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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER WITH VARIANCE
	:	ORDER 0008800
CAROL M. BROWN, D.O., RESPONDENT.	:	DHA Case No. SPS-21-0023
	:	DLSC Case No. 18 MED 486

BACKGROUND

On June 20, 2023, Administrative Law Judge Angela Chaput Foy, State of Wisconsin, Department of Administration, Division of Hearings and Appeals, issued a Proposed Decision and Order (PDO) in the above referenced matter. The PDO was mailed to all parties. The Division of Legal Services and Compliance (Division) filed a response on July 10, 2023, noting two typographical errors in paragraphs 19 and 20 of the Findings of Fact and otherwise requesting that the Medical Examining Board (Board) adopt the PDO in its entirety. Respondent filed objections to the PDO on July 10, 2023, citing numerous personal and professional reasons for procedural delays, proffering testimony from witnesses that Respondent asserts she was "forbidden" from calling, identifying numerous disputes in the procedural history, and arguing that the Findings of Fact show that the patient in question did get better in Respondent's care. The Division filed a response on July 19, 2023, opposing any modification to the PDO other than the two minor corrections previously noted.

On August 16, 2023, the Board met to consider the merits of the PDO. The Board voted to approve the PDO with a variance. The PDO is attached hereto and incorporated in its entirety into this Final Decision and Order with Variance (Order).

VARIANCE

Pursuant to Wis. Stat. §§ 440.035(1m) and 448.02, the Board is the regulatory authority and final decision maker governing disciplinary matters of those credentialed by the Board. The matter at hand is characterized as a class 2 proceeding pursuant to Wis. Stat. § 227.01(3)(b). The Board may make modifications to a PDO, in a class 2 proceeding, pursuant to Wis. Stat. § 227.46(2). In the present case, the Board adopts the PDO in its entirety except for the following variances:

Findings of Fact

Paragraph 19 of the Findings of Fact is corrected to change the date Dr. Rock and Craig Becker called CPS from June 24, 2018 to July 24, 2018.

Paragraph 20 of the Findings of Fact is corrected to change the date Dr. Rock spoke to Dr. Wiley from June 24, 2018 to July 24, 2018.

The Board finds that correcting these errors is necessary to make the record accurate.

Discipline

The PDO as written by the Administrative Law Judge imposes a thirty (30) day suspension on Respondent, completion of four (4) hours of education concerning the treatment of cystic fibrosis patients, and a limitation requiring quarterly chart review by a Board-approved Reviewer for a minimum of twelve (12) quarters resulting in favorable reports on Respondent's practice. However, the Board does not believe that the oversight measures imposed upon Respondent by the Administrative Law Judge are adequate to protect the health, safety, and welfare of the public. Based on Respondent's inexplicable and irrational behavior in this matter, the Board believes that a fitness for duty assessment and additional oversight of Respondent is

supported by the evidence in the record. This determination is also supported by prior board action.

In the case of *In the Matter of Disciplinary Proceedings Against Zulfiqar Ali M.D.,* the Board issued an order with a variance requiring an evaluation of the Respondent based upon the Respondent's prolonged irrational conduct. *In the Matter of Disciplinary Proceedings Against Zulfiqar Ali M.D.,* Order No. 0003287 (Jun. 25, 2014)[1]. The Respondent in that case failed to take steps to ensure a patient had an adequate airway despite clear medical evidence in front of him and contrary to the advice and requests of other professionals. The Board concluded that an evaluation in that matter was consistent with the purposes of professional discipline as defined in *State v. Aldrich,* 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976). While the *Ali* case also involved some inappropriate interactions between the Respondent and staff, the Board pointed primarily to the Respondent's failure to take appropriate action and heed the warnings from other professionals as the concerning behavior that warranted an evaluation.

The record in this matter reflects a series of critical and ongoing medical errors which endangered the health, welfare, or safety of patient KH. Respondent treated KH for several months without appropriately documenting what treatment she performed, what recommendations she made, or the reasons why she prescribed medications to KH. Despite KH's condition continuing to deteriorate under her care, Respondent failed to consult with or refer KH to a cystic fibrosis specialist, and when a cystic fibrosis specialist did get involved in KH's care, Respondent did not defer to the specialist's expertise. This course of action is even more troubling in the light of the fact that Respondent acknowledged at the first visit with KH that Respondent was not a cystic fibrosis specialist. Based on the evidence in the record, the

[1] The Order can be found here: https://online.drl.wi.gov/decisions/2014/ORDER0003287-00009994.pdf.

Board concludes that additional evaluation and oversight are necessary in order to protect the health, safety, and welfare of the public and ensure Respondent's fitness to practice.

ORDER

The Proposed Order on pages 16-19 of the PDO is removed and replaced with the following:

For the reasons set forth above, IT IS ORDERED:

1. The license and registration of Respondent, Carol M. Brown, D.O., to practice medicine and surgery in the state of Wisconsin (license number 20848-21), and her right to renew that license and registration, are SUSPENDED for thirty (30) days from the date of this Order.

2. Respondent's license and registration to practice medicine and surgery in the State of Wisconsin (license number 20848-21), and her right to renew such license and registration, are LIMITED as follows:

a. Within ninety (90) days of the date of this Order, Respondent shall, at her own expense, successfully complete four (4) hours of education on the topic of managing patients with Cystic Fibrosis, offered by a provider pre-approved by the Board or the Board's designee, including taking and passing any exam offered for the course(s).

b. Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below.

c. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted

by the Board, and also may not be used in future attempts to upgrade a credential in Wisconsin.

d. The Board or Board's designee may change the number of credit hours and/or education topics in response to a request from Respondent. The Board or Board's designee may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

e. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all the ordered education.

