



**Scott Walker,**  
**Governor**  
**Dave Ross, Secretary**

---

**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**March 16, 2016**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**8:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A) Adoption of Agenda (1-5)**

**B) Minutes of February 17, 2016 – Review and Approval (6-11)**

**C) Administrative Updates**

- 1) Department and Staff Updates
- 2) Board Members – Term Expiration Dates
  - a) Mary Jo Capodice – 07/01/2018
  - b) Greg Collins – 07/01/2016
  - c) Rodney Erickson – 07/01/2015 (Appointed for Second Term)
  - d) Suresh Misra – 07/01/2015
  - e) Carolyn Ogland Vukich – 07/01/2017
  - f) Michael Phillips – 07/01/2017
  - g) David Roelke – 07/01/2017
  - h) Kenneth Simons – 07/01/2018
  - i) Sridhar Vasudevan – 07/01/2016
  - j) Timothy Westlake – 07/01/2016
  - k) Russel Yale – 07/01/2016
  - l) Robert Zondag – 07/01/2018
  - m) Bradley Kudick – Effective 07/01/2016 (Public Member)**
- 3) Introductions, Announcements and Recognition
- 4) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
- 5) Informational Items

**D) 8:00 A.M. – APPEARANCES – DS/PS Attorney Yolanda McGowan, David J. Houlihan, M.D. and Attorney Frank Doherty (Optional) – Presentation on Petition for Summary Suspension and Designation of Hearing Official**

- 1) 15 MED 002 – David J. Houlihan, M.D. **(12-57)**

**E) Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments**

- 1) Continuing Education Liaison
  - 2) Council on Physicians Assistants
    - a) Reappointment **(58)**
      - 1) Jeremiah Barrett – Reappointment until 7/1/2020 (First Term 7/18/2012-7/1/2016) – Amendment to Reappointment Motion
    - b) Appointment **(59-60)**
      - 1) Nadine Miller, PA-C – Appointment from 7/1/2016-07/1/2020
- F) Legislative/Administrative Rule Matters (61-63)**
- 1) Update on SB 568/AB 726 Relating to Board and Council Reorganization and Various Other Changes
  - 2) Update on SB 698 Relating to Duties and Powers of DSPS
  - 3) Update on AB 768 Relating to the Diagnosis and Treatment of Lyme Disease
  - 4) Update on AB 852 Relating to Informed Consent for Performance of Certain Elective Procedures Prior to the Full Gestational Term of a Fetus and Other Provisions
  - 5) Update on SB 715/AB 867 Relating to Creating a Medicolegal Investigation Examining Board and Other Provisions
  - 6) Update on SB 762 Relating to Licensure of Primary Spinal Care Practitioners
  - 7) News Article Relating to Telemedicine
  - 8) Update on Pending Legislation and Possible and Pending Rulemaking Projects
- G) Interstate Medical Licensure Compact Commission – Report from Wisconsin’s Commissioners**
- H) Federation of State Medical Boards (FSMB) Matters (64-65)**
- 1) FSMB Ethics and Professionalism Committee – Draft Position Statements – Practice Drift, Duty to Report, Sale of Goods by Physicians and Physician Advertising, Compounding of Medications by Physicians – Stakeholder Review and Comment
- I) Health Research Group Study – Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003-2013 (66)**
- J) Speaking Engagement(s), Travel, or Public Relation Request(s), and Report(s) (67)**
- 1) Request to Speak with Atty. Patrick Koenen, Hinshaw & Culbertson, L.L.P. Regarding Telemedicine
- K) Screening Panel Report**
- L) Newsletter Matters**
- M) Informational Items**
- N) Items Added After Preparation of Agenda**
- 1) Introductions, Announcements and Recognition
  - 2) Administrative Updates
  - 3) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
  - 4) Education and Examination Matters
  - 5) Credentialing Matters
  - 6) Practice Matters
  - 7) Future Agenda Items
  - 8) Legislation/Administrative Rule Matters
  - 9) Liaison Report(s)
  - 10) Newsletter Matters

- 11) Annual Report Matters
- 12) Informational Item(s)
- 13) Disciplinary Matters
- 14) Presentations of Petition(s) for Summary Suspension
- 15) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 16) Presentation of Proposed Decisions
- 17) Presentation of Interim Order(s)
- 18) Petitions for Re-Hearing
- 19) Petitions for Assessments
- 20) Petitions to Vacate Order(s)
- 21) Petitions for Designation of Hearing Examiner
- 22) Requests for Disciplinary Proceeding Presentations
- 23) Motions
- 24) Petitions
- 25) Appearances from Requests Received or Renewed
- 26) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

O) Future Agenda Items

P) Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).**

**Q) Full Board Oral Interview of Candidates for Licensures**

- 1) **APPEARANCE – Adnan Qureshi, M.D. (68-120)**
- 2) **Henry Bikhazi, M.D. (121-210)**

**R) Request for Waiver of 24 Months of ACGME/AOA Approved Post Graduate Training**

- 1) **Toshio Takayama, M.D. (211-260)**

**S) Voluntary Surrender Request – Approval Needed**

- 1) **Cameron F. Parsa, M.D. (261-262)**

**T) Deliberation on Petition for Summary Suspension and Designation of Hearing Official**

- 1) **15 MED 002 – David J. Houlihan, M.D. (12-57)**

**U) Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

**1) Monitoring (263-294)**

- a) **Paul Strapon, M.D. – Requesting to Apply for a Limited DEA Certificate (265-275)**
- b) **Kirsten Peterson, M.D. – Requesting Unlimited License (276-294)**

**2) Complaints**

**3) Administrative Warnings**

- a) **14 MED 466 – R.M.R. (295-296)**

**4) Proposed Stipulations, Final Decisions and Orders**

- a) **14 MED 250 – Earl L. Anderson, M.D. (297-305)**
- b) **14 MED 270 – Abel A. Garibaldi, M.D. (306-312)**
- c) **14 MED 281 – Bruce Cardone, M.D. (313-319)**

- d) 14 MED 434 – Dudley Johnson, M.D. **(320-325)**
- e) 14 MED 607 – Paul Awa, M.D. **(326-331)**
- f) 15 MED 047 – Thomas J. Kalinosky, D.O. **(332-341)**
- g) 15 MED 049 – Michael C. Macatol, M.D. **(342-354)**
- h) 15 MED 210 – Mohammad R. Khan, M.D. **(355-362)**
- i) 15 MED 264 – Michael D. Plooster, M.D. **(363-368)**
- j) 15 MED 268 – David J. Engstrand, M.D. **(369-375)**
- 5) **Case Closings**
  - a) 14 MED 347 **(376-400)**
  - b) 15 MED 441 **(401-411)**

**V) Orders Fixing Costs – Discussion and Consideration**

- 1) Jonathan G. Peterson, M.D. **(412-419)**
- 2) Roger A. Pellmann, M.D. **(420-428)**

**W) Open Cases**

**X) Consulting With Legal Counsel**

**Y) PLANNED PARENTHOOD OF WISCONSIN, INC., et al., Plaintiffs-appellees, v. BRAD D. SCHIMEL, Attorney General of Wisconsin, et al., Defendants-Appellants – Consulting with Amber Cardenas, Board Legal Counsel (429-430)**

**Z) Deliberation of Items Added After Preparation of the Agenda**

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petition(s) for Summary Suspensions
- 7) Proposed Stipulations, Final Decisions and Orders
- 8) Administrative Warnings
- 9) Proposed Decisions
- 10) Matters Relating to Costs
- 11) Complaints
- 12) Case Closings
- 13) Case Status Report
- 14) Petition(s) for Extension of Time
- 15) Proposed Interim Orders
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

AA) Open Session Items Noticed Above not Completed in the Initial Open Session

BB) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

CC) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

**ADJOURNMENT**

**ORAL INTERVIEW OF CANDIDATE(S) FOR LICENSURE**

**ROOM 124D/E**

**11:15 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Interviews of One (1) Candidate  
for Licensure –Dr. Vasudevan & Dr. Westlake

**NEXT MEETING DATE APRIL 20, 2016**

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
FEBRUARY 17, 2016**

**PRESENT:** Mary Jo Capodice, D.O.; Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D.; Michael Phillips, M.D.(*via GoToMeeting*); David Roelke, M.D.; Kenneth Simons, M.D.; Sridhar Vasudevan, M.D.; Timothy Westlake, M.D.; Russell Yale, M.D.; Robert Zondag

**EXCUSED:** Carolyn Ogland Vukich, M.D.

**STAFF:** Tom Ryan, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments to the Agenda:**

- *Added: Item E.2: WCA Support Announcement Letter*
- *Correct: Item I: “Wisconsin’s Commissioners” to “Wisconsin’s Commissioner”*
- *Removed Item S: Proposed Final Decisions and Orders*

**MOTION:** Greg Collins moved, seconded by Suresh Misra, to adopt the agenda as amended. Motion carried unanimously.

**MINUTES OF JANUARY 20, 2016 – REVIEW AND APPROVAL**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to approve the minutes of January 20, 2016 as published. Motion carried unanimously.

**ELECTIONS, APPOINTMENTS, REAPPOINTMENTS, CONFIRMATIONS, AND  
COMMITTEE, PANEL AND LIAISON APPOINTMENTS**

**Reappointment – Council of Physicians Assistants – Jeremiah Barrett**

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to reappoint Jeremiah Barrett to the Council on Physicians Assistants for a term to expire 07/01/2016. Motion carried unanimously.

**MOTION:** David Roelke moved, seconded by Russell Yale, to affirm the Chair’s appointment of Timothy Westlake as the sole legislative liaison. Motion carried unanimously.

**LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

**Review and Respond to Clearinghouse Report and Public Hearing Comments Concerning  
Clearinghouse Rule 15-087 Relating to Telemedicine**

**MOTION:** Greg Collins moved, seconded by Robert Zondag, to appoint a committee of the Board consisting of David Roelke, Carolyn Ogland, Kenneth Simons and Robert Zondag to work with DSPS staff to revise Clearinghouse Rule 15-087 relating to telemedicine. Motion carried unanimously.

**WIS. STAT. § 448.14 ANNUAL REPORT REQUIREMENT/MEDICAL EXAMINING BOARD –  
CALENDAR YEAR 2015 – BOARD REVIEW FOR APPROVAL**

**MOTION:** Robert Zondag moved, seconded by Greg Collins, to approve the Wis. Stat. § 448.14 Annual report for calendar year 2015. Motion carried unanimously.

**FEDERATION OF STATE MEDICAL BOARDS (FSMB) MATTERS**

**FSMB 2016 House of Delegates and Annual Meeting – April 28-30, 2016 – San Diego, California –  
Consider Attendance**

**MOTION:** Russell Yale moved, seconded by David Roelke, to designate Rodney Erickson to attend the FSMB 2016 Annual Meeting on April 28-30 in San Diego, California and authorize travel. Motion carried unanimously.

**CLOSED SESSION**

**MOTION:** David Roelke moved, seconded by Suresh Misra, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Mary Jo Capodice – yes; Greg Collins – yes; Rodney Erickson – yes; Suresh Misra – yes; Michael Phillips – yes; David Roelke – yes; Kenneth Simons – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; Russell Yale – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 9:21 a.m.

**RECONVENE TO OPEN SESSION**

**MOTION:** Suresh Misra moved, seconded by Robert Zondag, to reconvene in Open Session at 11:10 a.m. Motion carried unanimously.

**VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION**

**MOTION:** Russell Yale moved, seconded by Mary Jo Capodice, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

**REQUEST FOR WAIVER OF 24 MONTHS OF ACGME/AOA APPROVED POST  
GRADUATE TRAINING**

**Olusola Adedipe**

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to deny a waiver to the 24-month post-graduate training program accredited by the ACGME, to Olusola Adedipe, per Wis. Stat. § 448.05(2)(c). Motion carried. Opposed: 2

**DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC)  
MATTERS**

**Complaints**

***15 MED 278 – Michael H. Malek, M.D.***

**MOTION:** David Roelke moved, seconded by Suresh Misra, to find probable cause to believe that Michael H. Malek, M.D., DLSC case number 15 MED 278, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

*(Robert Zondag abstained from deliberation and voting in the matter concerning, DLSC case number 15 MED 278.)*

***13 MED 501 – R.S.***

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to issue an Administrative Warning in the matter of DLSC case number 13 MED 501 – R.S. Motion carried unanimously.

***14 MED 580 – D.H.***

**MOTION:** Timothy Westlake moved, seconded by Greg Collins, to issue an Administrative Warning in the matter of DLSC case number 14 MED 580 – D.H. Motion carried unanimously.

***15 MED 052 – S.A.H.***

**MOTION:** David Roelke moved, seconded by Russell Yale, to issue an Administrative Warning in the matter of DLSC case number 15 MED 052 – S.A.H. Motion carried unanimously.

***15 MED 344 –R.S.S.***

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to issue an Administrative Warning in the matter of DLSC case number 15 MED 344 – R.S.S. Motion carried unanimously.

***13 MED 187 – Vance A. Masci, M.D.***

**MOTION:** Timothy Westlake moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Vance A. Masci, M.D., DLSC case number 13 MED 187. Motion carried.

*(Sridhar Vasudevan recused himself and left the room for deliberation and voting in the matter concerning Vance A. Masci, M.D., DLSC case number 13 MED 187.)*

***13 MED 492 and 15 MED 310 – Nosheen Hasan, M.D.***

**MOTION:** Suresh Misra moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Nosheen Hasan, M.D., DLSC case numbers 13 MED 492 and 15 MED 310. Motion carried unanimously.

***14 MED 251 – Waleed S. Najeeb, M.D.***

**MOTION:** Russell Yale moved, seconded by Rodney Erickson, to reject the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Waleed S. Najeeb, M.D., DLSC case number 14 MED 251. Motion carried. Opposed: 2

***14 MED 274 – Leonardo Aponte, M.D.***

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Leonardo Aponte, M.D., DLSC case number 14 MED 274. Motion carried unanimously.

***14 MED 383 – Jonathan Hayward, P.A.***

**MOTION:** Greg Collins moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jonathan Hayward, P.A., DLSC case number 14 MED 383. Motion carried unanimously.

***14 MED 559 – James R. Feltes, M.D.***

**MOTION:** Suresh Misra moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against James R. Feltes, M.D., DLSC case number 14 MED 559. Motion carried unanimously.

***15 MED 186 – Jeremias B. Vinluan, M.D.***

**MOTION:** Greg Collins moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jeremias B. Vinluan, M.D., DLSC case number 15 MED 186. Motion carried unanimously.

**Case Closings**

**CASE CLOSING(S)**

**MOTION:** Greg Collins moved, seconded by Mary Jo Capodice, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 14 MED 060 – A.P. *No Violation*
  2. 14 MED 530 – M.C.J. *No Violation*
  3. 15 MED 030 – S.M. *No Violation*
  4. 15 MED 084 – J.P. *No Violation*
  5. 15 MED 086 – D.M. *No Violation*
  6. 15 MED 087 – J.H. *No Violation*
  7. 15 MED 088 – J.K. *No Violation*
  8. 15 MED 089 – S.D. *No Violation*
  9. 15 MED 090 – M.R. *No Violation*
  10. 15 MED 091 – C.G. *No Violation*
  11. 15 MED 092 – N.K. *No Violation*
  12. 15 MED 104 – E.J.U. and P.W.O. *No Violation*
  13. 15 MED 161 – S.C. and S.S. *No Violation*
  14. 15 MED 212 – P.S. and J.P.F. *No Violation*
  15. 15 MED 288 – J.J.N. *No Violation*
  16. 15 MED 308 – R.S. *Prosecutorial Discretion (P3)*
- Motion carried unanimously.

***14 MED 220 – V.M.***

**MOTION:** Robert Zondag moved, seconded by David Roelke, not to close DLSC case number 14 MED 220 against V.M. for *No Violation*. Motion carried unanimously.

***14 MED 601 – H.B.A.***

**MOTION:** Timothy Westlake moved, seconded by David Roelke, to close DLSC case number 14 MED 601 against H.B.A. and J.O. for *No Violation*. Motion carried unanimously.

***15 MED 053 – T.D.***

**MOTION:** Russell Yale moved, seconded by David Roelke, to close DLSC case number 15 MED 053 against T.D. for *No Violation*. Motion carried unanimously.

***15 MED 083 – C.T.***

**MOTION:** Robert Zondag moved, seconded by David Roelke, to close DLSC case number 15 MED 083 against C.T. for *No Violation*. Motion carried unanimously.

***15 MED 244 – D.V.D.***

**MOTION:** David Roelke moved, seconded by Robert Zondag, to close DLSC case number 15 MED 244 against D.V.D. for *No Violation*. Motion carried unanimously.

**DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES**

**MOTION:** Mary Jo Capodice moved, seconded by Timothy Westlake, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

*(Suresh Misra excused himself from the meeting at 11:13 a.m.)*

*(Michael Phillips excused himself from the meeting at 11:39 a.m.)*

*(Mary Jo Capodice excused herself from the meeting at 11:50 a.m.)*

### **ADJOURNMENT**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to adjourn the meeting.  
Motion carried unanimously.

The meeting adjourned at 11:54 a.m.

DRAFT

**State of Wisconsin  
Department of Safety and Professional Services**

**AGENDA REQUEST FORM**

<b>Name and Title of Person Submitting the Request:</b>  Meena Balasubramanian on behalf of Attorney Yolanda McGowan Division of Legal Services and Compliance		<b>Date When Request Submitted:</b>  March 14, 2016 Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 8 work days before the meeting for Medical Board ▪ 8 work days before meeting for all other boards	
<b>Name of Board, Committee, Council:</b>  Medical Examining Board			
<b>Board Meeting Date:</b>  March 16, 2016	<b>Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>How should the item be titled on the agenda page?</b> Presentation of Petition for Designation of Hearing Official in Case Number 15 MED 002, David J. Houlihan, M.D.	
<b>Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>Is an appearance before the Board being scheduled? If yes, by whom?</b> <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	<b>Name of Case Advisor(s), if required:</b>  Dr. Sridhar Vasudevan	
<b>Describe the issue and action the Board should address:</b>  If the Board Orders the Summary Suspension for Respondent, then the Board, or its appointed delegates, must designate a member of the Board, an employee of the Department or an administrative law judge employed by the Department of Administration to preside over a hearing to show cause and issue the Order for Designation of Hearing Official.			
<b>Authorization:</b>			
		3/14/16	
Signature of person making this request		Date	
Supervisor signature (if required)		Date	
Bureau Director signature (indicates approval to add late items to agenda)		Date	
<b>Directions for including supporting documents:</b>  1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board's Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** MEDICAL EXAMINING BOARD

**Board Meeting Date:** March 16, 2016

**Person Submitting Agenda Request:** Meena Balasubramanian, Paralegal

**Person requesting an appearance:** Yolanda Y. McGowan, Prosecuting Attorney

**Mailing address:** Department of Safety and Professional Services

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

**Email address:** yolanda.mcgowan@wi.gov

**Telephone #:** 608-266-3679

**Reason for Appearance:** Consideration of Petition for Designation of Hearing Official in case number 15 MED 002, DAVID J. HOULIHAN, M.D.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?** Yes, Attorney Frank M. Doherty at Hale Skemp Hanson Skemp & Sleik

**Attorney's mailing address:** 505 King Street, Suite 300, La Crosse, WI 54601

**Attorney's e-mail address:** FMD@haleskemp.com

**Phone Attorney:** 608-784-3540

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

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

---

PETITION FOR DESIGNATION OF HEARING OFFICIAL

---

Yolanda Y. McGowan, the attorney assigned to this matter, on behalf of the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance, requests that the Wisconsin Medical Examining Board designate, under Wis. Stat. § 227.46(1), a member of the Board, an employee of the Department or an administrative law judge employed by the Department of Administration to preside over a hearing to show cause provided for in Wis. Admin. Code § SPS 6.09. This request is made pursuant to Wis. Admin. Code §§ SPS 6.09 and 6.11(1)(a) and is based on the following:

1. The Petition for Summary Suspension, with accompanying attachments, in this matter was filed with the Medical Examining Board on March 14, 2016.

