed to appear at the prehearing conference on October 31, 2022, failed to answer the telephone when the ALJ called, and failed to be ready to proceed with the prehearing conference as scheduled. Additionally, the Division filed a Motion for Default in advance of the prehearing conference, on October 13, 2022, and the Respondent did not respond to the motion. Therefore, the Respondent is in default and findings and an order may be entered based on the Amended Complaint.

Violations

The Board has the authority to impose discipline against the Respondent. Wis. Stat. § 448.02(3). If a licensed physician is found guilty of unprofessional conduct after an investigation and disciplinary hearing, the Board may "suspend or revoke any license or certificate granted by the board to that person." Wis. Stat. § 448.02(3)(c).

Unprofessional conduct for physicians that is grounds for the Department to take disciplinary action includes, but is not limited to:

a. Engaging in false, misleading, or deceptive advertising. Wis. Admin. Code § Med 10.03 (1)(k).
b. Knowingly, negligently, or recklessly making any false statement, written or oral, in the practice of medicine and surgery which creates an unacceptable risk of harm to a patient, the public, or both. Wis. Admin. Code § Med 10.03 (1)(e).
c. Employing illegal or unethical business practices. Wis. Admin. Code § Med 10.03(1)(d).
d. Departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person. Wis. Admin. Code § Med 10.03(2)(b).
e. Failing to establish and maintain timely patient health care records, including records of prescription orders, under s. Med 21.03, or as otherwise required by law. Wis. Admin. Code § Med 10.03(3)(e).

f. Except as provided in par. (j), a violation or conviction of any laws or rules of this state, or of any other state, or any federal law or regulation that is substantially related to the practice of medicine and surgery. Wis. Admin. Code § Med 10.03(3)(i).

The Respondent violated Wis. Admin. Code § Med 10.03 (1)(k) when he advertised his Clinic's DHS certification to offer "Ambulatory Detoxification Service" on his Clinic website but failed to meet the DHS requirement that a registered nurse be available on a 24-hour basis on multiple occasions. Advertising a service in which not all requirements are met is false, misleading, and deceptive.

The Respondent's statements about the DHS certification for "Ambulatory Detoxification Service" also violated Wis. Admin. Code § Med 10.03 (1)(e). The Respondent advertised that the Clinic was certified to provide such services on the its website, and the Respondent referenced the provision of such services in patient medical records. Because he failed to make a registered nurse available on a 24-hour basis on multiple occasions, a requirement of the certification, the advertisement of the service, or the provision of the service to patients, without meeting the requirements is a false statement, made knowingly, negligently, or recklessly, which creates an unacceptable risk of harm to patients and/or the public.

The Respondent also violated Wis. Admin. Code § Med 10.03(1)(d). Continuing to advertise this service, and providing this service as referenced in patient medical records, despite not meeting its requirements on multiple occasions, is illegal and an unethical business practice.

The Respondent's statements to and about the Division, the DHS, the Medical Examining Board, and others charged with assisting the Board to carry out its duties, are demonstrative of the Respondent's unethical business practices and also violate Wis. Admin. Code § Med 10.03(1)(d). The investigation in this matter was initiated and conducted on behalf of the Board in order to ensure the protection and safety of the public. The Respondent's vulgar emails, along with the posting on the Clinic's website, disparage the Board and demonstrates that the Respondent doubts the legitimacy and purpose of the Board. The Respondent's practice is subject to the Board's jurisdiction. Public statements that could lead a patient to conclude that the Respondent's practice is not subject to that valid jurisdiction or should not be subject to an investigation to ensure the protection and safely of the public is unethical.

The Respondent violated Wis. Admin. Code § Med 10.03(2)(b) by hiring a patient, Peer Support G, who was actively receiving substance abuse treatment services to contemporaneously provide substance abuse treatment to others without Peer Support G having the proper training and required credentials. The standard of minimally competent medical practice would be for a practitioner in Respondent's position to confirm that a current patient was properly trained and credentialed before terminating the provider/patient relationship and employing the patient to provide the same or similar treatment services to others. The Respondent's failure to meet this standard created an unacceptable risk of harm to patients.