3. Respondent's license and registration to practice medicine and surgery in the State of Wisconsin (license number 20848-21), and her right to renew such license and registration, are further LIMITED as follows:

a. Within thirty (30) days of the date of this Order, Respondent shall, at her own expense, undergo a neuropsychological evaluation with a psychiatrist or psychologist (Evaluator), preapproved by the Board or its designee. The Evaluator shall be licensed in good standing in Wisconsin. The Evaluator shall have never evaluated or treated nor had a professional or personal relationship with Respondent and shall be experienced in evaluating whether a health care professional is fit to practice. The purpose of this evaluation shall be to assess Respondent's fitness for duty.

b. Prior to evaluation, Respondent shall provide a copy of this Final Decision and Order with Variance to the Evaluator.

c. Respondent shall provide the Evaluator with authorizations to communicate with all physicians, mental health professionals, and facilities at which Respondent has been treated or evaluated.

d. Within fifteen (15) days of the completion of the evaluation, a written report regarding the results of the assessment shall be submitted to the Department Monitor at the address below. The report shall address whether Respondent suffers from any condition(s) that may interfere with her ability to practice safely and competently and, if so, shall provide any recommended limitations for safe and competent practice.

e. Respondent shall comply with any and all reasonable requests by the Evaluator for purposes of scheduling and completing the evaluation, including additional testing the Evaluator deems helpful. Any lack of reasonable and timely cooperation, as determined by the Evaluator, may constitute a violation of an order of the Board.

f. Respondent shall execute necessary documents authorizing the Division to obtain records of the evaluation, and to discuss Respondent and her case with the Evaluator. Respondent shall execute all releases necessary to permit disclosure of the final evaluation report to the Board or its designee. Certified copies of the final evaluation report shall be admissible in any future proceeding before the Board.

g. Upon review of the evaluator's assessment, the Board may suspend or impose additional limitations upon Respondent's license as appropriate to address any recommendations resulting from the evaluation in its discretion. Such discretionary determinations are not reviewable.

h. Respondent is responsible for ensuring that the results of the evaluation are sent to the Department Monitor.

4. Respondent's license and registration to practice medicine and surgery in the state of Wisconsin (license number 20848-21), and her right to renew such license and registration, are further LIMITED as follows:

a. Within sixty (60) days from the date of this Order, Respondent shall engage the services of a physician, preapproved by the Board or its designee, to serve as a chart reviewer (Reviewer) for purposes of this Order. The Reviewer shall be a physician practicing in the area of primary care medicine, licensed to practice medicine and surgery in Wisconsin, and who has not been disciplined by the Board.

b. The request for pre-approval shall be accompanied by the proposed Reviewer's current curriculum vitae or other summary of qualifications and a letter from the proposed Reviewer confirming that he or she has read this Final Decision and Order with Variance and agrees to undertake the duties of a Reviewer as set out in this Order.

c. The proposed Reviewer shall be actively engaged in the practice of medicine and surgery and shall not have any personal relationship, past or present, with Respondent that could reasonably be expected to compromise the proposed Reviewer's ability to render fair and unbiased reports to the Board.

d. Within ninety (90) days of the date of this Order, and on a monthly basis for a period of at least thirty-six (36) months thereafter, the Reviewer shall review ten (10) randomly selected charts of patients Respondent has seen in the preceding

month. The Reviewer shall review the aforementioned charts for the purposes of confirming that Respondent is providing care and treatment to those patients within the scope of her practice and to a level of minimal competence, including but not limited to whether Respondent is appropriately referring patients to primary care physicians and/or specialists when necessary, and whether Respondent is keeping appropriate documentation concerning treatment, treatment recommendations, and the reasons for prescriptions.

e. The Reviewer shall immediately report, in writing, any unprofessional conduct, incompetent practice, serious gap in knowledge, or suspected violation of this Order to the Department Monitor. If a report reflects any of the aforementioned issues, the Board may impose additional limitations as appropriate in its discretion and such discretionary determinations are not reviewable.

f. The Reviewer shall file monthly reports with the Board at the direction of the Department Monitor. The reports shall specifically address the topics identified in subparagraph (d) above. It is Respondent's responsibility to ensure these reports are submitted as directed.

g. After the timely submission of at least thirty-six (36) consecutive favorable monthly reports, and with a written recommendation from the Reviewer expressly supporting the request, Respondent may petition the Board for modification or termination of any part of this limitation. Whether to modify or remove the terms of this limitation is in the sole discretion of the Board or its designee and is not reviewable.

h. Respondent is responsible for all costs associated with the Reviewer.

i. The Reviewer shall have no duty or liability to any patient or third party, and the Reviewer's sole duty is to the Board.

5. In the event Respondent violates any term of this Order, Respondent's license and registration (license number 20848-21), or the right to renew her license and registration, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

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

7. Requests for pre-approval, reports, petitions, payment of costs (made payable to the Department of Safety and Professional Services), and any other requests or submissions related to this Order, shall 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

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

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

WISCONSIN MEDICAL EXAMINING BOARD

By: Clarence Chu (M.D.) 10/11/2023

A Member of the Board Date

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against Carol M. Brown, D.O., Respondent	DHA Case No. SPS-21-0023 DLSC Case No. 18 MED 486

PROPOSED DECISION AND ORDER

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

Carol M. Brown, D.O., by

Attorney John Richardson
53 W. Jackson Blvd., Suite 836
Chicago, IL 60604
John.Richardson@firmrichardson.com

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

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

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

PRELIMINARY RECITALS AND PROCEDURAL HISTORY

On April 9, 2021, the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division) filed a Complaint and Notice of Hearing alleging that Carol M. Brown, D.O. (Respondent) is subject to discipline by the Wisconsin Medical Examining Board (Board) for engaging in violations related to her Wisconsin license to practice osteopathic medicine. The matter was referred to the Division of Hearings and Appeals for hearing, and Administrative Law Judge (ALJ) Angela Chaput Foy was appointed to preside

over a Class 2 hearing. The ALJ conducted a telephonic prehearing conference with the parties on May 19, 2021, and confirmed issues for hearing, established a scheduling order, and scheduled a hearing.

Following the May 19, 2021, prehearing conference, issues arose related to the Respondent's[1] failure to identify witnesses and schedule depositions. The ALJ held a status conference on July 21, 2021, and issued an order resetting discovery and disclosure deadlines. The Respondent's deadline to file an amended witness list was then extended two more times upon request, to accommodate her attorney's health and other emergencies, to August 20, 2021.

On September 10, 2021, the Division filed a motion to compel related to scheduling the Respondent's deposition, and a motion *in limine* to exclude some of the 22 experts and 35 character witnesses identified by the Respondent. The ALJ set a briefing schedule to provide the Respondent an opportunity to respond. The Respondent filed her response a day after her deadline, and initially excluded the Division from her filing. On October 7, 2021, the ALJ granted the Division's motion and ordered the parties to choose a deposition date at the next prehearing conference scheduled for October 28, 2021. Additionally, the Respondent was ordered to file an amended witness list with an offer of proof for each witness and a statement as to how each witness's testimony was relevant and not repetitious on or before October 22, 2021.

On October 22, 2021, the Respondent filed what was labeled as an amended witness list (3rd); however, it was the same document filed and signed August 20, 2021, and it did not include an offer of proof as ordered. It was also not provided to the Division. At 11:34 pm on October 27, 2021, the Respondent filed an amended witness list (4th), which reduced the number of experts and provided offers of proof for proposed experts, but not for proposed character witnesses.