2. On March 14, 2016, Respondent was provided notice of the time and place of the presentation of the Petition for Summary Suspension by certified mail with a return receipt requested in an envelope properly stamped and addressed to Respondent at his address of record at W5119 Knobloch Road, La Crosse, Wisconsin 54601; by regular mail in an envelope properly stamped and addressed to Respondent at his address of record at W5119 Knobloch Road, La Crosse, Wisconsin 54601; by regular mail in an envelope properly stamped and addressed to Respondent's attorney, Frank M. Doherty at Hale Skemp Hanson Skemp & Sleik, 505 King Street, Suite 300, La Crosse, Wisconsin 54601; by electronic mail to Respondent at his email address of record at david.houlihan@va.gov; and by electronic mail to Respondent's attorney at FMD@haleskemp.com.

3. The Petition for Summary Suspension will be presented to the Medical Examining Board on March 16, 2016, at which time Respondent, Respondent's attorney, and the prosecuting attorney may be present and will have the opportunity to be heard during the determination of probable cause by the Medical Examining Board.

4. On March 16, 2016, the Order of Summary Suspension may be issued by the Medical Examining Board.

5. Pursuant to Wis. Stat. § 448.02(4)(b), Respondent is entitled to a hearing to show cause why an Order of Summary Suspension should not be continued.

Petition for Designation of Hearing Official  
In the matter of disciplinary proceedings against  
David J. Houlihan, M.D., Case No. 15 MED 002

6. Petitioner requests the Medical Examining Board designate, under Wis. Stat. § 227.46(1), an administrative law judge employed by the Department of Administration to preside over a hearing to show cause provided for in Wis. Admin. Code § SPS 6.09 in the event such hearing is requested, or alternatively, a member of the Board or an employee of the Department.

Dated in Madison, Wisconsin, this 14<sup>th</sup> day of March, 2016.



Yolanda Y. McGowan, Attorney  
State Bar No. 1021905  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison, WI 53707-7190  
(608) 266-3679  
Yolanda.McGowan@wisconsin.gov  
Fax (608) 266-2264

**State of Wisconsin  
Department of Safety and Professional Services**

**AGENDA REQUEST FORM**

<b>Name and Title of Person Submitting the Request:</b>  Meena Balasubramanian on behalf of Attorney Yolanda McGowan Division of Legal Services and Compliance		<b>Date When Request Submitted:</b>  March 14, 2016 Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 8 work days before the meeting for Medical Board ▪ 8 work days before meeting for all other boards	
<b>Name of Board, Committee, Council:</b>  Medical Examining Board			
<b>Board Meeting Date:</b>  March 16, 2016	<b>Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>How should the item be titled on the agenda page?</b> Presentation of Petition for Summary Suspension in Case Number 15 MED 002, David J. Houlihan, M.D.	
<b>Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>Is an appearance before the Board being scheduled? If yes, by whom?</b> <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	<b>Name of Case Advisor(s), if required:</b>  Dr. Sridhar Vasudevan	
<b>Describe the issue and action the Board should address:</b>  The Board must decide whether to grant the Petition for Summary Suspension. Respondent has the right to appear during open session presentation to be heard [Wis. Stat. § 448.02(4)].  The Board must decide whether there is probable cause to believe that: 1. Respondent has violated the Board's statutes and rules; 2. It is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare.  The Board must also decide whether there is probable cause to file a formal Complaint to take this matter to hearing.			
<b>Authorization:</b>			
 _____ Signature of person making this request		3/14/16 _____ Date	
_____ Supervisor signature (if required)		_____ Date	
_____ Bureau Director signature (indicates approval to add late items to agenda)		_____ Date	
<b>Directions for including supporting documents:</b>  1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board's Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** MEDICAL EXAMINING BOARD

**Board Meeting Date:** March 16, 2016

**Person Submitting Agenda Request:** Meena Balasubramanian, Paralegal

**Person requesting an appearance:** Yolanda Y. McGowan, Prosecuting Attorney

**Mailing address:** Department of Safety and Professional Services

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

**Email address:** yolanda.mcgowan@wi.gov

**Telephone #:** 608-266-3679

**Reason for Appearance:** Presentation of Notice and Petition for Summary Suspension in case number 15 MED 002, DAVID J. HOULIHAN, M.D.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?** Yes, Attorney Frank M. Doherty at Hale Skemp Hanson Skemp & Sleik

**Attorney's mailing address:** 505 King Street, Suite 300, La Crosse, WI 54601

**Attorney's e-mail address:** FMD@haleskemp.com

**Phone Attorney:** 608-784-3540

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

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

---

NOTICE OF PRESENTATION OF PETITION FOR SUMMARY SUSPENSION

---

To: Respondent David J. Houlihan, M.D., and  
Frank M. Doherty, Attorney for Respondent  
Hale Skemp Hanson Skemp & Sleik  
505 King Street, Suite 300  
La Crosse, WI 54601

PLEASE TAKE NOTICE that the Petitioner, Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, will present the attached Petition for Summary Suspension to the Wisconsin Medical Examining Board at the following date, time and place:

Date: March 16, 2016  
Time: 8:00 a.m.  
Place: Room 121A  
1400 E. Washington Avenue  
Madison, Wisconsin 53703

Dated at Madison, Wisconsin this 14<sup>th</sup> day of March 2016.



Yolanda Y. McGowan, Prosecuting Attorney  
Wisconsin State Bar No. 1021905  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190, Madison, WI 53707-7190  
Tel. (608) 266-3679  
Fax (608) 266-2264  
Yolanda.McGowan@wisconsin.gov

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
 : DLSC Case Number 15 MED 002  
DAVID J. HOULIHAN, M.D., :  
RESPONDENT. :

---

PETITION FOR SUMMARY SUSPENSION  
Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6

---

Yolanda Y. McGowan, being duly sworn on oath, upon information and belief, deposes and states, as follows:

1. I am an attorney employed by the Wisconsin Department of Safety and Professional Services (Department), Division of Legal Services and Compliance. In the course of my job duties, I have been assigned to the investigation and prosecution of case number 15 MED 002 involving Respondent David J. Houlihan, M.D., for the Wisconsin Medical Examining Board (Board).

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is Post Office Box 7190, Madison, Wisconsin 53707-7190.

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

4. Respondent's most recent address on file with the Department is W5119 Knobloch Road, La Crosse, WI 54601.

BACKGROUND

5. At all times pertinent to this matter, Respondent practiced medicine at the Veterans Administration Medical Center located in Tomah, Wisconsin (Tomah VA). Respondent's practice specialty is psychiatry. He is not board certified in any medical specialties recognized by the American Board of Medical Specialties.

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

7. 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.

8. Effective January 16, 2015, Respondent's clinical privileges at Tomah VA were summarily suspended based upon concerns that Respondent's clinical practice did not meet the accepted standards of practice and potentially constituted an imminent threat to patient welfare.

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

10. Respondent's employment was terminated and his clinical privileges were revoked based on the determination that:

- a. Respondent failed to provide appropriate medical care to at least 22 patients between 2005 and 2014, and
- b. Respondent engaged in professional misconduct involving eight reported incidents of abuse of authority occurring between 2008 and 2013.

11. The Department opened case number 15 MED 002 to investigate the reported overdose/mixed drug toxicity death of a Tomah VA patient. The investigation is ongoing.

12. In January 2016, Department staff interviewed Respondent in connection with the above-referenced investigation. During the interview, Respondent reported to the Department that he was not employed, and had not been employed since his termination from Tomah VA.

13. In February 2016, Department staff became aware of conflicting reports regarding Respondent's employment status.

14. On February 24, 2016, in response to a Department inquiry, Respondent notified the Department that he had resumed practicing medicine in Wisconsin.

#### 15 MED 002

15. At all times pertinent to 15 MED 002, Respondent was the Chief of Staff at Tomah VA. 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.

16. In or around 2003, Patient A (a male born in 1978) presented to Tomah VA to establish care. He returned to Tomah VA in 2005 requesting treatment for addiction. He reported using/abusing opioids he received from a friend.

17. From 2005 through 2013, Patient A was seen intermittently at Tomah VA for treatment of addiction and numerous significant mental health diagnoses including PTSD, generalized anxiety disorder, ADHD, and Bi-polar I Disorder.

18. In October 2013, Patient A reported to Tomah VA officials that he had recently used opioids and was afraid of a complete relapse.

