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Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Petition for Summary Suspension Against David J. Houlihan, M.D., Respondent

DHA Case No. SPS-16-0027
DLSC Case No. 15 MED 002
00046 03

**DECISION AND ORDER RESTORING RESPONDENT'S LICENSE TO PRACTICE MEDICINE AND SURGERY**

The parties to this summary suspension proceeding are:

David J. Houlihan, M.D., by

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

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

Attorneys Yolanda McGowan and Joost Kap
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

## PROCEDURAL HISTORY

On March 16, 2016, the Wisconsin Medical Examining Board (Board) issued an order summarily suspending Respondent's license. In issuing its emergency suspension, the Board found that there was probable cause to believe that Respondent David J. Houlihan, M.D., (Respondent) had engaged in unprofessional conduct and/or negligence and that it was necessary to immediately suspend his license and registration to practice medicine and surgery in order to

protect the public health, safety or welfare, pursuant to Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. 6. The Order of Summary Suspension identified several areas in which the Board concluded that Respondent engaged in unprofessional conduct and/or negligence: (1) Respondent's treatment and documentation with respect to Patient A, particularly with respect to his prescription of Suboxone; (2) Respondent's prescription practices and documentation of such in his patient health care records; (3) Respondent's abuse of authority with respect to staff members.

The Order of Summary Suspension was properly served on Respondent. A Notice of Hearing and formal Complaint commencing a disciplinary proceeding was served on Respondent on March 23, 2016, in compliance with Wis. Stat. § 448.02(4)(b), by the Wisconsin Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division). The Division's Complaint is based on the same conduct as that alleged in these summary suspension proceedings.

On March 16, 2016, Respondent requested a hearing to show cause why the summary suspension should not be continued. On March 16, 2016, the Board issued an Order Designating Hearing Official, which ordered Chief Legal Counsel for the Department to designate an attorney of the Department or an Administrative Law Judge (ALJ) of the Department of Administration, Division of Hearings and Appeals, to preside over the hearing to show cause and to make findings and issue an order as to whether the Order of Summary Suspension should be continued. Consistent with the Board's Order Designating Hearing Official, on March 18, 2016, Chief Legal Counsel for the Department designated an ALJ at the Division of Hearings and Appeals to preside over the show cause hearing and to make findings and issue an order in this matter. The Division issued a Notice of Hearing to Show Cause on March 18, 2016.

On March 29, 2016, the ALJ convened a telephone prehearing conference with counsel for Respondent and the Division, at which a hearing and related deadlines were established. The ALJ issued a Scheduling Order on March 29, 2016, setting a hearing for April 4-5, 2016. Consistent with the Scheduling order, the parties filed exhibit and witness lists and exhibits on April 1, 2016. In addition, the Division filed an Amended Notice of Hearing to Show Cause on April 1, 2016, amending the original notice to clarify that this was a class III proceeding under Wis. Stat. § 227.01(3)(c), not a class II proceeding under Wis. Stat. § 227.01(3)(b) as indicated in the original notice. The ALJ held an additional telephone conference on April 1, 2016, at which the ALJ granted the Division's motion, with no objection from Respondent, to seal the records in this matter to the extent authorized by law, in order to protect the privacy interests of the patients involved. For these same reasons, and with no objection from Respondent, the ALJ also granted the Division's request to exclude members of the public from the hearing.

A show cause hearing was held in this matter in Madison, Wisconsin on April 4-5, 2016, within the 20-day time period set forth in Wis. Admin. Code SPS § 6.09(2). Respondent testified for approximately a day and a half and the Division also called as an expert witness a medical doctor specializing in the area of psychiatry. Volumes of exhibits were received into evidence and the parties provided oral closing statements. This Decision and Order follows.

## FINDINGS OF FACT

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

2. Respondent is certified by the American Board of Psychiatry and Neurology. (Resp. Ex. 101, p. 2)

3. Respondent worked as a psychiatrist at the Veterans Administration Medical Center located in Tomah, Wisconsin (Tomah VA) from 2002-2015. (Resp. Ex. 101)

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

5. In his role as Chief of Staff, Respondent provided and directed or supervised the provision of healthcare services to veterans of the United States Military. (Houlihan Hrg. Test.)

6. Many mental health patients at Tomah VA presented with complex, refractory (treatment-resistant) mental health issues, and co-morbidity (having more than one serious mental health issue). Of these patients, Respondent treated some of the most difficult patients. (Resp. Ex. 103, p. 4769; Houlihan Hrg. Test.)

7. Effective January 16, 2015, Tomah VA summarily suspended Respondent's clinical privileges at Tomah VA. He was given administrative duties at Tomah VA. (Div. Ex. C)

8. Tomah VA's summary suspension was based on concerns that Respondent's medication prescribing practices did not meet accepted standards of practice and potentially constituted an imminent threat to patient welfare. (Div. Ex. C; Houlihan Hrg. Test.)