On October 28, 2021, the ALJ conducted an adjourned prehearing conference and issued amended scheduling orders which required the parties to file an expert report or affidavit from each expert a party anticipated calling no later than November 30, 2021. Despite having previously identified up to 22 expert witnesses, the Respondent did not file any expert reports or affidavits.

The Respondent sought adjournments for prehearing conferences scheduled for both December 9, 2021 and January 12, 2022 because of counsel's health.[2] The adjournments were granted.

On February 8, 2022, the ALJ conducted an adjourned prehearing conference. The October 7, 2021 order granting the Division's motion was clarified to state that the Respondent

[1] At all times during the pendency of this matter, the Respondent was represented by Attorney John Richardson. In this procedural summary, all references to actions by the Respondent are by her attorney. The Respondent did not communicate individually unless specifically noted.

[2] The Respondent, by counsel, made the requests to adjourn the day before each scheduled conference.

was precluded from offering testimony from witnesses that were not identified as ordered. Additionally, the order required any prehearing motions to be filed on or before March 1, 2022.

Between March 1, 2022 and March 3, 2022, the Respondent sent several emails indicating that she was filing a motion, but the motion was not included. On March 4, 2022, the Respondent filed a motion to reconsider the February 8, 2022 order and included an amended witness list (5th).

On April 8, 2022, the ALJ partially granted the Respondent's motion to reconsider and amended the February 9, 2022 Prehearing Conference Report and Order to permit the Respondent to call Dr. Ann Auburn and Dr. William Shaw as experts, and to call the mother of the patient[3] at issue as a witness. A prehearing conference was scheduled for April 20, 2022 to schedule the hearing.

On April 20, 2022, neither the Respondent nor her attorney appeared for the prehearing conference. The Division moved for default. The Respondent reported a scheduling error in counsel's office by email later that day. On April 25, 2022, the ALJ issued an order denying the Department's motion for default and rescheduling the prehearing conference for April 26, 2022.

On April 26, 2022, the ALJ held an adjourned prehearing conference and set new deadlines for discovery, final witness lists, and the filing of proposed exhibits. The order stated that proposed exhibits not provided by September 14, 2022 as ordered may be excluded. The parties agreed on a hearing date of September 28, 2022, and the hearing was duly noticed.

On June 9, 2022, the Division moved for default because the Respondent was failing to comply with discovery by not producing her experts for deposition. On June 22, 2022, the ALJ held a status conference to select specific dates for the depositions of two experts and denied the Division's motion for default.

On September 12, 2022, the Division filed its final witness list and proposed exhibits. On September 19, 2022, the Division moved to preclude the Respondent from calling any witnesses or presenting any exhibits at hearing because of the failure to file a final witness list and proposed exhibits by September 14, 2022 as ordered. This motion was granted.

On September 22, 2022, the Respondent sought to adjourn the hearing scheduled for September 28, 2022, because of the health of her attorney. At that time, a medical professional provided written notice that Attorney Richardson was not medically able to practice law as it related to this particular case. The ALJ adjourned the hearing, but explicitly cautioned the Respondent individually that it would not be continued again for Attorney Richardson's health, putting her on notice that it may be necessary for her to engage new counsel or co-counsel or represent herself. The parties agreed on a hearing date of November 10, 17, and 18, 2022 and the hearing was duly noticed.

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[3] To protect the privacy of the minor patient whose care is at issue in this matter, she is referred to by her initials, K.H. This April 8, 2022 order permitted the Respondent to call K.H.'s mother as a witness.

Pursuant to due notice, the hearing began on November 10, 2022, and continued on November 17, 2022, in Madison, Wisconsin. Partway through the day on November 17, 2022, the parties reached a settlement and signed a stipulation. The ALJ held the case in abeyance pending the Board's approval of the parties' stipulation. The Board was scheduled to consider the matter on December 21, 2021.

On December 21, 2022 at 2:34 am, the Respondent filed an "emergency" motion seeking to rescind the stipulation because the Respondent wanted to revoke her consent to the settlement. Over the Division's objection, the ALJ granted the motion to rescind the consent order and the parties convened for a status and scheduling conference on February 20, 2023, at which time the parties agreed on a continued hearing date of April 13 and 14, 2023, and the continued hearing was duly noticed.

On March 9 and March 23, 2023, the Respondent indicated that she would be seeking to recall expert witnesses who had already testified at the initial November hearing dates. The Division objected, and the parties disputed who would bear the expense of recalling the expert witnesses, if allowed. An order addressing the witnesses' continued testimony and associated costs was issued on March 29, 2023.

On March 28, 2023, the Respondent filed an "emergency" motion to reschedule the continued hearing scheduled for April 13, 2023, based on her attorney's medical appointment and the Respondent's work schedule. The motion was denied.

On April 6, 2023, the Respondent filed an "amended emergency motion" to reschedule the continued hearing scheduled for April 13, 2023 because she learned one of the witnesses she was seeking to recall, Dr. Rock, was unavailable after she contacted him about the hearing on April 4, 2023. The request to reschedule the continuation of the hearing was denied.

Pursuant to due notice, the hearing continued on April 13 and 14, 2023, in Madison, Wisconsin. Following the testimony on April 13, 2023, the Respondent renewed her request to reschedule the hearing. The request was denied.

The hearing was recorded by stenographer. Dr. Brown appeared by Attorney John Richardson, and the Division appeared by Attorney Carley Peich Kiesling. Testimony was heard from Dr. Michael Rock, Dr. Donna Diamond, and Dr. Carol Brown. The record includes the hearing transcript and the Division's Exhibits 1–12.

The parties submitted post-hearing briefs on the issue of discipline and costs. At the conclusion of the hearing on April 14, 2023, the ALJ ordered the Division to file a statement expressing the discipline it was seeking on or before April 21, 2023. The Division timely filed this statement. Closing briefs not to exceed ten pages of argument were due, simultaneously, on or before May 19, 2023. The Division timely filed its ten-page brief with an additional three-page proposed order. The Respondent filed her fifteen-page brief, with seven additional pages of exhibits, on May 20, 2023. The Division objected to the Respondent's closing as untimely, and because the Respondent was attempting to file additional evidence in her exhibits. The

Division's objections are sustained, and the exhibits filed May 20, 2023 are excluded from evidence.