19. On April 8, 2014, following trials of various treatment alternatives, Tomah VA psychiatrist Dr. K.<sup>1</sup> prescribed Patient A 8 mg of Suboxone<sup>®</sup> to be taken once daily following the patient's reported cravings for "pain pills." A seven-day supply of Suboxone<sup>®</sup> was mailed to Patient A on the same date.

20. On April 16, 2014, Patient A contacted Tomah VA and reported experiencing bad side effects from using Suboxone<sup>®</sup>, including bright red discoloration and burning sensations on his face; itching and swelling of his hands; trouble swallowing, and the sensation that his throat was swelling. Patient A requested termination of the Suboxone<sup>®</sup> prescription.

21. On April 23, 2014, Patient A contacted Tomah VA requesting additional Suboxone<sup>®</sup> medication, but at a significantly lower dosage. On April 24, 2014, Patient A received a seven-day supply of 2 mg of Suboxone<sup>®</sup>.

22. On April 28, 2014, Patient A again contacted Tomah VA and requested additional Suboxone<sup>®</sup> after reportedly taking his seven-day supply in four days. Dr. K. refused to provide additional Suboxone<sup>®</sup> until Patient A presented for weekly urine drug screens, and attended meetings with a Tomah VA case manager, and alcohol or other drug support groups.

23. On April 30, 2014, Patient A notified Tomah VA that he no longer wanted Suboxone<sup>®</sup> as he had researched it and "it was not for him."

24. On May 28, 2014, Patient A was admitted to Tomah VA for anxiety and suicidal threats. He was discharged on June 30, 2014, then re-admitted on July 11, 2014, having reportedly taken benzodiazepines at a higher rate than prescribed.

25. At the time of the above-described discharge and re-admission, Patient A's list of outpatient medications included, in part: clonazepam, diazepam, diphenhydramine, duloxetine HCL, hydroxyzine pamoate, temazepam, tramadol, and zolpidem.<sup>2</sup> These medications were prescribed to Patient A by Dr. D., an inpatient psychiatrist at Tomah VA, and an active participant in the care and treatment of Patient A.<sup>3</sup>

26. On July 23, 2014, Patient A asked to be discharged from Tomah VA against medical advice for what he characterized as a lack of treatment when he was "going crazy." On July 25, 2014, Patient A was discharged from Tomah VA and transferred, at his request, to the Veterans Administration Medical Center in Madison, WI.

---

<sup>1</sup> Dr. K., upon information and belief, is not, was not, and has never been licensed as a physician by the State of Wisconsin Medical Examining Board, and is not a subject of this investigation.

<sup>2</sup> Medications prescribed to Patient A and referenced herein will be more specifically described in an exhibit to Investigator Reynolds' Affidavit in support of this petition.

<sup>3</sup> Dr. D. is a Wisconsin-licensed physician and co-Respondent in 15 MED 002. Separate disciplinary action is being pursued against Dr. D. based upon Dr. D.'s role in the care and treatment of Patient A.

27. On August 10, 2014, Patient A returned to Tomah VA and was re-admitted following reports of suicidal thoughts, feeling out of control, and complaints of low back pain. Dr. D. developed an interdisciplinary treatment and education plan which included tapering down the benzodiazepines Patient A was taking.

28. On August 22, 2014, while Patient A was still receiving inpatient care at Tomah VA, Respondent saw Patient A for an outpatient appointment for "Pharmacy Management" and "Further Evaluation." Respondent anticipated assuming Patient A's care upon his expected discharge from inpatient treatment.

29. On August 28, 2014, Dr. D. consulted Respondent for what Dr. D. documented in Patient A's healthcare chart as Patient A's request "...to go back on Suboxone<sup>®</sup> in hopes that it will help alleviate his chronic pain and potentially decrease his overall level of anxiety...." Dr. D. charted Respondent's agreement to restart Suboxone<sup>®</sup> at a dosage of 8 mg twice daily.

30. On August 29, 2014, Respondent prescribed Patient A 8 mg of Suboxone<sup>®</sup> twice daily.

31. On the morning of August 29, 2014, Patient A was administered the first of three doses of Suboxone<sup>®</sup> in a 24 hour period. The second dose was administered the same evening and the third dose, the following morning.

32. On the afternoon of August 30, 2014, Patient A was found unresponsive in his Tomah VA hospital room, and was pronounced dead a few hours later.

33. When Respondent prescribed Suboxone<sup>®</sup> for Patient A, he did not adjust or cause to be adjusted, any of the medications Patient A was receiving at the time, which included:

- a. atomoxetine 80 mg daily,
- b. diazepam 20 mg 3x daily,
- c. diphenhydramine HCL 50 mg as needed,
- d. duloxetine 60 mg 2x daily,
- e. hydroxyzine pamoate 50 mg as needed,
- f. quetiapine fumarate 50 mg 2x daily as needed,
- g. quetiapine fumarate 100 mg daily at night as needed,
- h. temazepam 30 mg every night, and
- i. tramadol 50mg 4x daily as needed.

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

35. When Respondent prescribed Suboxone<sup>®</sup> to Patient A, Patient A's history of frequently adjusting and/or discontinuing medications on his own; taking medications that were not prescribed for him; taking excessive amounts of benzodiazepines and other medicines, and obtaining controlled substances illegally was reflected in the patient's Tomah VA healthcare record.

36. Patient A had no active opioid prescriptions at the time Respondent prescribed him Suboxone<sup>®</sup>, and had reported no opioid use since October 2013, and no opioid addiction since 2010.

37. When prescribing Suboxone<sup>®</sup> to Patient A, Respondent did not in any way document the prescription order, including its risks and benefits.

38. When prescribing Suboxone<sup>®</sup> to Patient A, Respondent did not inform Patient A:

- a. of the risks and benefits of treatment with Suboxone<sup>®</sup>, particularly in a patient with a reported allergic reaction to Suboxone<sup>®</sup>, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments;
- b. of the significant risks associated with adding Suboxone<sup>®</sup> to the list of other controlled substance medications Patient A was receiving, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments;
- c. of the risks and benefits of treatment with Suboxone<sup>®</sup> in a patient who had no active opioid addiction or who was not otherwise using or abusing opioids; and
- d. that Suboxone<sup>®</sup> for the use of pain and/or anxiety was not an FDA-approved use of Suboxone<sup>®</sup>, or of the risks and benefits associated with using Suboxone<sup>®</sup> for the treatment of pain or anxiety.

39. A minimally competent and reasonable physician would have known that adding Suboxone<sup>®</sup> to the treatment plan of a patient already receiving multiple other controlled substances with sedating properties would subject the patient to an unacceptable risk of adverse health consequences, up to, and including over-sedation, increased respiratory depression, mixed-drug toxicity, and/or death.

40. A minimally competent and reasonable physician would have known that a patient simultaneously receiving diazepam, Suboxone<sup>®</sup>, temazepam, and tramadol, or any combination of two or more of these controlled medications at the same time, would subject the patient to an unacceptable risk of adverse health consequences, up to, and including increased respiratory depression, over-sedation, mixed-drug toxicity, and/or death.

41. A minimally competent and reasonable physician would have known that with Patient A's history of dependence on and abuse/misuse of controlled substances, that prescriptions for multiple and significant dosages of controlled substances would subject Patient

A to an unacceptable risk of adverse health consequences, up to, and including increased respiratory depression, over-sedation, mixed-drug toxicity, and/or death.

42. A minimally competent and reasonable physician treating Patient A:
- a. would have reduced, discontinued or otherwise modified Patient A's controlled substance medications to reduce the unacceptable risk of adverse health consequences to the patient;
  - b. would not have added an additional controlled substance with sedative properties (Suboxone<sup>®</sup>) to the medications the patient was already receiving; and/or
  - c. would have utilized extreme caution and careful monitoring of the patient to protect against an unacceptable risk of harm due to increased respiratory depression and other risks of adverse health consequences created by the concurrent administration of multiple benzodiazepines and opioids.

43. A minimally competent and reasonable physician would have assessed the risks and benefits, and evaluated the appropriateness of prescribing 8 mg of Suboxone<sup>®</sup> twice daily to a patient with reported allergic reactions to Suboxone<sup>®</sup> which included facial redness, throat swelling, and difficulty swallowing.

44. A minimally competent and reasonable physician would have informed Patient A of the potential for complications regarding treatment with Suboxone<sup>®</sup> alone, and in combination with the other controlled substance medications Patient A was receiving, particularly in a patient with no active opioid abuse or use, and a reported potentially severe allergic reaction to Suboxone<sup>®</sup>.

45. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician in the care and treatment of Patient A.

46. Respondent David J. Houlihan, M.D., by the conduct described in paragraphs 15-45, was negligent in his treatment of Patient A.

47. Respondent David J. Houlihan, M.D., departed from or failed to conform to the standard of minimally competent medical practice as set forth in paragraphs 15-45, creating the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(b) (Oct. 2013)<sup>4</sup>.

48. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence as set forth in paragraphs 28-37, created the unacceptable risk that Patient A would suffer adverse health

---

<sup>4</sup> All references to Chapter Med of the Wisconsin Administrative Code are to the version of the Code in effect at the time of the alleged conduct: November 2002 for conduct occurring prior to October 1, 2013, and October 2013 for conduct occurring on and after October 1, 2013.

consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(c) (Oct. 2013).

49. Respondent David J. Houlihan, M.D., by providing care and treatment to Patient A without informing him about the risks and benefits of treatment as described in paragraphs 28-45, and about the availability of other alternate medical modes of treatment and the risks and benefits of these treatments, created the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(j) (Oct. 2013).

50. Respondent David J. Houlihan, M.D., by failing to establish and maintain timely patient health care records as described in paragraph 37, engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(e) (Oct. 2013).