9. Effective November 9, 2015, Respondent's employment at Tomah VA was terminated and his clinical privileges were revoked. (Div. Ex. D, Houlihan Hrg Test.)

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

a. Respondent failed to provide appropriate medical care to at least 20 patients between 2005 and 2014, and

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

(Div. Ex. D)

11. Respondent disagrees with Tomah VA's grounds for termination. He believes the reason for the suspension and termination was an article which appeared in the media on January 8, 2015, regarding allegations of overprescribing pain and psychiatric medications at Tomah VA and the death of a patient (Patient A) at the facility, which generated significant political attention and controversy. (Resp. Exs. 102, 103; Houlihan Hrg. Test.)

12. Until the January 8, 2015 article in the newspaper, Respondent had received promotions at Tomah VA. According to his hearing testimony, he had also received positive evaluations from his superiors and from peers during the peer review process. There is no evidence in the record to suggest that at any time during his approximately 13 years at Tomah VA, he was instructed to reduce medication dosages or have those whom he oversaw do so or that he change his own or others' practices with respect to prescribing medications in combination for patients. (Resp. Ex. 101; Houlihan Hrg. Test.)

Prescribing Practices at Tomah VA

13. Commencing in 2011, the Department of Veterans Affairs Office of Inspector General (OIG) conducted two inspections of prescribing practices at Tomah VA. The first was based on a complaint received in March 2011. Allegations were substantiated with respect to the prescribing practices for two of the patients identified in the complaint. As a result, the Veterans Health Administration provided an action plan that included a review of refill/lab testing policies by VISN[1] 12 (a regional network of VA service providers), evaluating practice trends and working with Chief of Staff at Tomah VA to evaluate pain approaches and effectiveness. Other allegations were not substantiated. (Resp. Ex. 103, pp. 4765-4766)

14. A more in-depth inspection was conducted by OIG after a complaint was received in August 2011 regarding overprescribing at Tomah VA. The inspection team included two physicians board certified in psychiatry, two physicians board certified in internal medicine, a physician board certified by the American Board of Physical Medicine and Rehabilitation, a pharmacist and other health care personnel. The inspection covered approximately January 1, 2011, through September 12, 2012, and included interviews with Respondent and many others, review of medical records and other related records, review of background materials, treatment guidelines, medical research and analyses of data relating to early prescription refills and prescribing practices. The inspection looked specifically at Respondent's prescribing practices and at allegations that Respondent abused his authority in his interaction with subordinates with respect to prescribing controlled substances. The patient records reviewed included those of selected individuals from a list of the 100 patients at Tomah VA receiving the highest doses of opioids. The inspection was administratively closed in March of 2014 in a report issued by OIG (2014 OIG Report). (Resp. Ex. 103; Houlihan Hrg. Test.)

15. On or about June of 2014, the OIG also released a White Paper (OIG White Paper), reconfirming the conclusions in its 2014 OIG Report and providing additional detail with respect to the administrative closure. (Resp. Ex. 103, pp. 4764-4776)

[1] VISN stands for Veterans Integrated Service Network. (Resp. Ex. 103, p. 4766)

16. The 2014 OIG Report did not substantiate the majority of allegations made in various complaints OIG received. The OIG did not substantiate the allegations that opioids were prescribed inappropriately to particular individuals or in inappropriate doses. The OIG noted:

> The appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current medical and psychiatric status, social situation, and other factors. The clinical decision making underlying this process is based on the practitioner's clinical judgement and other acts that vary from patient to patient.

(*Id.*, pp. 4782-4783) The OIG concluded:

> Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies.

(*Id.*, p. 4785)

17. However, the 2014 OIG Report further concluded: "Nevertheless, our inspection raised potentially serious concerns that should be brought to the attention of VISN 12 management for further review. In particular, we noted that the amounts of opioid equivalents prescribed by [Respondent] . . . both in aggregate and per individual patient, were at considerable variance compared with most opioid prescribers in the VISN." (*Id.*)

18. Respondent was the seventh highest opioid prescriber in VISN 12. The OIG noted that patient populations can vary from facility to facility, and that complexity of patient case mix can vary from provider to provider. (*Id.*, p. 4784)

19. The 2014 OIG Report did not substantiate the allegation that "'opioids are contraindicated for PTSD [post-traumatic stress disorder], but that is part of [Respondent's] treatment plan.'" The OIG concluded that Respondent did not treat PTSD with opioids. In its subsequent White Paper, the OIG also stated that opioids are not contraindicated in PTSD. (*Id.*, pp. 4767, 4785)