FINDINGS OF FACT

1. The Respondent, Carol Marie Brown, D.O., PH.D., FAARFM, ABAARM, is licensed in the state of Wisconsin to practice osteopathic medicine, having license number 20848-21, first issued on July 11, 1977. She has practiced as a physician for 44 years and started private practice in 1989. (Complaint; Answer; Dr. Brown testimony, Day 3 Tr. at 188-189, Day 4 Tr. at 6)

2. At all times relevant to this matter, Dr. Brown was a physician practicing osteopathic and integrative medicine and family medicine in Oak Creek, Wisconsin. (Complaint and Answer) She previously worked in emergency medicine. (Dr. Brown testimony, Day 3 Tr. at 189)

3. Beginning on approximately April 25, 2017, Dr. Brown treated KH, a patient with cystic fibrosis. KH lived in Shiocton, Wisconsin, and at the time she started seeing Dr. Brown, she was five years old. KH's parents were seeking an integrative medicine doctor for their daughter. They had resisted traditional therapies for cystic fibrosis. (Dr. Rock testimony, Day 1 Tr. at 44; Ex. 5 at 2)

4. Cystic fibrosis is a genetic disease. It causes lung issues with recurrent infections. Cystic fibrosis patients have difficulty fighting bacterial infections. They have a chloride channel defect in their sweat glands, both in their airways and other parts of the body, which causes a thick sticky mucus. A person cannot fight infections well with that mucus, and that can cause a progressive loss of lung function. Without specialty care, a patient with cystic fibrosis can have a dramatically decreased lifespan. (Dr. Rock testimony, Day 1 Tr. at 31-33, 105-106)

5. KH had received specialized medical care for her cystic fibrosis from Dr. Peter Holzwarth, M.D. at a cystic fibrosis center at St. Vincent's Hospital in Green Bay, Wisconsin. Prior to seeing Dr. Brown, KH last saw Dr. Holzwarth on July 20, 2016. (Dr. Rock testimony, Day 1 Tr. at 44, 159; Ex. 2 at 3)

6. On April 25, 2017, Dr. Brown first saw KH. Dr. Brown informed KH and her mother that she provided integrative medicine not covered by insurance. At this first office visit, Dr. Brown recommended some common integrative medicine tests for KH: a Great Plains stool test, a urine test, a hair analysis, and EnteroLab for gluten intolerance testing. (Complaint and Answer; Dr. Diamond testimony, Day 2 Tr. at 284, 287, 290-291; Exhibit 9 at 37, 39)

7. On June 16, 2017, Dr. Brown had a phone call with KH's mother. They reviewed some test results. Dr. Brown ordered different tests and recommended nutritional supplements

for KH. Additionally, Dr. Brown recommended that she "consider routine visits to CF clinic if [KH]'s health changes." (Dr. Diamond testimony, Day 2 Tr. at 291-293; Ex. 9 at 33)

8. On March 1, 2018, Dr. Brown saw KH again in person because she was ill. KH had a temperature of 100.1, a high heart rate of 138, coughing, stomachache, and shortness of breath. Dr. Brown diagnosed her with pneumonia and prescribed the antibiotic azithromycin, with three refills, and DuoNeb, a nebulizer of the two medications ipratropium bromide and albuterol. (Dr. Diamond testimony, Day 2 Tr. at 293-296; Ex. 9 at 28-29)

9. On March 9, 2018, Dr. Brown saw KH again, but KH's health had not significantly improved. She still had an elevated temperature, high heart rate, and heavy breathing. Dr. Brown did not record any additional treatment or recommendations in her records. (Dr. Diamond testimony, Day 2 Tr. at 298; Ex. 9 at 24-27)

10. On May 1, 2018, Dr. Brown prescribed KH Addipak saline vials. She did not note in her records why she wrote the prescription. (Dr. Diamond testimony, Day 2 Tr. at 300; Ex. 9 at 10)

11. On June 25, 2018, KH's mother took KH to see Dr. Jasmine Wiley because she was looking for medical care closer to their home. Dr. Wiley was in Shawano, Wisconsin. Dr. Wiley discussed her role with KH's mother: while she could manage KH's primary care, she was not a pediatric pulmonologist or a cystic fibrosis specialist, and KH still needed to establish care with a cystic fibrosis clinic. Dr. Wiley made a formal referral to a cystic fibrosis specialist, Dr. Michael Rock. (Dr. Diamond testimony, Day 2 Tr. at 305-307; Ex. 4 at 4-7)

12. Dr. Michael Rock, M.D. is a pediatric pulmonologist with the division of pulmonology and sleep medicine, in the department of pediatrics, at the University of Wisconsin since January 1, 1995. He is a professor and practicing physician. He sees patients in Madison, and at outreach clinics in Green Bay and Oshkosh, Wisconsin, and Rockford, Illinois. He has been the director of the Cystic Fibrosis Center, which is accredited by the Cystic Fibrosis Foundation, since about April of 1995. (Dr. Rock testimony, Day 1 Tr. at 28-31; Ex. 6)

13. On July 17, 2018, Dr. Rock saw KH. She was very sick. Dr. Rock reviewed KH's medical history by discussing her care with her mother and reviewing Dr. Holzwarth's records. KH's body mass index had fallen from the 24th percentile in July of 2016, when Dr. Holzwarth last saw her, to a 0.13 percentile in July of 2018. KH was malnourished. She had a pale pasty appearance. Dr. Rock heard a wet sounding cough and crackles when he listened to her chest. He observed abnormal suprasternal notch retractions, meaning the area above the breastbone went in and out with breathing. She also had a rapid heart rate, and she had mild to moderate clubbing of her digits. His office administered a spirometry test of KH's pulmonary function using a measure called FEV1

(forced expiratory volume in one second) to measure her lung function. When Dr. Holzwarth had done this testing in 2016, KH had been in the 90% range. In Dr. Rock's office, the value for KH had decreased to 26% predicted. (Dr. Rock testimony, Day 1 Tr. at 43-45, 54-55; Ex. 5 at 450)

14. Dr. Rock advised KH's mother that KH needed to be hospitalized in a Cystic Fibrosis Foundation-certified center, either St. Vincent Hospital in Green Bay or the children's hospital in Madison. He described KH as the sickest child he had seen in 30 years. He was concerned about the crackles in her chest, wet sounding cough, low pulmonary function, and very low body mass index. She needed two separate IV antibiotics and a nebulized antibiotic, specific vitamins (cystic fibrosis patients can have low levels of the fat-soluble vitamins A, E, D, and K), and Orkambi, a modulator drug that helps to partially correct the chloride channel defect. She needed intensive airway clearance multiple times a day and nutritional rehabilitation. Additionally, KH's family needed reeducation on how to properly care for her and how to administer an FDA-approved pancreatic enzyme, instead of the over-the-counter plant-based enzyme her mother had been administering, and to have her return for regular specialty cystic fibrosis care every three months. (Dr. Rock testimony, Day 1 Tr. at 44, 57-55, 63, 129-132; Ex. 2 at 5)