#### REVIEW OF CLINICAL PRACTICES

51. On or about February 12, 2015, the Veterans Administration (VA) commenced a focused review of Respondent's clinical practice. The review was conducted by a five-member panel including three psychiatrists (Reviewers) who actively practiced in VA facilities outside the Tomah region.<sup>5</sup>

52. The Reviewers were provided access to patient charts of 27 randomly selected patients to whom Respondent had prescribed opioids or Suboxone<sup>®</sup> in 2014, and were asked to provide opinions regarding each patient record on the following five questions:

- a. Did the provider meet generally accepted standards of clinical practice?
- b. Was the medical treatment provided by provider appropriate including the drugs used, drug combinations and dosing of drugs prescribed?
- c. Was there appropriate documentation to justify the treatment provided?
- d. Did the provider practice within their scope for their specialty and practice?
- e. Do you have concerns about any other aspects of care and/or patient safety?

53. The Reviewers concluded that the records reviewed raised the following issues and concerns related to Respondent's clinical practice: inappropriate care, prescriptive practices, including inappropriate or unsafe prescribing; acting beyond the scope of practice of general psychiatry; inadequate documentation, and failure to discuss risks and benefits of treatment.<sup>6</sup>

54. An Executive Summary of the Reviewers' findings provides the following:

---

<sup>5</sup> Two of the three psychiatrists are Mental Health Service Line Chiefs servicing facilities treating over 10,000 mental health patients, one of whom is also part of an interdisciplinary pain management program team. The third psychiatrist specializes in substance abuse disorders and leads a substance abuse clinic.

<sup>6</sup> Respondent was provided access to the referenced patient health care charts and given an opportunity to respond both orally and in writing to the Reviewers' findings prior to the VA's final decision to terminate him and revoke his clinical privileges.

- a. Respondent met the standard of care in only two of the 27 cases reviewed (8%);
- b. Respondent's care was inappropriate in 84% of the cases reviewed, and his documentation in these cases was inadequate to even support the inappropriate care provided;
- c. Respondent's prescribing of opioids was inappropriate or unsafe in 80% of the cases reviewed;
- d. Respondent's prescribing of psychostimulants was inappropriate or unsafe in 28% of the cases reviewed;
- e. Respondent prescribed combinations of drugs that were unsafe in 84% of the cases reviewed, including high dose benzodiazepines prescribed in conjunction with opioids and/or hypnotics in 76% of the cases reviewed;
- f. Respondent continued prescribing narcotic medications despite specific, written evidence in the medical record of reported adverse effects associated with the prescribed medications in 80% of the cases;
- g. Respondent inappropriately prescribed stimulants in 28% of the cases, in that there was questionable credible clinical indication to justify the use of stimulants;
- h. Respondent prescribed multiple benzodiazepines concomitantly in 24% of the cases reviewed;
- i. In 16% of the cases reviewed, Respondent prescribed multiple benzodiazepines in combination with stimulants and opioids to patients whose records reflected active or concurrent substance abuse; and
- j. Respondent failed to appropriately monitor for diversion or abuse, giving rise to concerns for patient safety in 76% of the cases reviewed.

55. The Reviewers found that Respondent routinely provided care outside the scope of a general psychiatric practice by providing pain management services as the primary focus of treatment to patients presenting with mental health complaints.

56. Respondent, as an outpatient-clinic psychiatrist, acted in many instances as the sole health care provider for patients presenting with complaints of chronic pain. Respondent prescribed various combinations of controlled substances, in dosages greatly exceeding the recommended daily amount, for periods extending 12 years, and to patients who had no primary healthcare provider. Respondent did not refer these patients to primary care, pain management, or other providers, nor did he consult with any specialists in treating patients with chronic pain complaints.

57. When treating patients presenting with chronic pain complaints, Respondent routinely prescribed opioids in doses that greatly exceeded the recommended maximum daily amount, and without sufficient supporting documentation.

58. In at least four cases, Respondent treated patients complaining of chronic pain with high doses of controlled substances in direct contradiction of written recommendations by other, more qualified providers, and/or without consulting other, more qualified providers.

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

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

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

62. Respondent David J. Houlihan, M.D., has practiced, is practicing, and/or is attempting to practice under a license when unable or unwilling to do so with reasonable skill and safety, as set forth in paragraphs 51-61, and has thereby created, is creating, and/or will create an unacceptable risk of harm to patients or the public. By said conduct, Respondent engaged in, is engaging in, or will engage in unprofessional conduct as defined by Wis. Admin. Code §§ Med 10.02(2)(h), (i), (q) and (za) (Nov. 2002) and Wis. Admin. Code §§ Med 10.03(2)(a), (b), (c) and (e) (Oct. 2013).

63. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence as set forth in paragraphs 51-61, has created, is creating, and/or will create the unacceptable risk that patients have suffered, are suffering or will suffer adverse health consequences, up to, and including risk of accidental death or injury due to over-sedation, substance abuse, mixed-drug toxicity or other adverse side effects. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002) and Wis. Admin. Code §§ Med 10.03(2)(b) and (c) (Oct. 2013).

64. Respondent David J. Houlihan, M.D., by the conduct described in paragraphs 51-61, practiced medicine beyond the scope of his license, practiced medicine when unable or unwilling to do so with reasonable skill and safety, departed from or failed to conform to the standard of minimally competent medical practice, and performed medical acts without required informed consent, thereby creating the unacceptable risk that patients would suffer adverse health consequences from lack of appropriate chronic pain management, including risk of injury or death due to over-sedation, substance abuse, inadequate treatment of chronic pain, and adverse side effects of medications used alone or in combination with others. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code §§ Med

10.02(2)(h), (j) and (u) (Nov. 2002) and Wis. Admin. Code §§ Med 10.03(2)(a), (b) and (j) (Oct. 2013).

#### ABUSE OF AUTHORITY

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

66. On July 23, 2015, the ABI issued a report finding that on multiple occasions spanning several years, Respondent engaged in inappropriate, unfair, and intimidating actions which fostered an environment in which Tomah VA staff felt unable to openly communicate concerns about potentially unsafe prescribing practices, and deliberately refrained from communicating with or consulting with Respondent about patient care issues to avoid hostility and confrontation. The ABI report concluded that Respondent's inappropriate conduct was sufficiently egregious to constitute an abuse of his authority as Chief of Staff.

67. Respondent's subsequent termination and loss of clinical privilege at Tomah VA were due, in part, to findings that on multiple occasions between 2008 and 2013, Respondent engaged in conduct that was disruptive, threatening, or harsh, or otherwise negatively impacted members of the hospital's pharmacy, social work, and physician assistant staff in the performance of their duties. Respondent's disruptive behavior was the result of Tomah VA staff members questioning Respondent's prescriptive practices, as described above.

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

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

70. Respondent David J. Houlihan, M.D., by engaging in repeated or significant disruptive behavior or interactions with hospital personnel, or otherwise abusing his authority as Tomah VA Chief of Staff as set forth in paragraphs 65-69, created an unacceptable risk that the quality of patient care at Tomah VA would be adversely impacted. Respondent's conduct tends to constitute a danger to the health, welfare, or safety of patient or public, and constitutes unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002).

71. Based upon the foregoing, there is probable cause to believe that:

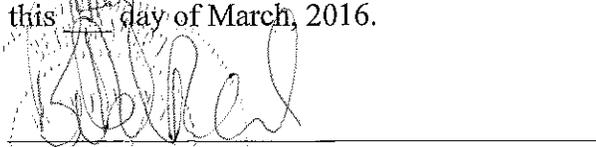
- a. Respondent is engaging in, has engaged in, or is likely to engage in unprofessional conduct, and as such, is subject to discipline pursuant to Wis. Stat. § 448.02(3).



Petition for Summary Suspension  
In the matter of the disciplinary proceedings against  
David J. Houlihan, M.D., Case No. 15 MED 002

Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison, WI 53707-7190  
Tel. (608) 266-3679; Fax (608) 266-2264

Subscribed and sworn to before me  
this 3 day of March, 2016.



Notary Public

My Commission expires 3-27-2016.

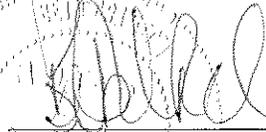


Affidavit of McGowan  
In re the disciplinary proceedings against  
David J. Houlihan, M.D., Case No. 15 MED 002



Yolanda Y. McGowan  
Prosecuting Attorney

Subscribed and sworn to before me  
this 14 day of March, 2016.



Notary Public  
Dane County, Wisconsin  
My Commission expires on 3-27-2016.

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

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

---

AFFIDAVIT OF REGINA REYNOLDS

---

STATE OF WISCONSIN )  
 ) ss  
COUNTY OF DANE )

Regina Reynolds, being duly under oath, deposes and states, as follows:

1. I am a consumer protection investigator, employed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance (Department). In the course of my professional duties, I have been assigned on behalf of the Medical Examining Board to the investigation of case number 15 MED 002 concerning Respondent David J. Houlihan, M.D.

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is P.O. Box 7190, Madison, Wisconsin 53707-7190.