20. The 2014 OIG Report found that some patients at Tomah VA had a pattern of early refill requests, which can be potential risk behavior for substance abuse. In its White Paper, the OIG noted that of the records reviewed, it found 179 instances where controlled substances from Respondent's patients were refilled more than three days early and that early refills are a "daily occurrence" at the Tomah VA pharmacy. The OIG noted that Tomah VA had policies and procedures in place to monitor early refills and that the undesirability of early refills and potential for drug misuse or diversion needs to be balanced against potential risk and harm associated with opiate withdrawal. (*Id.*, pp. 4768, 4782)

21. The OIG substantiated the allegation that negative urine drug screens (UDS) are not acted on and that controlled substances are still prescribed in the face of a negative UDS. (*Id.*, p. 4782)

22. The OIG did not substantiate the allegation that opioid contracts are not being encouraged by Respondent. In the cases reviewed, all of Respondent's patients had entered into contracts with Respondent under which they agreed to certain requirements designed to ensure abuse or diversion of medications would not occur. (*Id.*, p. 4782; Houlihan Hrg. Test.)

23. With respect to pharmacist concerns regarding over-prescription of opioids, the OIG White Paper noted there was testimony indicating that part of the problem was that the pharmacists had no experience working with the complex medical/psychiatric issues facing the veterans at Tomah VA and did not have knowledge regarding the overall picture for each patient. (*Id.*, pp. 4769-4770)

24. Respondent testified that he was informed by VA management that the OIG investigation had been administratively closed and that no wrongdoing was found. He testified that he was not instructed to change his or others' prescribing methods at Tomah VA as a result of the OIG investigation and that he was not provided with a copy of the OIG Report or White Paper until after the January 8, 2015 article. (Houlihan Hrg. Test.)

25. With regard to early refills of prescriptions, Respondent testified that the policy was that if the early refill was for more than three days, the circumstances had to be justified in writing, and that he did so. (*Id.*)

26. Respondent testified that after the OIG investigations, the policy was that there had to be at least one urine drug screen per year. (*Id.*)

27. On or about February 12, 2015, the United States Veterans Administration commenced a review of Respondent's clinical practices at Tomah VA. VA reviewers were provided access to medical charts of patients to whom Respondent had prescribed opioids and/or Suboxone in 2014. The record contains reviews by three VA reviewers, at least two of whom are board certified psychiatrists and practiced in the VA system, with respect to 14 patients for whom Respondent provided care. (Div. Exs. F, F(a), G, G(a) and M)

28. With respect to at least seven of the patients reviewed, the VA reviewers concluded that Respondent's practice did not meet the standard of care and created an unreasonable risk of harm to the public. (Div. Exs. F and G)

29. Reviews for the 14 patients included findings that Respondent provided care outside the scope of general psychiatric practice by treating patients' pain. Further conclusions included that when treating patients presenting with chronic pain complaints, Respondent:

a. used an inappropriate and unsafe combination of benzodiazepines and narcotics;

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

c. did not refer these patients to primary care, pain management or other providers or consult with such providers;

d. prescribed opioids without sufficient supporting documentation; and

e. prescribed opioids against the recommendation of the patient's primary care physician.

(Div. Exs. F(a), G(a) and M).

30. During his testimony, Respondent disputed several of the VA reviewers' findings. For example, he testified that patients had primary care physicians and/or were referred to Respondent by primary care physicians and that he routinely consulted with other health care providers regarding his patients' treatment. (Houlihan Hrg. Test.)

31. Both Respondent and the Division's expert in psychiatry, Dr. Jeffrey Marcus, disagreed with the VA reviewers' suggestion that it is outside a psychiatrist's scope of practice to treat pain. Dr. Marcus stated that it is "perfectly appropriate" for psychiatrists to do so if they are part of a medical team for the patient and are monitoring the patients for safety. (Houlihan and Marcus Hrg. Test.)

32. Both Respondent and Dr. Marcus disagreed with the VA reviewers that there is a bright-line maximum amount of opioids that may be prescribed. (*Id.*)

33. In most other respects, Dr. Marcus agreed with the VA reviewers' findings. (Marcus Hrg. Test.)

34. The record does not show, and the Division's expert did not testify, that benzodiazepines may not be prescribed in combination with opiates or narcotics. Respondent testified that there are no professional guidelines for prescribing benzodiazepines in conjunction with opioids and that 40 percent of the general population who are on opiates are also on benzodiazepines. (Houlihan Hrg. Test.)

35. Respondent agreed that combining an opioid and a benzodiazepine can create a risk of harm and that, although the practice is not prohibited, it must be monitored. When combining medications, a physician must weigh the risk with the possibility of improving the patient's condition. Respondent believed he adequately monitored his patients. (Houlihan Hrg. Test.)