15. KH's mother was resistant to hospitalization. Dr. Rock advised that he would call KH's mother to follow up on which hospital they chose for care. (Dr. Rock testimony, Day 1 Tr. at 60; Ex. 2 at 6)

16. On July 18, 2018, Dr. Brown prescribed KH the antibiotic Bactrim, with two refills. She did not note in her records what, if any contact with KH or her family prompted the prescription. (Dr. Diamond testimony, Day 2 Tr. at 301; Ex. 9 at 10)

17. On July 23, 2018, Dr. Rock and a social worker, Craig Becker, jointly called KH's mother to follow up. KH's mother informed them that instead of going to the hospital, KH was going to have a peripherally inserted central catheter (PICC line) placed for outpatient IV antibiotics. KH's mother would not share with Dr. Rock which provider was ordering the PICC line. Dr. Rock repeated his recommendation for KH to be hospitalized in a Cystic Fibrosis Foundation-certified center for IV antibiotics, intensive airway clearance, and nutritional rehabilitation. (Dr. Rock testimony, Day 1 Tr. at 61-63; Ex. 3 at 20)

18. On July 23, 2018, Dr. Brown ordered a PICC line for KH, which was placed by Dr. Bradley Hartmann, a physician in Neenah, Wisconsin with Radiology Associates of Fox Valley. (Ex. 3 at 18)

19. On June 24, 2018, Dr. Rock and Mr. Becker, the social worker, called Outagamie County Child Protective Services (CPS) to file a report for child neglect. Dr. Rock reported that KH was not receiving the treatment she needed. (Dr. Rock testimony, Day 1 Tr. at 64-65; Ex. 3 at 20)

20. Also on June 24, 2018, Dr. Rock talked to Dr. Wiley, who had referred KH to him. He informed her that he had reached an impasse with KH's mother regarding KH's care, and that he had called CPS. Dr. Wiley informed Dr. Rock that Dr. Brown was the physician that ordered the PICC line for KH. (Dr. Rock testimony, Day 1 Tr. at 65-66; Ex. 3 17-18).

21. On July 26, 2018, Dr. Brown saw KH because her respiratory infections had reoccurred or not resolved. She prescribed KH IV antibiotics. (Dr. Diamond testimony, Day 2 Tr. at 312-316; Ex. 8 at 18, Ex. 9 at 15)

22. On July 26, 2018, and again on July 27, 30, 31, and August 1, 2018, Dr. Brown treated KH, via the PICC line, with IV tobramycin, an antibiotic, in addition to a B12 vitamin, specifically, methyl cobalamin. (Dr. Diamond testimony, Day 2 Tr. at 321-323; Ex. 9 at 208-212)

23. On or about July 26, 2018, Dr. Rock and Dr. Brown spoke on the phone. Dr. Brown told Dr. Rock that KH was receiving tobramycin, an IV antibiotic, on an outpatient basis, that she was seeing KH twice a week, and that she had sent respiratory secretions for a DNA test to look for pathogens. Dr. Rock emphasized to Dr. Brown that this treatment was inadequate, and that KH needed to be hospitalized for the recommended cystic fibrosis treatment. (Dr. Rock testimony, Day 1 Tr. at 66-68, 253; Ex. 3, 015)

24. On August 9, 2018, Dr. Rock filed a complaint with the Department and the Medical Examining Board, based on his concerns for KH, his understanding of how Dr. Brown was treating KH, and the care KH was not receiving. (Ex. 1)

25. On August 16, 2018, KH was admitted to the hospital by Dr. Holzwarth. KH was underweight, in respiratory distress, and had retractions, orthopnea, labored breathing, shortness of breath, high pulse of 145, and a temperature of 101.6. She was pale, had a pulse oximetry of 86 percent, and difficulty breathing. In his record of the history of present illness, Dr. Holzwarth indicated that that KH had a PICC line in and had received tobramycin via that PICC line on five occasions. (Dr. Rock testimony, Day 1 Tr. at 77, 82-83, 169; Dr. Diamond testimony, Day 2 Tr. at 333, 337-338; Ex. 5 at 9, 11; Ex. 9 at 198)

26. During her hospital stay, KH's health improved. Her pulmonary status responded well to the standard cystic fibrosis treatments including IV and nebulized antibiotics. Her spirometry improved, she had positive weight gain, and her parents were compliant with treatments in the hospital. (Dr. Diamond testimony, Day 2 Tr. at 339-340; Ex. 5 at 12)

27. On August 30, 2018, KH was discharged from the hospital. (Dr. Diamond testimony, Day 2 Tr. at 340)

28. On December 4, 2018 and February 28, 2019, the Department intake staff sent a request to Dr. Brown for a response to the complaint by March 14, 2019. On March 14, 2019, Dr. Brown's attorney responded to the Department, requesting a one-month extension. The

Department granted an extension to respond by April 1, 2019. Dr. Brown did not respond by April 1, 2019. (Complaint and Answer)

29. On June 19, 2019, the Department received Dr. Brown's detailed written response to the complaint and attachments from her attorney. (Complaint and Answer) The response included Dr. Brown's chart for KH. (Ex. 8)

30. On March 23, 2021, Dr. Brown provided a second set of medical records for KH through counsel. (Ex. 9) It contained some additional records to what was previously provided in 2019. (Dr. Diamond testimony, Day 2 Tr. at 280-281; *Cf.* Exs. 8 and 9)

31. On April 9, 2021, the Division filed a Complaint against Dr. Brown's license requesting discipline and costs for allegedly engaging in unprofessional conduct by departing from or failing to conform to the standard of minimally competent medical practice, by failing to establish and maintain timely patient health care records, and by failing to cooperate in a timely manner with the Board's investigation of a complaint filed against a license holder.

32. On April 29, 2021, Dr. Brown timely filed an Answer to the Complaint.

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).

Violations

The Division alleges that Dr. Brown engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03, and therefore is subject to discipline pursuant to Wis. Stat. § 448.02(3). Unprofessional conduct for physicians that is grounds for the Division to take disciplinary action includes, but is not limited to:

a. 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, regardless of whether the act or omission resulted in actual harm to any person. Wis. Admin. Code § Med 10.03(2)(b).

b. 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).

c. Failing to cooperate in a timely manner with the board's investigation of a complaint filed against a license holder. Wis. Admin. Code § Med 10.03(3)(g).