3. In the course of my professional duties, I obtained the following:

- a. authorized copies of health care records for Respondent's patient identified as Patient A for purposes of the Summary Suspension Petition.<sup>1</sup>
- b. January 16, 2015 Memorandum from the Department of Veterans Affairs Medical Center Director directed to Dr. David J. Houlihan regarding Summary Suspension of Privileges. (Exhibit A)
- c. July 23, 2015 Memorandum from the Department of Veterans Affairs Administrative Board of Investigation (ABI) regarding the Report of Investigation - Tomah VA Medical Center related to alleged abuse of authority by Dr. Houlihan. (Exhibit B)
- d. October 29, 2015 Letter from the Department of Veterans Affairs, Tomah VA Medical Center, addressed to David J. Houlihan, M.D. regarding the

---

<sup>1</sup> Given the volume and confidential nature of these records, copies will not be attached.

decision to remove him from federal employment and revoke his clinical privileges effective November 9, 2015. (Exhibit C)

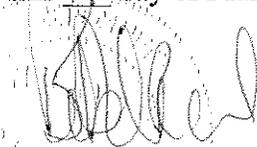
- e. Executive Summary (undated) of clinical review panel findings. (Exhibit D)

4. I was present on January 26, 2016, when Respondent was interviewed at the office of the Department of Safety and Professional Services. Respondent's attorney was present during the interview. Respondent was told that the interview was conducted on behalf of the Medical Examining Board and that Respondent needed to be truthful. During that interview, Respondent stated he was not employed, and had not been employed since being terminated from Tomah VA Medical Center.

5. Attached as Exhibit E is the list of medications prescribed to Patient A and information I compiled regarding the medications.

  
Regina Reynolds  
Consumer Protection Investigator

Subscribed and sworn to before me  
this 14 day of March, 2016.

  
\_\_\_\_\_  
Notary Public  
Dane County, Wisconsin  
My Commission expires on 3.27.2016.

**DEPARTMENT OF  
VETERANS AFFAIRS**

**Memorandum**

Date: January 16, 2015

From: Medical Center Director, Extension 61777

Subj: Summary Suspension of Privileges

To: Dr. David J. Houlihan

1. This is to notify you that your privileges are summarily suspended effective January 16, 2015. This action is being taken upon the recommendation of VA Central Office since concerns have been raised to suggest that aspects of your clinical practice do not meet the accepted standards of practice and potentially constitute an imminent threat to patient welfare. These concerns relate to complaints about your medication prescribing practices. This suspension is in effect pending a comprehensive review of these allegations.

2. You have the opportunity to provide any information you desire to provide regarding these concerns. Correspondence needs to be sent within 14 calendar days from your receipt of this notice, and be addressed to:

Human Resources Officer  
Department of Veterans Affairs  
500 E. Veterans Street  
Tomah, WI 54660

3. The comprehensive review of the reasons(s) for the summary suspension must be accomplished within 30 calendar days of the suspension, with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to me for consideration and action. Within 5 working days of receipt of the recommendations, I will make a decision either to restore your privileges to an active status or that the evidence warrants proceeding with a reduction or revocation process. Since you cannot perform clinical duties during the review, you are removed from patient care and placed in an administrative position assigned to the Regional Office in La Crosse Wisconsin to perform administrative duties as instructed by VISN 12.

4. Should the comprehensive review result in a tentative decision by me to restrict or revoke your privileges, and if appropriate, to take an adverse personnel action, you will be notified at that time of your rights as per VHA Handbook 1100.19 and VA Directive and Handbook 5021. You have a right to be represented by an attorney or other representative of your choice throughout the proceedings.

Page 1 of 2



004880

35

5. Summary suspension pending comprehensive review and due process is not reportable to the National Practitioner Data Bank (NPDB). However, if a final action against your clinical privileges is taken for professional incompetence or improper professional conduct, both the summary suspension and the final action, if greater than 30 days, will be reported to the NPDB, and a copy of the report must be sent to the State licensing boards in all states in which you hold a license and in the state of Wisconsin.

6. If you surrender or voluntarily accept a restriction of your clinical privileges, including by resignation or retirement, while your professional competence or professional conduct is under investigation during these proceedings or to avoid investigation, VA is required to file a report to the NPDB, with a copy to the appropriate State licensing board(s), pursuant to VA regulations in title 38 Code of Federal Regulations (CFR) Part 46 and VHA Handbook 1100.17, National Practitioner Data Bank Reports.

7. It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients (see 38 CFR Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) pursuant to the provisions of VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

8. If you have any questions, please contact David P. Dechant, Human Resources Officer at 608-372-1209 or [david.dechant@va.gov](mailto:david.dechant@va.gov).

  
Mario V. DeSanctis, FACHE

Received by: \_\_\_\_\_



Date: \_\_\_\_\_

1/16/15

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 23, 2015  
**From:** Administrative Board of Investigation  
**Subj:** Report of Investigation – Tomah VA Medical Center  
**To:** Director, Office of Accountability Review (OAR)

**PRELIMINARY STATEMENT**

Per your request, the Administrative Investigation Board (AIB) is separately submitting this report concerning the limited scope described below.<sup>1</sup> A prior report was submitted on May 22, 2015 addressing other issues listed in your memorandum dated March 11, 2015 (Ex. 1).

1. Scope: The issues addressed in this report are:

a. Whether the Tomah VA Medical Center's (VAMC) Chief of Staff abused his authority by adversely treating employees, particularly those in Pharmacy Service, for raising concerns regarding medication prescribing practices, overmedication, or possible drug diversion.

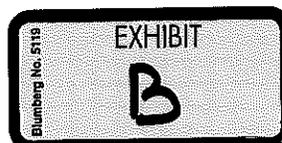
b. Whether any other Tomah VAMC leader, manager, or provider abused his or her authority by adversely treating employees, particularly those in Pharmacy Service, for raising concerns regarding medication prescribing practices, overmedication, or possible drug diversion.

2. Persons Interviewed

a. The names and positions of persons interviewed under oath or affirmation are listed on Attachment B.<sup>2</sup>

<sup>1</sup> Clinical findings referenced in this report or assertions made by any witness regarding clinical standards of care or the appropriateness of clinical practices were beyond the scope of this administrative investigation and were not evaluated. Consequently, this Board does not presume to reach any conclusion regarding the appropriateness of any clinical issues raised herein.

<sup>2</sup> Ryan Honl, the identified whistleblower in this case, acknowledged that he did not have firsthand knowledge of prescribing or medication issues, but began receiving information from other employees after making unrelated whistleblower disclosures pertaining to his own employment (Honl, p. 9, line 1- p. 10, line 3). Mr. Honl provided the Board with a 114 page document including copies of the VA Office of Inspector General Healthcare Inspection Report No. 2011-04212-HI-0267 regarding medication issues at Tomah VA Medical Center; the whistleblower complaint he filed with Office of Special Counsel and supporting attachments; e-mails



b. Persons with whom unsworn informal telephone interviews were conducted or who were contacted and either did not respond or declined to participate are identified on Attachment C.

c. Congressman Ron Kind and Senator Tammy Baldwin provided the names of numerous employees, former employees, patients, family members and friends of patients to be interviewed (Attachments D and E). The names of these persons are incorporated into the earlier witness lists provided in Attachments B and C.

d. Exhibits are numerically listed on a separate document. The Board heard wide ranging testimony covering an expansive period of time. Individual summaries of relevant testimony are provided below to provide a fuller understanding of events that have transpired including, in some cases, the witnesses' perception of events.

**DOCUMENTS PARTIALLY REDACTED**

## 12. Conclusions

a. The Board finds by preponderant evidence that on multiple occasions between 2005 and 2014, Dr. Houlihan engaged in inappropriate actions which fostered an environment in which staff felt unable to openly communicate concerns about potentially unsafe prescribing practices. The Board concludes these actions were unfair, intimidating, and sufficiently egregious to constitute an abuse of Dr. Houlihan's authority as Chief of Staff.

---

<sup>91</sup> This claim appears to relate to Tomah VA Police Report No. 201501231530-7202, dated January 23, 2015, wherein several employees in Mental Health Service reported two incidents involving Mr. Honl in which he allegedly exhibited aggressive behavior on September 23, 2014 and October 8, 2014 (Attachment J). Mr. Honl resigned on October 14, 2014. Mr. Honl also complained that this report was prepared months after his resignation on October 14, 2014 and contained several references to his mental health condition, including the word "crazy" (Honl, p. 39, lines 2 – 20; p. 42, line 23 – p. 45, line 1).

b. The Board did not find evidence that any other Tomah VAMC leader, manager, or provider abused his or her authority by adversely treating employees for raising concerns regarding medication issues. The Board did note that a pharmacist, described an unpleasant discussion with [redacted] regarding a prescription and [redacted] described another incident between another pharmacist and [redacted], however, these events are insufficient to constitute an abuse of authority (Fact 6q and 6qq).

c. The specific factual findings on which the conclusion regarding Dr. Houlihan is based are:

- In 2005, after [redacted], a contract nurse practitioner, informed a patient that he ([redacted]), was going to review the patient's medical chart to determine why the patient was receiving narcotics, Dr. Houlihan called [redacted] and told him he could either write the prescription or find another job (Fact 3a-b).
- Beginning in about 2008, after [redacted], a non-supervisory probationary pharmacist, notified Dr. Houlihan of her concerns regarding a prescription he had written, he told her he was sick of pharmacists questioning his prescriptions, his clinical judgment, and his authority. He also told her that if she didn't want to fill the prescription then she could find the patient a new doctor and he was going to notify her supervisor (Fact 4a-g).
- On another occasion, in connection with a prescription that was being questioned, Dr. Houlihan angrily told [redacted] that he was sick of the fucking pharmacists and wanted to see her supervisor (Fact 4l-m).
- At other times Dr. Houlihan entered Pharmacy Service and yelled at [redacted], then a supervisory pharmacist, to control her pharmacists (Fact 4k).
- In about June 2009, Dr. Houlihan facilitated [redacted]'s removal after she had previously questioned and refused to fill several prescriptions Dr. Houlihan had written (Fact 4u-ff). The Board finds that her questioning and refusal to fill these prescriptions were a contributing factor to her removal (Fact 4a-ff). The Board considered Dr. Houlihan's testimony that [redacted] was removed for unreasonably holding prescriptions without contacting providers and for unprofessional conduct towards him rather than for refusing to fill prescriptions (Fact 4i, j, y, dd). However, the Board notes the absence of any corroborating evidence to support his assertions, [redacted]'s staunch denial of this allegation, the lack of any reference to these allegations in the evidence folder on which [redacted]'s probationary removal was based, and the specific

statement in [redacted]'s ROC that [redacted] refused to fill prescriptions after clarification from providers (Footnote 23, Fact 4w, x).