Patient A

36. Patient A was a patient at Tomah VA at various times from 2003 until his death at the facility on August 30, 2014. He was in his 20s and 30s during this time period. (Resp. Ex. 104, p. 4852)

37. On or about 2003, Patient A presented to Tomah VA to establish care. (*Id.*)

38. Patient A returned to Tomah VA in 2005 requesting treatment for addiction; he reported opioid dependence. (*Id.*)

39. From 2005 through 2014, Patient A was seen intermittently at Tomah VA for mental health diagnoses, including PTSD, generalized anxiety disorder, attention deficit hyperactivity disorder (ADHD) and bi-polar I disorder. (*Id.*)

40. On August 10, 2014, Patient A was admitted to the acute psychiatric unit of Tomah VA following reports of suicidal thoughts, high anxiety and insomnia. He also reported that he had been having withdrawal symptoms from benzodiazepines. (Resp. Ex. 104, p. 4853; Div. Ex. H, p. 323)

41. On August 14, 2014, Patient A was transferred to a short stay mental health recovery unit, which allowed him to leave the hospital approximately three times per day for two-hour periods. Patient A was supposed to remain on Tomah VA campus grounds, which is a 173-acre campus, includes a homeless facility and had at times been the subject of concerns regarding possible drug dealing and/or use. (Resp. Ex. 104, pp. 4850, 4854; Houlihan Hrg. Test.)

42. During the time of his August 2014 inpatient treatment, Patient A was being treated by Dr. D. (Div. Ex. H)

43. According to Respondent's hearing testimony, which is not contradicted by other evidence, the only time Respondent saw Patient A was on August 22, 2014. According to his medical notes, Respondent saw Patient A for "pharmacy management" and "further evaluation." Respondent testified that the reason for this meeting is that Respondent anticipated assuming Patient A's care upon his expected discharge from inpatient treatment. (Div. Ex. H, p. 150; Houlihan Hrg. Test.)

44. According to Patient A's medical records, on August 28, 2014, Dr. D spent 45 minutes with Patient A, with the majority of this time spent on coordination of care, counseling and discussion of diagnosis and treatment. According to Dr. D's medical notes, Dr. D met with Patient A, Patient A's father, and a team social worker and discussed patient A's medications and progress. Dr. D noted that Patient A indicated feeling overwhelmed and like he could not relax. Dr. D recommended that Patient A reduce his dosage of atomoxetine to 40 mg each day and that he restart Suboxone. Dr. D noted that she had talked to Respondent who agreed with restarting Patient A on Suboxone at 8 mg per day. Dr. D noted that Patient A agreed to try Suboxone and was told it would likely be available to start the next day. Dr. D's notes further state that Patient A "is back on his prior dose of quetiapine. He indicates that he would like to go back on Suboxone in hopes that it will help alleviate his chronic pain and potentially decrease his overall level of anxiety without having the potential for addiction as had been a problem for him previously." (Div. Ex. H, pp. 126-128)

45. Dr. D's notes further indicate that Patient A would have staff checks for supervision every two hours, continue to have independent off unit privileges for two hours up to three times daily, and continue to attend group therapy meetings. At the time that Suboxone was prescribed on August 28, 2014, Respondent's prescriptions included atomoxetine, diazepam, diphenhydramine, duloxetine, hydroxyzine pamoate, quetiapine, temazepam, and tramadol. Several of these were on an "as needed" basis, and had to be requested of, and administered by,

medical professional staff while he was inpatient. (Div. Ex. H, pp. 126-127, unnumbered pages under tab for 8/29/2014; Houlihan Hrg. Test.)

46. Suboxone, which contains buprenorphine, is a Schedule III narcotic under Wis. Stat. § 961.18(5m)(a).

47. On and prior to August 28, 2014, Suboxone was approved by the United States Food and Drug Administration to treat patients with opioid dependence. Off-label use of Suboxone for the treatment of pain is not prohibited under DEA requirements. According to the DEA, a physician who prescribes, dispenses or administers Suboxone for the treatment of pain would be required to register with DEA as a practitioner with Schedule III privileges. The registration requirement is waived for physicians using Suboxone for the FDA-approved purpose of treatment of opioid dependence. (Resp. Ex. 106)

48. Dr. D did not have the required registration to be able to prescribe Suboxone for off-label use and therefore spoke with Respondent about writing a prescription because Respondent was authorized to do so. (Div. Ex. H, p. 126; Houlihan Hrg. Test.)

49. Off-label use of medication is relatively common in the area of psychiatry. (Resp. Ex. 104, p. 4854, n.4; Houlihan and Marcus Hrg. Test.)