The Respondent violated Wis. Admin. Code § Med 10.03(3)(e) because of the deficiencies in his patient records found in the DHS 2019 survey and 2020 review including (1)

the Respondent prescribed medication to Clinic patients whose patient records did not contain a medication consent form; (2) multiple Clinic patient records did not contain a treatment plan signed by the Medical Director; and (3) various Clinic patient records did not contain a discharge summary, and/or contained an incomplete discharge summary. These deficiencies constitute a failure to establish and maintain timely patient health care records, including prescription orders.

Finally, the Respondent is in violation of Wis. Admin. Code § Med 10.03(3)(i) because of his violation of other laws and regulations. The Respondent hired uncredentialed staff to provide substance abuse counseling, in violation of Wis. Admin. Code § DHS 75.03(4)(d). The Respondent prescribed medication to Clinic patients whose patient records did not contain a medication consent form, in violation of Wis. Admin. Code § DHS 94.09(4). Multiple Clinic patient records did not contain a treatment plan signed by the Medical Director, in violation of Wis. Admin. Code § DHS 75.03(13)(a). Various Clinic patient records did not contain a discharge summary, and/or contained an incomplete discharge summary, in violation of Wis. Admin. Code § DHS 75.03(17). These laws and administrative rules are substantially related to the practice of medicine and surgery.

By engaging in the above-described actions, the Respondent committed unprofessional conduct. Because of this unprofessional conduct and his failure to participate in these proceedings and make arguments to the contrary, the Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3)(c).

Discipline

The Division recommends that the Respondent's license to practice medicine and surgery in the state of Wisconsin be suspended indefinitely, pursuant to the terms and conditions of the Order below. Because the Respondent has been found in default, and because the recommended discipline is consistent with the purposes articulated in *Aldrich,* I adopt the Division's recommendation.

The three purposes of discipline in a professional misconduct case are: (1) to promote the rehabilitation of the credential holder; (2) to protect the public from other instances of misconduct; and (3) to deter other credential holders from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976).

The recommended discipline is consistent with the purposes articulated in *Aldrich.* This is not the Respondent's first instance of misconduct before the Board. In 2015, the Board reprimanded the Respondent and required a mentor for the Respondent because the Respondent committed multiple violations related to prescribing opioids. A mentor is an uncommon restriction applied to serious instances of misconduct. A mentor is required by the Board when the Board finds that the physician cannot or should not continue practicing without oversight by another professional. As such, the discipline imposed by the Board against the Respondent in 2015 was intended to put the Respondent on clear notice that he was required to abide by the laws governing his profession and the authority of the Board.

Approximately five years following the aforementioned reprimand and mentor requirement, the Respondent was again under investigation by the Board for not abiding by the laws governing his profession. In the current matter, the Respondent engaged in serious misconduct by repeatedly violating the DHS code provisions applicable to his Clinic. The Respondent's actions in violating the DHS code provisions were negligent at a minimum (incomplete patient records), and intentional at other times (advertising and documenting that he was certified to offer and did offer Ambulatory Detoxification Services even though he did not employ the required nurse, and hiring an uncredentialed substance abuse counselor). The Respondent made decisions affecting the Clinic and its patients that were not in the best interests of the Clinic or patients (hiring a current patient to provide services that required training and a credential). Moreover, when investigated and questioned about his activities during the hearing stage of this matter, the Respondent reacted in an angry, vulgar, and disparaging manner.

Indefinitely suspending the Respondent's license protects the public and deters other physicians from engaging in similar conduct. The Wisconsin Supreme Court has acknowledged that "the purpose of licensing statutes is not to benefit those persons licensed to practice under the statutes, but rather to protect the public by the requirement of a license as a condition precedent to practicing in a given profession. The granting of a license pursuant to such a statute has been characterized as a privilege." *Gilbert v. State Medical Examining Board,* 119 Wis. 2d 168, 188, 349 N.W. 2d 68 (1984). "Such statutes are grounded in the state's police power to protect the public welfare through safeguarding the life, health, and property of its citizens." *Id.* "Protection of the public is the purpose of requiring a license." *State ex rel. Green v. Clark*, 235 Wis. 628, 631, 294 N.W. 25 (1940).

The Respondent's repeated disregard of the Board's authority and the laws in place to protect public health and welfare demonstrates that an indefinite suspension is necessary. Reprimanding and requiring a mentor in 2015 were insufficient to deter the Respondent from again committing serious misconduct and disregarding the Board's authority. An indefinite suspension is now necessary and appropriate to protect patients and the public and to deter other physicians from engaging in similar conduct.