- In about September 2009, in an e-mail submitted to the VISN 12 Pharmacy Executive, and copied to the Associate Chief of Staff and a pharmacy staff member, Dr. Houlihan referred to two pharmacists by name and described them as "overtly malignant" because, in his opinion, new pharmacists were following their lead in refusing to fill prescriptions (Fact 9a).

- In 2010, Dr. Houlihan informed [redacted] a non-supervisory social worker that he believed had questioned a patient's medication, that if this happened again, he (Dr. Houlihan) would sue him for slander and he ([redacted]) would be fired (Fact 8gg – mm).

- After the VA Office of Inspector General began an investigation of prescribing practices at Tomah in 2012, Dr. Houlihan commented in the presence of [redacted], a non-supervisory pharmacy staff member, and others that someone in pharmacy had reported him to OIG and he did not appreciate it (Footnote 29). Dr. Houlihan also notified [redacted] Pharmacy Chief, that he did not trust the pharmacist that he believed reported him to OIG (Fact 6oo).

- Between about 2010 -2013, on some occasions when concerns were raised regarding prescriptions, Dr. Houlihan made comments in the presence of [redacted] RN, then Mental Health Service Line Manager, such as "who the heck do they think they are ...that they can question me, what do they know?" or sometimes make generalized comments like "pharmacy's got to watch their butt". [redacted] described Dr. Houlihan's responses as so vigorous, defensive, and aggressive that he did not feel comfortable bringing up medication concerns because he already knew what Dr. Houlihan's response would be (Fact 8j).

- During this same time period (March 2010 – April 2013), Dr. Houlihan made the comment in the presence of [redacted], a non-supervisory physician assistant, would not be working there much longer if he continued to question or attempted to change medication for patients (Fact 8k).

- On June 7, 2013, Dr. Houlihan directly e-mailed [redacted] a non-supervisory physician assistant, and stated in pertinent part that he (Dr. Houlihan) took personal issue with [redacted] changing meds on Dr. Houlihan's Veterans. In bold font, Dr. Houlihan stated "I expect this practice to stop immediately." Dr. Houlihan continued by stating "This will be the last time I address this issue" (Fact 8l-m).

- At other times, in connection with staff questioning Dr. Houlihan's prescribing practices, Dr. Houlihan made comments such as "how many pharmacology classes did you have" or "why are you telling me how to prescribe" (Fact 9b).
- On other occasions, Dr. Houlihan made statements to [redacted], a supervisory pharmacist, that "pharmacy's not part of this team"; "pharmacy, you're not in the exam room; "the prescriber is the one taking responsibility; you just fill prescriptions" (Fact 6ii).

d. With regard to [redacted], the Board concludes that Dr. Houlihan was not involved in the decision to remove [redacted] and that [redacted] concerns regarding medication issues were not a contributing factor to his removal. [redacted], then Mental Health Service Line Manager, testified that he made the decision to remove [redacted] based upon time and attendance issues, along with other issues presented to him, combined with earlier matters raised in [redacted] pre-employment reference check (Fact 5f). [redacted], immediate supervisor at that time, confirmed in a report of contact used to support the action that [redacted] had been involved in multiple and repeated inappropriate behaviors (Fact 5c-e).

e. With regard to [redacted], the Board concludes that the negative personnel actions which occurred in 2009 – 2013 were not due to raising concerns about medication prescribing practices.<sup>92</sup> [redacted], although concerned about medication practices, had not raised or openly complained about such issues since at least 2004 shortly after Dr. Houlihan arrived and then only in a peripheral manner (Fact 8o-r). In 2008, [redacted] was appointed, with Dr. Houlihan's concurrence, to the position of Acting Director of the RRTP and permanently reassigned to the position in January 2009 (Fact 8s). It's unlikely Dr. [redacted] would have been placed in this position if Dr. Houlihan intended to retaliate against him. There also is no evidence [redacted] had any conflict with Dr. Houlihan regarding medication issues between this supervisory appointment in 2008 and 2009 when Dr. Houlihan initially disapproved [redacted] promotion request and [redacted] performance rating was first lowered. In fact, [redacted] indicated that during this time period he notified Dr. Houlihan of a possible drug diversion and Dr. Houlihan discharged the offender alleged to have been selling the drugs (Fact 8w). Further, the Board notes that beginning in 2009, [redacted]; while strident in his disagreement with the actions taken, never attributed these actions to retaliation for raising medication issues. Further, [redacted] recent theory that his removal from a supervisory position was based

<sup>92</sup> The Board's conclusion that the actions about which [redacted] complains did not constitute retaliation for questioning medication practices should not be construed as a finding by the Board that the actions taken were otherwise proper or supportable. The Board's authority is expressly limited to determining whether [redacted] and others were treated unfairly due to raising concerns regarding medication practices. Accordingly, once this determination was made, the Board did not expand its scope to reach additional conclusions regarding the overall appropriateness of the actions.

upon Dr. Houlihan's belief that he (Dr. [redacted]) either wrote or was somehow responsible for the anonymous complaint to Congressman [redacted] office that was subsequently referred to the OIG is chronologically impossible. Dr. [redacted] verbally informed Dr. [redacted] of his pending removal from the position on August 23, 2011 (Fact 8v). The anonymous complaint is dated August 24, 2011, one day after Dr. [redacted] first notified Dr. [redacted] of the reassignment and, based upon the remaining date stamp, does not appear to have been received by Congressman [redacted]'s office until September 28, 2011 (Fact 8x). Clearly, the anonymous complaint was written after discussions regarding Dr. [redacted] potential reassignment were already underway and there is no evidence of any connection between the two events.

f. With regard to Mr. [redacted]; the Board concludes that the disciplinary actions taken against him were supportable based on witness statements contained in the evidence file and do not constitute retaliation for raising concerns regarding medication practices (Fact eee – kkk).

g. There was insufficient evidence to verify the retaliation claims presented by Ms. [redacted] (Facts 8aaa-ddd).

h. With regard to Ms. [redacted] the Board concludes that Dr. Houlihan did not retaliate against her for notifying Ms. [redacted] of possible drug diversion. Her scope of practice was limited to outpatient duties after she was placed in the outpatient palliative care clinic following Dr. Houlihan and Ms. [redacted] agreement that this assignment would best accommodate her administrative role with VISN 12 and also maintain her clinical skills (Facts 8aaaa). Additionally, Dr. Houlihan actually supported Ms. [redacted] for a position as the Tomah Palliative Care Coordinator after she notified Ms. [redacted] about possible drug diversion (Fact 8zzz). Ms. [redacted] conversation with Ms. [redacted] in August 2012 about possible drug diversion was very casual and brief, with no apparent connection to a subsequent decision in April 2013 to limit Ms. [redacted] outpatient duties (8xxx).

## 12. Recommendations

The Board recommends the initiation of appropriate corrective action against Dr. Houlihan based on the conclusions herein.



DEPARTMENT OF VETERANS AFFAIRS  
Tomah VA Medical Center  
500 E. Veterans Street  
Tomah, WI 54660

October 29, 2015

David J. Houlihan, MD  
W5119 Knobloch Rd  
La Crosse, WI 54601

1. In connection with the notice of proposed removal and revocation of clinical privileges dated September 17, 2015, a decision has been made to remove you from federal employment and revoke your clinical privileges effective November 9, 2015, based on the following sustained charges and specifications:

**CHARGE I: Failure to provide appropriate medical care to Patient #1**

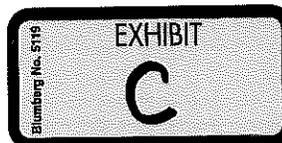
**Specification 1:** Between July 29, 2005 and November 12, 2010, you prescribed two benzodiazepines (lorazepam and temazepam) in combination with an opioid (oxycodone or oxycodone/acetaminophen) to Patient #1, who had substance abuse in the history, increasing the potential for adverse effects. The medication combination in this patient did not meet the standard of care.

**Specification 2:** Between July 29, 2005 and November 12, 2010, you prescribed two benzodiazepines (lorazepam and temazepam) in combination with an opioid (oxycodone or oxycodone/acetaminophen) to Patient #1. Your documentation was insufficient to support the medications used in the treatment of this patient. The clinical history, response to treatment, discussion of side effects and treatment plan were not adequately documented. You failed to provide adequate justification for your treatment regimen. Your treatment did not meet the standard of care.

**Specification 3:** Between June 4, 2012 and December 22, 2014, you prescribed 30 mg tablets of oxycodone (opioid) to Patient #1 with dosing of up to 240 mgs per day. The dosage prescribed exceeded the standard of care. Your treatment did not meet the standard of care.