50. On August 29, 2014, Respondent wrote a prescription for Suboxone, not for opioid dependence, but to address Patient A's anxiety and pain. Patient A's medical notes indicate that his alcohol abuse and opioid dependency were in remission. Respondent's prescription was for buprenorphine 8 mg/nalozone 2 mg, to be taken sublingually (under the tongue) two times per day. (Resp. Ex. 104, p. 4854; Div. Ex. H, p. 128; Houlihan Hrg. Test.)

51. Patient A had been prescribed and had taken Suboxone at various points in the past. (Div. Ex. H; Houlihan Hrg. Test.)

52. On one of these prior occasions, on April 16, 2014, Patient A informed nursing staff at Tomah VA that he believed he was allergic to Suboxone. He stated that his face was turning bright red, and felt like it was burning, he had itching and his hand was swollen. He stated when he went to bed at night, his throat felt like it was swelling and he had trouble swallowing. (Div. Ex. H, pp. 1054-1055)

53. Respondent testified that Patient A's records show that he had not actually experienced an allergic reaction to Suboxone at that time, but had an ear infection. According to Respondent, Patient A remained on Suboxone after reporting he had experienced an allergic reaction and during the time he was being treated for an ear infection. (Houlihan Hrg. Test.)

54. Respondent testified that one of his reasons for prescribing Suboxone to Patient A was his belief that the only stability Patient A had was in 2011 when he was on Suboxone for eight months. (*Id.*)

55. On the morning of August 29, 2014, Patient A was administered the first of three doses of Suboxone in a 24-hour period. According to the 2015 OIG Report, that morning, a social worker documented that Patient A's thought process was "'clear,'" and a nursing assessment noted, "'Resident is oriented to person, oriented to place, oriented to time, oriented to situation . . . Resident is alert . . . Resident exhibits appropriate behaviors.'" (Resp. Ex. 104, p. 4854)

56. Patient A's second dosage was received at August 29, 2014, at 8:36 p.m., and a third dose was administered August 30, at 8:09 a.m. Respondent testified that Patient A's requests for medications 11 times following his dosages of Suboxone indicated to him that Patient A was not over-medicated. (Resp. Ex. 104, p. 4855; Houlihan Hrg. Test.)

57. On August 30, 2014, at 7:35 a.m., Patient A was given tramadol for complaints of a headache. He reported his pain at "10," and stated it was "the worst pain ever." Approximately an hour later, the nurse reported that Patient A "reported little effect for his migraine" and entered a "9" in reference to his headache. Nursing staff contacted the Medical Officer of the Day who ordered Fioricet, one tablet of which was administered at 8:59 a.m. on August 30. Patient A then laid down in his bed and "was left to recover from his pain." At approximately 1:10 p.m. on August 30, a nursing staff member checked on Patient A and noted that Patient A was "asleep and snoring." Another nursing note stated that Patient A was checked on at 2:45 p.m. on August 30 and Patient A was found unresponsive. (Resp. Ex. 104, pp. 4855-4856)

58. Resuscitation efforts were unsuccessful and medical notes indicate that Patient A died at 3:39 p.m. on August 30, 2014. Patient A's autopsy report noted the cause of death as mixed drug toxicity (tramadol, diazepam, diphenhydramine, and buprenorphine). It further noted a finding of pulmonary edema with evidence of terminal aspiration. (*Id.*, pp. 4856-4857)

59. The OIG conducted an investigation with respect to Patient A's death. In a report issued on August 6, 2015 (2015 OIG Report), the OIG agreed with the autopsy report's conclusion that Patient A's death was caused by mixed drug toxicity. The OIG noted that the pathologist indicated that no individual drug stood out as being lethal. The OIG agreed with the consultant forensic toxicologist that the additive respiratory depressant effect of buprenorphine (contained in Suboxone) and its metabolite norbuprenorphine, along with diazepam and its metabolites, were the plausible mechanism of action for Patient A's death. (Resp. Ex. 104, pp. 4857-4858)

60. The OIG noted that these drugs were prescribed at Tomah VA but the possibility could not be excluded that Patient A self-administered additional doses of any of the medications. The OIG noted the consultant forensic toxicologist's conclusion that "'[i]t is impossible to state how the dosing regimen applied correlates to the postmortem blood concentration observed. Similarly, the possibility that the decedent received additional drug (Suboxone), in some form or fashion, cannot be excluded.'" (*Id.*, pp. 4862, 4857-4858)

61. Respondent testified that following Patient A's death, in meeting with Patient A's family, the focus was on how Patient A got extra medications into his room. (Houlihan Hrg. Test.)