The Department maintains that Dr. Brown tried to treat a pediatric cystic fibrosis patient suffering from advanced lung disease, which exceeded her scope of practice as an integrative medicine and family medicine physician. While Dr. Brown initially treated KH with integrative medicine treatments, when KH began to exhibit pneumonia symptoms in March 2018, Dr. Brown prescribed oral antibiotics on multiple occasions over the next months without consulting with a cystic fibrosis specialist to ensure that the antibiotics were appropriate even when the oral antibiotics did not resolve the infection. Not only did Dr. Brown not consult a specialist, but she failed to regularly discuss and encourage KH's mother to take KH to a specialist. When KH finally did see a specialist, Dr. Rock, on July 17, 2018, Dr. Brown did not defer to Dr. Rock. Instead, she assured KH's mother that KH could be treated without hospitalization. Dr. Brown also exceeded her scope of practice by administering IV tobramycin to KH via a PICC line.

On the other hand, Dr. Brown's position is that she is not a one-dimensional doctor, but has decades of experience, including 23 years of experience in emergency medicine, which requires identifying and treating illnesses. Dr. Brown was seeing KH because KH's mother wanted KH off medications for as long as possible and to do what they could naturally. Dr. Brown had no obligation to refer KH to a specialist because KH's mother had told her that KH had a specialist, Dr. Holzwarth, who was allowing KH to come to the cystic fibrosis clinic annually, instead of the typical requirement to visit each quarter. Dr. Brown argues that in July 2018, KH was not as sick as Dr. Rock suggests, and she asserts that the low spirometry reading may have been because KH was intimidated by Dr. Rock or because KH just had difficulty with the machine as a young child. Regarding the PICC line in late July 2018, Dr. Brown asserts that it was not for antibiotics. Dr. Brown asserts she administered IV Ag-Hydrosol (silver) to KH via PICC line, and that silver is a natural supplement she used to treat KH for possible mold toxicity.

Upon careful consideration of the testimony and evidence presented in this matter, the record supports a finding that Dr. Brown deviated from the standard of minimally competent medical practice in her care provided to KH in 2018 when she superseded the care of a specialist, that Dr. Brown failed to establish and maintain legible and complete patient health care records for her care provided to KH, and that Dr. Brown failed to cooperate with the Board's investigation. Dr. Brown is therefore subject to discipline by the Board. *See* Wis. Stat. § 448.02(3).

A. Standard of Care Violation

The Division alleges that Dr. Brown departed from the standard of minimally competent medical practice and created an unacceptable risk of harm to KH by failing to involve a cystic fibrosis specialist in KH's care, ignoring and failing to defer to a cystic fibrosis specialist's plan of care once a specialist was involved, and practiced outside the scope of her integrative medicine practice, by administering IV tobramycin to KH as an outpatient.

In the spring of 2018, KH was sick, and she saw Dr. Brown on March 1 and March 9, 2018. Dr. Brown diagnosed KH with pneumonia and prescribed antibiotics with multiple refills. KH next saw Dr. Wiley, on June 25, 2018, when her mother sought care closer to home. Dr. Wiley referred KH to a specialist. KH then saw Dr. Rock, a pediatric pulmonologist and cystic fibrosis specialist, on July 17, 2018. Dr. Rock was concerned about KH's advanced lung disease and significant decline since she had last seen a specialist two years before. He recommended specific care, which included hospitalization for two IV antibiotics, a nebulized antibiotic, specific vitamins, a modulator drug called Orkambi, intensive airway clearance multiple times a day, nutritional rehabilitation, and education for the family.

Instead of supporting or complementing the specialist's recommendations, Dr. Brown ignored and superseded it. KH was not hospitalized. Instead, Dr. Brown prescribed an antibiotic and ordered a PICC line placed, without an office visit. KH then saw Dr. Brown on July 26, 27, 30, 31, and August 1, 2018 for IV tobramycin. Within that window of time when she was administering an antibiotic via a PICC line, Dr. Brown spoke to Dr. Rock by phone. While the parties dispute exactly what was said in that call, it is undisputed that the call occurred within this window. Dr. Brown also spoke to CPS. Therefore, Dr. Brown clearly knew that a specialist was involved and had outlined specific care and concerns for KH. Dr. Brown did not defer to that care; she disregarded it. She continued to treat KH her own way.

Whether Dr. Brown was administering IV tobramycin - supplanting other care of conditions caused by KH's cystic fibrosis - or whether Dr. Brown was administering IV vitamins and antimicrobials as part of her integrative care for KH's overall wellbeing is the crux of the dispute between the parties. Dr. Brown disputes that she was administering IV tobramycin, and instead claims that she used the PICC line for IV B12 vitamins and the antimicrobial Ag-Hydrsol. The preponderance of the evidence does not support this claim. The evidence showed that she administered IV tobramycin. On July 26, 2018, in the first set of Dr. Brown's records, she wrote, "Will add IV antibiotic." (Ex. 8 at 18) This same notation occurs in the second set of records. (Diamond testimony, Day 2 Tr. at 312-316, 324; Ex. 9 at 15) In her chart, Dr. Brown references tobramycin and the pediatric dosing for five days: "Pseudamonas, tobra, 12 milligrams per kilogram. Q24 hours times five days." (Diamond testimony, Day 2 Tr. at 312-316, 324; Ex. 9 at 20) Dr. Brown ordered a PICC line, and a PICC line dressing change. Dr. Diamond, the Division's expert, testified that a significant procedure, like the insertion of a PICC line, would not be done to deliver B12 to a patient, which can be administered in other ways. The only reason to order an invasive procedure like a PICC line would be to deliver the antibiotic. (Diamond testimony, Day 2 Tr. at 325) Dr. Brown's records include a letter from KH's mother, which indicated that Dr. Brown assured her that KH could be treated for nutrition and infection

without hospitalization, and then arrangements were made for the PICC line insertion at ThedaCare in Neenah. (Diamond testimony, Day 2 Tr. at 330) (Ex. 9 at 181-182) Dr. Holzwarth's record on August 16, 2018, indicates that KH had a PICC line in, and that KH had received tobramycin on five occasions prior to hospitalization on August 16, 2018. (Ex. 9 at 198) Finally, Dr. Rock testified that Dr. Brown told Dr. Rock that she administered IV tobramycin to KH in their call in late July. (Rock testimony, Day 1 Tr. at 67-38, 352)

The Division presented two experts at the hearing in this matter: Dr. Michael Rock, a pediatric pulmonologist, and Dr. Donna Diamond, an integrative medicine and family medicine physician. It is clear from their testimony that the standard of care for a patient with cystic fibrosis, especially when suffering from an infection in her lungs, is to receive specialized care from a pediatric pulmonologist. If a physician is not trained in that specialized care, then that physician must refer the patient to a specialist to meet that standard of care. No evidence was presented that this was not the standard. Dr. Brown failed to conform to the standard when she superseded her plan over the specialist's.