The recommended discipline is consistent with Board precedent. In *the Matter of Disciplinary Proceedings Against Manuel J. Thomas, M.D.,* Order Number 0007046 (October 21, 2020) the Board indefinitely suspended Dr. Thomas' license as a result of Dr. Thomas failing to cooperate in a timely manner with the Board's investigation, practicing medicine without a valid/current license, and defaulting in the hearing proceedings before the Board. A stay of suspension was conditioned upon Dr. Thomas cooperating with the Board's investigation and providing additional evidence that established that Dr. Thomas' prescribing practice meets the standard of minimal competence.[1] In *In the Matter of Disciplinary Proceedings Against Natasha R. Shallow, M.D.,* Order Number 0005403 (December 20, 2017), the Board indefinitely suspended Dr. Shallow's license and/or right to renew such license following Dr. Shallow's suspension of her medical license in various other states. The Board found that Dr. Shallow suffered from one or more untreated and ongoing mental and/or physical health conditions. Dr.

[1] *In the Matter of Disciplinary Proceedings Against Manuel J. Thomas, M.D.,* Order Number 0007046

Shallow defaulted in the proceedings before the Board. A condition of lifting the suspension required Dr. Shallow to submit to a competency exam.[2] In *In the Matter of the Disciplinary Proceedings Against Angelina M. Montemurro, M.D.,* Order Number 0002139 (March 18, 2015), the Board indefinitely suspended Dr. Montemurro's license after she failed to comply with a mental health examination requirement and subsequently defaulted during the hearing proceedings. The suspension order required that a condition of lifting the suspension was for Dr. Montemurro to complete a competency exam.[3] *See also In the Matter of Disciplinary Proceedings Against Michael N. Mangold, M.D.,* Order Number 0002433 (May 15, 2013) (Board suspended Dr. Mangold's license indefinitely or until a showing that he recognized the authority of the Board and understood his obligations to comply with the Board's orders for practicing medicine without a valid license)[4]; and, *In the Matter of Disciplinary Proceedings Against Ossama Abdellatif, M.D.*, Order Number LS0904201MED (September 16, 2009) (Board suspended Dr. Abdellatif's license indefinitely for failing to cooperate with the Board's investigation and practicing medicine under another name).[5]

Based upon the facts of these cases and the factors set forth in *Aldrich,* an indefinite suspension of the Respondent's license, pursuant to the terms and conditions of the Order below, is warranted.

Costs

The Board is vested with discretion concerning whether to assess all or part of the costs of this proceeding against the Respondent. *See* Wis. Stat. § 440.22(2). In exercising such discretion, the Board must look at aggravating and mitigating facts of the case; it may not assess costs against a licensee based solely on a "rigid rule or invocation of an omnipresent policy," such as preventing those costs from being passed on to others. *Noesen v. State Department of Regulation & Licensing, Pharmacy Examining Board,* 2008 WI App 52, ¶¶ 30-32, 311 Wis. 2d. 237, 751 N.W.2d 385.

In previous orders, Boards have considered the following factors when determining if all or part of the costs should be assessed against a respondent: (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 respondent's cooperation with the disciplinary process; (5) prior discipline, if any; (6) the fact that the Department is a program revenue agency, funded by other licensees; and (7) any other relevant circumstances. *See In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008). It is within the Board's discretion as to which of these factors to consider, whether other factors should be considered, and how much weight to give any factors considered.

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[2] *In the Matter of Disciplinary Proceedings Against Natasha R. Shallow, M.D.*, Order Number 0005403
[3] *In the Matter of the Disciplinary Proceedings Against Angelina M. Montemurro, M.D.*, Order Number 0002139
[4] *In the Matter of the Disciplinary Proceedings Against Michael N. Mangold, M.D.*, Order Number 0008486
[5] *In the Matter of the Disciplinary Proceedings Against Ossama Abdellatif, M.D.*, Order Number LS0904201MED

Considering the above factors, it is appropriate for the Respondent to pay the full costs of the investigation and these proceedings. The Respondent defaulted and the factual allegations identified in the Amended Complaint were deemed admitted. The Respondent's misconduct involves negligently, intentionally, and repeatedly violating laws related to his clinic's practice of substance abuse treatment. The Respondent was intentionally uncooperative in his use of vulgar and defamatory language towards the Board and various state agencies and their personnel, in addition to his failure to appear. The level of discipline sought in this case is serious and progressive. The Respondent's misconduct in the case at hand occurred after and in spite of receiving serious discipline and a mentor requirement from the Board in 2015.