62. In addition to the concern regarding Patient A's death caused by mixed drug toxicity, the OIG also found deficiencies with respect to the informed consent process for administering Suboxone. When prescribing Suboxone to Patient A, neither Respondent nor Dr. D informed Patient A of the risk and benefits of treatment with Suboxone. Respondent testified that he assumed that Dr. D had such a conversation with Patient A since Dr. D was Patient A's treating physician. He also noted that Patient A had taken Suboxone in the past. Respondent testified that "ideally," informed consent should have been undertaken with Patient A. (*Id.*, pp. 4859-4860, 4862; Houlihan Hrg. Test.)

Abuse of Authority

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

64. On July 23, 2015, the ABI issued a report finding that on multiple occasions spanning several years, Respondent engaged in inappropriate, unfair and intimidating actions which fostered an environment in which Tomah VA staff felt unable to openly communicate concerns about prescribing practices. (*Id.*, p. 3743)

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

66. The ABI report described numerous direct and negative interactions between Respondent and Tomah VA staff. (Div. Ex. N)

67. The ABI report concluded that Respondent facilitated the termination of one pharmacist, N.J., during her probationary period and that a contributing factor for her termination was her complaints regarding Respondent's prescribing practices. (*Id.*, pp. 3692, 3744)

68. The ABI report is contradicted by the 2014 OIG Report, which did not substantiate allegations of abuse of authority, intimidation or retaliation when staff questioned prescription practices. In addition, according to the OIG White Paper, the evidence reviewed by OIG did not support the allegation that N.J. was terminated from her position as a pharmacist during her probationary period in retaliation for refusing to fill a prescription. The White Paper states that N.J. was terminated because she had poor interpersonal skills, was caustic with clinicians and had generated complaints from patients. The White Paper indicates that the "culture of fear" with respect to pharmacists was largely generated by rumors regarding N.J.'s termination rather than by first-hand experience with Respondent. (Resp. Ex. 103, pp. 4781, 4772-4775)

69. However, the OIG also concluded that such beliefs regarding intimidation were widely held among pharmacy staff and among some other staff. The OIG concluded that perceptions of abuse of authority, intimidation and retaliation are "problematic" in themselves because they diminish or preclude the willingness to communicate concerns about potential

safety issues. It noted that collaboration provides a system of checks and balances that enhances patient safety and is "especially important in this setting given the quantities and dosage of opioids that were being utilized in seriously ill patients." The OIG identified an impasse between pharmacy staff and Respondent, with pharmacy staff being reluctant to question prescription practices and Respondent complaining that many pharmacists were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale. The OIG made several suggestions to the facility director and VISN management to increase better collaboration. (Resp. Ex. 103, pp. 4781, 4786)

70. The ABI report does not reference the 2014 OIG Report or White Paper.

Expert Testimony

71. Dr. Jeffrey Marcus was called as the Division's expert witness in this case. Dr. Marcus is a psychiatrist and is certified by the American Board of Psychiatry and Neurology. His practice has included complex psychiatric patients and he has had medical training at the VA in Madison, Wisconsin. Dr. Marcus reviewed patient records for patients A, 1 and 2. (Div. Ex. E; Marcus Hrg. Test.)

72. In his professional opinion, Respondent's charting for patients A, 1 and 2 did not show due diligence sufficient to demonstrate patient safety. Specifically, Dr. Marcus testified that the records did not show that an interdisciplinary medical team was used to address the patients' problems, that physical exams were conducted, that particular combinations or quantities of medications were justified, that non-medication alternatives were sufficiently explored or that the patients who were on multiple and/or high dosages were being sufficiently monitored. He further stated that the records relied heavily on templates, were not easy to follow and would be difficult for a new provider to utilize in providing care. (Marcus Hrg. Test.)

73. He opined that Respondent's documentation fell below the standard of care and created an unreasonable risk of harm to patients. (*Id.*)

74. Dr. Marcus was present in the room during the April 4-5, 2016 hearing in this matter and heard Respondent testify for approximately a day and a half. Dr. Marcus did not recall hearing Respondent say anything with respect to his practice or views with which Dr. Marcus strongly disagreed. (*Id.*)

75. Dr. Marcus was aware of a widespread program in the medical profession which was started approximately ten years ago in which pain was referred to as the "fifth vital sign." He stated that there was a perception at around that time that pain was being undertreated but that during approximately the last ten years, the concern has changed from undertreatment of pain to overtreatment of pain. (*Id.*)

76. When asked during cross-examination what, if any, bright line rules he believed Respondent violated, Dr. Marcus testified that Respondent failed to provide adequate documentation regarding issues of patient safety. Dr. Marcus also noted Respondent's increase in dosage for one of the patients to 240 mg. of oxycodone with no indication of urine drug

screen, and his lack of documentation of a physical assessment for a patient being treated for chronic pain. (*Id.*)

77. Dr. Marcus acknowledged there were very few clear-cut rules with respect to treatment in the practice of psychiatry, but that the one rule which had to be followed was keeping people safe. (*Id.*)