Dr. Brown also should have regularly discussed, recommended, and encouraged KH's mother to take KH to a cystic fibrosis specialist, before it got to the point when hospitalization was required. Dr. Brown should have clarified her role as an integrative medicine physician, and not a specialist, at the beginning of her relationship with KH and her family. This should have been repeated, and emphasized, and a referral should have been made in the spring of 2018, when KH was sick, and again when the initial round of antibiotics did not resolve her infection. The only reference to a conversation regarding a specialist in Dr. Brown's records is of the phone call on June 16, 2017, in which Dr. Brown stated, "to consider routine visits to CF clinic if health changes." The lack of referrals and discussion of the scope of integrative medicine is evidence that supports the conclusion that Dr. Brown was attempting to exceed her scope and KH's lung disease caused by cystic fibrosis.

A preponderance of the evidence supports a finding that Dr. Brown failed to meet the standard of care in treating KH by administering IV tobramycin to KH as an outpatient, and intentionally superseding a cystic fibrosis specialist's recommended care, creating an unacceptable risk of harm to KH.

B. Health Care Records Violation

Physicians are required to establish and maintain timely patient health care records, including records of prescription orders. Wis. Admin. Code § Med 10.03(3)(e). The records must include assessment or diagnosis and plan of treatment for the patient. Wis. Admin. Code § Med 21.03(2). Additionally, each patient record entry must be dated and sufficiently legible to allow interpretation by other practitioners for the benefit of the patient. Wis. Admin. Code § Med 21.03(3).

Dr. Brown's records of her care provided to KH are insufficient. It is not possible to review Dr. Brown's records and discern what treatment was provided to KH and why. Dr. Brown did not include her reasons for prescribing medication, her plan of treatment, or the dates of

particular events. On May 1 and July 18, 2018, prescriptions were ordered, but the records contain no notes regarding patient contact, why these prescriptions are necessary, or what is being treated. The handwriting on the records is hard to read, and at times, it is illegible. (*See e.g.* Ex. 9 at 7, 10, 15, 24) Some records are not dated. (*See e.g.* Ex. 9 at 7, 20) The records provide insufficient information for another provider to know the total treatment plan.

Dr. Brown's argument that she did not prescribe KH IV tobramycin emphasizes the insufficiency of her records, and it undermines her credibility. If her records were clear, what was prescribed and why would not be in debate. Instead, conflicting records complicate the matter. Dr. Brown's records for July 26, 2018 differ slightly between the two sets of records she produced to the Division. (Exs. 8 and 9). On July 26, 2018, in the first set of her records, Dr. Brown wrote, "Will add IV antibiotic." (Ex. 8 at 18). This same record appears in the second set of records produced to the Division. (Ex. 9 at 15). However, the second set also contains an additional page for July 16, 2018, which provides, "I will add IV antimicrobials," which was not present in the first set. (Ex. 9 at 15). Additionally, her chart references tobramycin and the pediatric dosing for five days. (Ex. 9 at 20) However, this record on tobramycin is undated, the handwriting is difficult to read, and no context for the reference to the drug is provided. If the records identified the date, assessment and diagnosis, and treatment plan for KH as required, it would have been clear whether Dr. Brown administered an IV antibiotic via PICC line for a lung infection in a pediatric cystic fibrosis patient as the evidence suggests, or whether Dr. Brown had a PICC line placed in a child to administer IV B12 vitamins and Ag-Hydrsol, which she labels with the terms antibiotics and antimicrobials interchangeably, in a child who was no longer very sick even though she had to be hospitalized, as Dr. Brown maintains.

A preponderance of the evidence supports a finding that Dr. Brown failed to maintain complete and legible records regarding her care of KH as required and is therefore subject to discipline.

C. Cooperation with Investigation Violation

When the Board makes a request, physicians are required to cooperate in a timely manner with the Board's investigation. Wis. Admin. Code § Med 10.03(3)(g). "There is a rebuttable presumption that a credential holder who takes longer than 30 days to respond to a request of the board has not acted in a timely manner." *Id.*

The Department sent Dr. Brown requests for information on February 28, 2019. It is undisputed by the parties that she did not respond within 30 days. While the Department allowed an extension to April 1, 2019, Dr. Brown did not respond until June 2019.

Additionally, Dr. Brown's production of records and delays in this process are evidence of her lack of cooperation. She produced one set of records, Exhibit 8, on June 19, 2019. Then she provided a second set of *almost* the same records on March 23, 2021, Exhibit 9, such that the two exhibits had to be scrutinized to determine the differences. Since the Complaint was filed, the procedural history of this matter demonstrates Dr. Brown's chronic dilatory behavior and non-compliance with orders. While it is unclear which are attributed to Dr. Brown individually

or her attorney, the result and intent was to frustrate and delay the Department's investigation and this process.

A preponderance of the evidence supports a finding that Dr. Brown failed to cooperate with an investigation by the Board after requests were made as required and is therefore subject to discipline.

Discipline

The Board is authorized to discipline the Respondent for engaging in unprofessional conduct. Wis. Stat. § 448.02(3). The Division recommends that Dr. Brown's license be suspended for 30 days and then subject to chart review by a Board-approved physician for a period of 3 years, that Dr. Brown be ordered to complete four hours of education on managing patients with cystic fibrosis, and that she be assessed the full costs of the proceeding. Because the record established that Dr. Brown engaged in the unprofessional conduct alleged, and because the recommended discipline is consistent with the purposes articulated in *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976), the Division's recommendation is adopted here.

"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). When a license is granted to an individual, Wisconsin is assuring the public that the licensed individual is competent in his or her profession. *Stringez v. Dep't of Regulation & Licensing Dentistry Examining Bd.*, 103 Wis. 2d 281, 287, 307 N.W.2d 664 (1981). The three purposes of discipline 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. *Aldrich*, 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976).

The recommended discipline is consistent with the purposes of discipline. Dr. Brown's failure to defer to the recommendations of a cystic fibrosis specialist constituted a danger to KH and is serious misconduct warranting a suspension of her license. The proposed chart reviews will allow the Board to confirm that Dr. Brown will provide competent care within the scope of her practice going forward. The education on the topic of cystic fibrosis will emphasize to Dr. Brown the importance of patients receiving care by qualified specialists, which will protect the public and educate her on the appropriate scope of care for her as an integrative medicine doctor, compared to care by a specialist. The suspension is necessary because Dr. Brown's violations were serious, and she takes no responsibility for them; they reflect a disregard for the rules in place to protect patients and govern the profession. The suspension and license limitations will deter other licensees from engaging in similar conduct.