Finally, the Department is a program revenue agency whose operating costs are funded by the revenue received from credential holders. It would be unfair to impose the costs of pursuing discipline in this proceeding on those licensees who have not engaged in misconduct. Therefore, it is appropriate for the Respondent to pay the full costs of the investigation and prosecution in this matter, as determined pursuant to Wis. Admin. Code § SPS 2.18.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board (Board) has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3).

2. The Respondent is in default by failing to answer the Amended Complaint and not appearing for the October 31, 2022 adjourned prehearing conference pursuant to Wis. Admin. Code § HA 1.07(3)(c) and Wis. Admin. Code § SPS 2.14.

3. The Respondent employed illegal or unethical business practices in violation of Wis. Admin. Code § Med 10.03(1)(d).

4. The Respondent knowingly, negligently, or recklessly made a false written statement, in the practice of medicine and surgery which creates an unacceptable risk of harm to a patient, the public, or both in violation of Wis. Admin. Code. § Med 10.03(1)(e).

5. The Respondent engaged in false, misleading, or deceptive advertising in violation of Wis. Admin. Code § Med 10.03(1)(k).

6. The Respondent departed from or failed to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person in violation of Wis. Admin. Code § Med 10.03(2)(b).

7. The Respondent failed to establish and maintain timely patient health care records in violation of Wis. Admin. Code § 10.03(3)(e).

8. The Respondent violated a law or rule of Wisconsin that is substantially related to practice of medicine and surgery in violation of Wis. Admin. Code § Med 10.03(3)(i).

9. As a result of these violations, the Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

10. An indefinite suspension of the Respondent's license to practice medicine and surgery in the state of Wisconsin is reasonable and appropriate, consistent with the purposes articulated in *Aldrich,* and consistent with Board precedent.

11. It is appropriate for the Respondent to pay the full costs of the investigation and prosecution in this matter pursuant to Wis. Admin. Code § SPS 2.18.

12. The Division of Hearings and Appeals has authority to issue this proposed decision pursuant to Wis. Stat. § 227.46 and Wis. Admin. Code § SPS 2.10.

ORDER

For the reasons set forth above, IT IS ORDERED:

1. The Respondent's license and registration to practice medicine and surgery in the state of Wisconsin (license no. 41661-20), and the Respondent's right to renew his license and registration, are SUSPENDED for an indefinite period.

2. The Respondent may petition the Board for a stay of the suspension after contacting the Department Monitor and providing any information requested by the Board or its designee in relation to this matter.

3. The Board or its designee may stay the suspension upon determination that the Respondent has cooperated with the Board concerning this matter, and has provided any information and/or has undergone any examinations requested by the Board in relation to this matter. This includes, but is not limited to, a competency examination pursuant to Wis. Stat. § 448.02(3)(b).

4. Should the Board require the Respondent to undergo a competency examination prior to staying the suspension, the Board may impose conditions and/or limitations on the Respondent's license in response to the results of the competency examination. Should the results of a competency examination reflect that the Respondent is not competent to practice medicine and surgery in the state of Wisconsin, the Board may deny a stay of suspension.

5. If the Board grants the Respondent's petition for a stay of suspension, the Board or its designee may impose any conditions and/or limitations on the Respondent's license deemed appropriate in order to protect the health, safety, and welfare of patients and the public.

6. The Respondent shall pay all recoverable costs in these matters in an amount to be established pursuant to Wis. Admin. Code. § SPS 2.18.

7. Petitions, payment of costs (made payable to the Department of Safety and Professional Services), and any other questions or submissions related to this Order, may be directed to the Department Monitor at:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

The Respondent may also submit payment online at: http://dspsmonitoring.wi.gov

8. The terms of this Order are effective the date the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin, on January 13, 2023.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Telephone: (414) 227-4025
FAX: (608) 264-9885
Email: Angela.ChaputFoy@wisconsin.gov

By: _____
Angela Chaput Foy
Administrative Law Judge