78. Dr. Marcus acknowledged that it was within a clinician's professional judgment to determine whether to continue with prescribed medications when a urine screen tests positive for illicit substances. (*Id.*)

79. Dr. Marcus did not review the 2014 OIG Report. (*Id.*)

80. Dr. Marcus agreed that physicians have different views on prescribing pain medications and that psychiatrist may disagree with each other without one of them falling below the standard of care. (*Id.*)

81. Dr. Marcus did not testify with respect to the abuse of authority allegation.

Prior Disciplinary Proceedings in Iowa

82. Prior to working at Tomah VA, Respondent practiced psychiatry in Iowa. On or about 2002, Respondent entered into a stipulation and order with the Iowa professional board. The Iowa board's action was based on information that Respondent had engaged in an inappropriate personal relationship with a patient or two patients. Respondent testified that this complaint was made to the Iowa board by his ex-wife while the two were in the process of divorce. (Houlihan Hrg. Test.)

Respondent's Conduct Following Termination from Tomah VA

83. After being terminated from Tomah VA, Respondent practiced general psychiatry in La Crosse for a brief period in early 2016, until his license was summarily suspended by the Board. Respondent testified that during this brief period of practice, he treated routine, non-complex psychiatric problems and did not prescribe any opiates, in part because of the fact that he had no nursing staff to monitor patients. (Houlihan Hrg. Test.)

84. By letter dated March 10, 2016, Respondent was informed by the American Board of Psychiatry and Neurology that he passed the 2016 Psychiatry Maintenance of Certification examination held February 1-5, 2016. According to the Performance Report for the examination, he received an "87" overall test score. With respect to specific relevant areas, Respondent received a score of 96 for mood disorders/depressive disorders and bipolar disorders, a score of 92 for psychotic disorders, a score of 85 for substance-related and addictive disorders, a score of 81 for various anxiety disorders, obsessive compulsive disorders and trauma and stress related disorders, a score of 77 for personality disorders and a score of 83 for ethics and forensic issues. (Resp. Ex. 113)

85. By notification dated March 10, 2015, Respondent was informed of continuing education credit he received for: (1) Risk Assessment, Patient Selection and Treatment Planning; (2) Initiating, Documenting, Monitoring and Discontinuing Opioid Therapy; and (3) Managing Special Risk Populations and Situations. (Resp. Ex. 113)

## DISCUSSION

It is important to state at the outset what this case is *not* about. It is not about whether Respondent engaged in wrongdoing under Wisconsin law. That determination will be resolved in a separate proceeding which is currently pending before this tribunal. In that other proceeding, Respondent will be afforded fuller due process protections, including the right to discovery, which is not available in this proceeding, and the right to a hearing on the merits of the case. Wis. Admin. Code § SPS 6.09(3). Likewise, this case is not about whether Respondent was wrongfully terminated from Tomah VA.

Rather, this case is an emergency proceeding involving the summary suspension of Respondent's medical license, a suspension which occurred prior to a contested case hearing. The issue in this matter is whether Respondent's summary suspension of his license should continue until a decision is reached in the companion case involving the underlying allegations of misconduct. Wis. Admin. Code § SPS 6.09(1). The Department has the burden to establish by a preponderance of the evidence that the summary suspension should continue. Wis. Admin. Code SPS § 6.09(4). In order to conclude that such an emergency suspension should be continued, it must be concluded that Respondent "has engaged or is likely to engage in such conduct that the public health, safety or welfare *imperatively requires emergency suspension* of the respondent's license." Wis. Admin. Code §§ SPS 6.06(1) and 6.07(7) (emphasis provided). *See also* Wis. Admin. Code § SPS 6.01(2).

Based on the evidence produced in this proceeding, the Department has not met its burden of establishing that the summary suspension should be continued while the underlying disciplinary proceeding is pending. Instead, this matter should proceed as do the overwhelming majority of disciplinary cases[2] that come before this tribunal, with no action taken on Respondent's license unless and until both parties have had the full opportunity to gather all relevant information, the evidence is heard by an impartial tribunal, and a determination is made based on all of the evidence presented that Respondent has engaged in wrongdoing which subjects him to disciplinary action under relevant Wisconsin law. Emergency suspension of a professional license is an extreme measure, as it deprives a person of the ability to earn a living in his or her profession without a conclusive finding of wrongdoing after full due process. Indeed, the Board may issue such an emergency order based solely on "probable cause" that a respondent has engaged in or is likely to engage in conduct such that the public health, safety or welfare imperatively requires emergency suspension. Wis. Admin. Code § SPS 6.06(1).