Based upon the facts of this case and the factors set forth in *Aldrich*, a one-month suspension of Dr. Brown's license, requiring education, and then limiting Dr. Brown's license, pursuant to the terms and conditions of the Order below, is reasonable and warranted.

Assessment of Costs

Assessment of costs is appropriate in this case pursuant to Wis. Stat. § 440.22(2) because a suspension and license limitation are recommended. The Board is vested with discretion concerning whether to assess all or part of the costs of this proceeding based on the aggravating and mitigating facts of the case. *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 licensee: (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 licensee'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).

Considering the above factors, it is appropriate for Dr. Brown to pay the full costs of the investigation and these proceedings. The Division has proven each of the alleged bases for discipline. The allegations of failing to meet the standard of care and failing to establish patient records are serious. Owing directly to Dr. Brown and/or her attorney's conduct, this administrative proceeding was delayed and unnecessarily complicated countless times, which significantly increased the time and cost of litigation.

Further, the Department is a program revenue agency, funded by credential holders. It would be unfair to impose the costs of pursuing discipline in this proceeding on licensees who have not engaged in misconduct. Therefore, it is appropriate for Dr. Brown 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 Division has the burden to prove its allegations by a preponderance of the credible evidence. Wis. Admin. Code §§ HA 1.12(3)(b) and 1.17(2).

3. The Respondent engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.03(2)(b) by departing from or failing to conform to the standard of minimally competent medical practice which created an unacceptable risk of harm to a patient.

4. The Respondent engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.03(3)(e) by failing to establish and maintain timely patient health care records.

5. The Respondent engaged in unprofessional conduct pursuant to Wis. Admin. Code § Med 10.03(3)(g) by failing to cooperate in a timely matter with the Board's investigation of a complaint filed against her.

6. As a result of the above violations, a suspension, license limitations including chart review, and required education are warranted, reasonable, and appropriate. Wis. Stat. § 448.02(3). *Aldrich,* 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976).

7. Pursuant to Wis. Stat. § 440.22, it is appropriate to assess the full costs of the proceedings against the Respondent based on the violations proven.

8. 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.

PROPOSED ORDER

For the reasons set forth above, IT IS ORDERED:

1. The license and registration of the Respondent, Carol M. Brown, D.O., to practice medicine and surgery in the state of Wisconsin (license number 20848-21), and her right to renew that license and registration, is SUSPENDED for 30 days from the date of this Order.

2. The Respondent's license to practice medicine and surgery in the State of Wisconsin (license number 20848-21), and her right to renew such license and registration, is LIMITED as follows:

    a. Within ninety (90) days of the date of this Order, the Respondent shall, at her own expense, successfully complete four (4) hours of education on the topic of managing patients with Cystic Fibrosis, offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

    b. The Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below.

    c. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board, and also may not be used in future attempts to upgrade a credential in Wisconsin.

    d. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison

may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

e. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all the ordered education.

3. Respondent's license and registration to practice medicine and surgery in the state of Wisconsin (license number 20848-21), and her right to renew such license and registration, is FURTHER LIMITED as follows:

   a. Within sixty (60) days from the date of this Order, the Respondent shall engage the services of a physician to serve as a chart reviewer (Reviewer) for purposes of this Order. The Reviewer shall be a physician practicing in the area of primary care medicine, licensed to practice medicine and surgery in Wisconsin, and who has not been disciplined by the Board.

   b. Within thirty (30) days of the date of this Order, the Respondent shall submit to the Department Monitor at the address below a written request for approval of a proposed Reviewer. The request for approval shall be accompanied by the proposed Reviewer's current curriculum vitae or other summary of qualifications and a letter from the proposed Reviewer confirming that he or she has read this Final Decision and Order and agrees to undertake the duties of a Reviewer as set out in this Order.

   c. The proposed Reviewer shall be actively engaged in the practice of medicine and surgery and shall not have any personal relationship, past or present, with the Respondent that could reasonably be expected to compromise the proposed Reviewer's ability to render fair and unbiased reports to the Department.

   d. The Board's monitoring liaison has the full and final authority to approve or reject a proposed Reviewer. This decision is based on an exercise of discretion and is not reviewable. The Board's monitoring liaison may approve, reject, or direct a change in the Reviewer for any of the following reasons: the Reviewer is unable to carry out the responsibilities set out in this order; the Reviewer requests the change; or the Reviewer fails to meet any requirement of this order.

   e. Effective the date of this Order, and on a quarterly basis, the Reviewer shall review ten (10) randomly selected charts of patients the Respondent has seen in the preceding quarter. The Reviewer shall review the aforementioned charts for the purposes of confirming that the Respondent is providing care and treatment to those patients within the scope of her practice and to a level of minimal competence, including but not limited to whether Respondent is appropriately referring patients to primary care physicians and/or specialists when necessary.

f. The Reviewer shall immediately report, in writing, any unprofessional conduct, incompetent practice, serious gap in knowledge, or suspected violation of this Order to the Department Monitor. If a report reflects any of the aforementioned issues, the Board may impose additional limitations as appropriate in its discretion and such discretionary determinations are not reviewable.

g. The Reviewer shall review patient charts, as set forth above, on a quarterly basis for a period of at least thirty-six (36) months.

h. The Reviewer shall file quarterly reports with the Department Monitor at the address below. The reports shall specifically address the topics identified subparagraph (e) above. It is the Respondent's responsibility to ensure these reports are submitted when due.

i. After the timely submission of at least twelve (12) consecutive favorable quarterly reports, and with a written recommendation from the Reviewer expressly supporting the request, the Respondent may petition the Board for modification or termination of any part of this limitation. The Board or its monitoring liaison shall modify or remove the terms of this limitation after the Respondent petitions the Board, and the Board or its monitoring liaison determines that the Respondent is in compliance with the requirements of this Order and doing so does not create an unacceptable risk to patients or the public. Whether to modify or remove the terms of this limitation is in the sole discretion of the Board or its monitoring liaison and is not reviewable.

j. The Respondent is responsible for all costs associated with the Reviewer.

k. The Reviewer shall have no duty or liability to any patient or third party, and the Reviewer's sole duty is to the Board.

4. In the event the Respondent violates any term of this Order, the Respondent's license (No. 20848-21), or the right to renew her license and registration, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until the Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

5. The Respondent shall pay all recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § SPS 2.18.

6. Petitions, payment of costs (made payable to the Department of Safety and Professional Services), and any other requests 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: https://dspsmonitoring.wi.gov.

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

Dated at Madison, Wisconsin on June 20, 2023.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Telephone: (414) 227-4025
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By: _____
Angela Chaput Foy
Administrative Law Judge