However, a licensee's rights to due process and to earn a livelihood in his or her profession must be balanced against the need to protect the public from those who practice their profession in a dangerous, incompetent, or unethical manner. Thus, summary suspension may

[2] In an email to the ALJ dated April 4, 2016, counsel for the Division indicated that she was aware of only five summary suspension actions, profession-wide, in the last eight years.

occur in circumstances where the public health, safety or welfare "imperatively requires emergency suspension" of a professional license. Wis. Admin. Code § SPS 6.06(1).

The evidence of record does not establish that the public health, safety or welfare imperatively requires emergency suspension of Respondent's license. As demonstrated at the two full days of hearing and as reflected in the findings of fact, above, at this stage of the proceedings, the evidence is contradictory and inconclusive as to whether Respondent violated Wisconsin laws in his prescribing or treatment practices, including with respect to Patient A. The same is true with respect to the allegation that Respondent abused his authority in his interactions with subordinates at Tomah VA. Significantly, the 2014 OIG report, while by no means completely uncritical of Respondent's prescribing practices, found "no wrongdoing," after what appears at this stage to have been a rigorous investigation. Indeed, not even the Division's expert witness testified that Respondent's actual prescription practices violated Wisconsin laws. With regard to intimidation of subordinates, the ABI and the OIG reports are in contradiction, with the ABI concluding that Respondent abused his authority and the OIG finding only that there was a perception of intimidation which should be addressed.

Respondent's uncontradicted testimony was that prior to 2015, the year in which he was terminated by Tomah VA, he was only informed that the OIG found no wrongdoing, and was never told to change his prescription practices. He further testified that he was unable to obtain a copy of the 2014 OIG Report or the OIG White Paper until 2015 and that prior to that, he had been led to believe by both management and peers in psychiatry that his performance was good. That testimony likewise was not contradicted. Thus, to the extent the Division's argument for continuance of emergency suspension is predicated on an assertion that Respondent had been warned to change his practices, that assertion is not supported by this record.

With respect to the incredibly sad death of Patient A, a young United States veteran, the evidence produced showed that Respondent's direct role with providing care was limited to prescribing Suboxone, which Respondent had previously taken, at the request of another physician. The evidence of record did not establish that Patient A died as a result of any allergic reaction to Suboxone. And although the evidence showed that Suboxone was one of the controlled substances identified in the mixed toxicity which led to Patient A's death, it also showed that it was not one substance which led to his death. The evidence also showed that based on a discrepancy between the concentrations of medications in Patient A's blood after he died and the medications prescribed by Tomah VA, it could not be ruled out that Patient A obtained and ingested substances which were outside those prescribed. To the extent that the evidence suggested any failures on Respondent's part with respect to informed consent in prescribing Suboxone, this failure would not require emergency suspension of Respondent's medical license.

Respondent's conduct following his termination from Tomah VA likewise does not assist the Division in establishing that the emergency suspension of Respondent's license should be continued. No evidence was produced to show that Respondent has engaged in any dangerous practices since leaving Tomah VA. To the contrary, the evidence produced at hearing was that Respondent practiced psychiatry for a short time in La Crosse earlier this year and that in doing so, he did not prescribe opioids, in part because of safety concerns for patients – namely, he did not have nursing staff to monitor the patients. The evidence further showed that Respondent passed his board certification examination, receiving some high scores in relevant areas, and that

he received credit for taking continuing education courses in relevant areas, including opioid therapy.

As stated, this decision does not determine whether Respondent engaged in unprofessional conduct or negligence or whether his license will ultimately be subject to disciplinary action. It certainly does not make any judgment with respect to whether Respondent is a good doctor or psychiatrist. Rather, it only concludes that the Division has not met its burden of establishing that the emergency suspension of Respondent's license should continue while the case on the merits of the Division's allegations is pending.

## CONCLUSIONS OF LAW

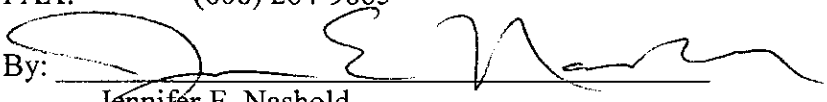
Because there has not been the requisite showing under Wis. Admin. Code § SPS 6.06(1) that Respondent has engaged or is likely to engage in such conduct that the public health, safety or welfare imperatively requires emergency suspension of Respondent's license, Wis. Admin. Code § SPS 6.06(1), the Division has not met its burden of establishing by a preponderance of the evidence that the summary suspension of Respondent's license should continue. *See* Wis. Admin. Code § SPS 6.09(4).

## ORDER

For the reasons set forth above, IT IS ORDERED that Respondent's license to practice medicine and surgery is hereby immediately restored.

Dated at Madison, Wisconsin on April 8, 2016.

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

By: 

Jennifer E. Nashold
Administrative Law Judge