**Specification 4:** Between June 4, 2012 and December 22, 2014, you prescribed 30 mg tablets of oxycodone (opioid) to Patient #1 with dosing of up to 240 mgs per day. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

*[Handwritten signature]* 10/30/15



000018

**CHARGE II: Failure to provide appropriate medical care to Patient #2**

**Specification 1:** Between November 25, 2011 and October 6, 2014, you prescribed a benzodiazepine (clonazepam) in combination with an opioid (oxycodone) to Patient #2, who had a documented history of substance abuse with alcohol and marijuana. The opioid dosage (oxycodone) was high, creating risk for adverse events. The medication combination did not meet the standard of care.

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

**Specification 3:** On December 16, 2013 and January 13, 2014, you prescribed methylphenidate (stimulant) to Patient #2. Patient #2 was also prescribed benzodiazepine (clonazepam) and an opioid (oxycodone) during the same timeframe. The medication combination did not meet the standard of care.

**Specification 4:** On December 16, 2013 and January 13, 2014, you prescribed methylphenidate (stimulant) to Patient #2. Patient #2 was also prescribed a benzodiazepine (clonazepam) and an opioid (oxycodone) during the same timeframe. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 6:** Between April 3, 2009 and August 15, 2011, you prescribed a benzodiazepine (clonazepam) in combination with an opioid (oxycodone) and an additional narcotic (hydrocodone/acetaminophen) to Patient #2. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE III: Failure to provide appropriate medical care to Patient #4**

**Specification:** On January 30, 2009, you prescribed methylphenidate (stimulant) to Patient #4. You continued Patient #4 on methylphenidate or another form of stimulant (dextroamphetamine) through January 8, 2015. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE IV: Failure to provide appropriate medical care to Patient #6**

**Specification:** Between October 25, 2013 and June 9, 2014, you prescribed dextroamphetamine (stimulant) to Patient #6. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE V: Failure to provide appropriate medical care to Patient #7**

**Specification:** Between April 11, 2011 and December 11, 2014, you prescribed a narcotic (hydrocodone/acetaminophen) to Patient #7. Your documentation and rationale was insufficient to justify the use of this medication in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE VII: Failure to provide appropriate medical care to Patient #9**

**Specification 1:** Between February 27, 2012 and August 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #9 in combination with benzodiazepine (diazepam). The medication combination in this patient with substance abuse and suicide risk histories did not meet the standard of care.

**Specification 2:** Between February 27, 2012 and August 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #9 in combination with benzodiazepine (diazepam). Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE VIII: Failure to provide appropriate medical care to Patient #10**

**Specification 3:** On May 12, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #10. The suboxone: buprenorphine/naloxone (opioid/narcotic) was prescribed in combination with a benzodiazepine (clonazepam) on May 12, 2014. The medication combination in this patient with alcohol dependence and suicide risk histories did not meet the standard of care.

**Specification 4:** On May 12, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #10. The suboxone: buprenorphine/naloxone (opioid/narcotic) was prescribed in combination with a benzodiazepine (clonazepam) on May 12, 2014. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE IX: Failure to provide appropriate medical care to Patient #11**

**Specification 2:** On September 13, 2013, you added the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) to Patient #11 without evaluating the criteria for the ADHD diagnosis. Your treatment did not meet the standard of care.

**Specification 3:** On December 10, 2012, you increased the dose of suboxone: buprenorphine/naloxone (opioid/narcotic) from 20mg to 24mg for Patient #11. Your documentation and rationale was insufficient to justify the suboxone: buprenorphine/naloxone (opioid/narcotic) change used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE X: Failure to provide appropriate medical care to Patient #12**

**Specification:** On September 30, 2013, you prescribed amphetamine/dextroamphetamine (stimulant) to Patient #12. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XI: Failure to provide appropriate medical care to Patient #13**

**Specification 1:** Between August 28, 2012 and November 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #13 in combination with the following benzodiazepines: diazepam between October 3, 2012 and March 22, 2013, and temazepam between November 30, 2012 and March 15, 2013. The medication combination did not meet the standard of care.

**Specification 2:** Between August 28, 2012 and November 19, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #13 in combination with the following benzodiazepines: diazepam between October 3, 2012 and March 22, 2013 and temazepam between November 30, 2012 and March 15, 2013. You added mirtazapine (noradrenergic and specific serotonergic antidepressant (NaSSA)) between October 15, 2012 and November 4, 2013, to the combination of suboxone: buprenorphine/naloxone and benzodiazepines above. The medication was added without documented assessment of the impact with existing medication regimen. You failed to provide adequate justification for your treatment regimen. Your treatment did not meet the standard of care.

**Specification 3:** On January 27, 2014, you prescribed methylphenidate (stimulant) to Patient #13. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XII: Failure to provide appropriate medical care to Patient #15**

**Specification 1:** Between August 30, 2013 and December 20, 2013, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #15 in combination with quetiapine fumarate (antipsychotic) between September 6, 2013 and December 20, 2013, and trazodone (serotonin antagonist and reuptake inhibitor (SARI)) on December 20, 2013. The medication combination did not meet the standard of care.

**Specification 2:** On October 25, 2013, you started Patient #15 on the stimulant (amphetamine/dextroamphetamine). Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 3:** Between October 25, 2013 and December 20, 2013, you prescribed the stimulant (amphetamine/dextroamphetamine) to Patient #15. The medication was

prescribed by you to treat PTSD. It is not standard care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.

**Specification 4:** On November 13, 2013, you prescribed clonazepam (benzodiazepine) to Patient #15. The medication was added without documented assessment of the impact on existing medication regimen. You failed to provide adequate justification for your treatment regimen. Your treatment did not meet the standard of care.

**CHARGE XIII: Failure to provide appropriate medical care to Patient #16**

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

**Specification 2:** Between March 29, 2010 and January 6, 2015, you treated Patient #16 with multiple medications and combinations of medications including diazepam (benzodiazepine) between March 29, 2010 and May 16, 2014, oxycodone (opioid) between March 29, 2010 and June 10, 2011, morphine (opioid) between September 12, 2011 and December 20, 2012, methadone (opioid) between June 25, 2013 and August 14, 2014, suboxone: buprenorphine/naloxone (opioid/narcotic) between February 28, 2013 and January 6, 2015, trazodone (antidepressant) between March 1, 2010 and August 30, 2013, venlafaxine (antidepressant) between March 29, 2010 and May 16, 2014, and tramadol (opioid) between April 30, 2010 and February 24, 2012. Your documentation and rationale was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XIV: Failure to provide appropriate medical care to Patient #17**

**Specification:** Between February 22, 2012 and January 7, 2015, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) to Patient #17. On December 14, 2012 you increased the dose of suboxone: buprenorphine/naloxone (opioid/narcotic) upon patient request for mood. Your documentation and rationale was insufficient to justify the suboxone: buprenorphine/naloxone (opioid/narcotic) change used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XVI: Failure to provide appropriate medical care to Patient #19**

**Specification 1:** Between October 23, 2012 and January 12, 2015, you prescribed morphine (opioid) to Patient #19. The dosage in some orders was 720 mg per day. The dosage prescribed exceeded the standard of care. Your treatment did not meet the standard of care.

**Specification 2:** Between October 23, 2012 and January 12, 2015, you prescribed morphine (opioid) to Patient #19. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 3:** Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient #19 in combination with morphine (opioid). The medication combination did not meet the standard of care.

**Specification 4:** Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient #19 in combination with morphine (opioid). Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 5:** Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient #19 in combination with morphine (opioid). In addition, you prescribed dextroamphetamine (stimulant) to Patient #19 on February 24, 2014. The medication combination did not meet the standard of care.

**Specification 6:** Between May 31, 2013 and June 6, 2014, you prescribed benzodiazepine (diazepam) to Patient #19 in combination with morphine (opioid). In addition, you prescribed dextroamphetamine (stimulant) to Patient #19 on February 24, 2014. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 7:** On February 24, 2014, you prescribed dextroamphetamine (stimulant) to Patient #19. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XVII: Failure to provide appropriate medical care to Patient #20**

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

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

**Specification 3:** Between January 16, 2004 and December 18, 2014, you prescribed methylphenidate (stimulant) to Patient #20. The medication was prescribed by you to treat PTSD. It is not standard care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.

**Specification 4:** Between January 16, 2004 and December 18, 2014, you prescribed methylphenidate (stimulant) to Patient #20. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XVIII: Failure to provide appropriate medical care to Patient #22**

**Specification 1:** Between September 9, 2008 and December 16, 2014, you prescribed clonazepam (benzodiazepine) to Patient #22. Between September 9, 2013 and December 12, 2014, you prescribed alprazolam (benzodiazepine) to Patient #22. Between November 26, 2012 and December 16, 2014 you prescribed temazepam (benzodiazepine) to Patient #22. Between November 11, 2014 and December 16, 2014 you prescribed lorazepam (benzodiazepine) to Patient #22. Between September 12, 2008 and December 16, 2014 you prescribed zolpidem tartrate (sedative/hypnotic) to Patient #22. In addition to combining the benzodiazepines and zolpidem tartrate above, including combining all four at once, on December 16, 2014, you prescribed refills for the four benzodiazepines and zolpidem tartrate together. The medication combination did not meet the standard of care.

**Specification 2:** Between September 9, 2008 and December 16, 2014, you prescribed clonazepam (benzodiazepine) to Patient #22. Between September 9, 2013 and December 12, 2014, you prescribed alprazolam (benzodiazepine) to Patient #22. Between November 26, 2012 and December 16, 2014, you prescribed temazepam (benzodiazepine) to Patient #22. Between November 11, 2014 and December 16, 2014, you prescribed lorazepam (benzodiazepine) to Patient #22. Between September 12, 2008 and December 16, 2014, you prescribed zolpidem tartrate (sedative/hypnotic) to Patient #22. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 3:** Between June 25, 2012 and December 22, 2014, you prescribed morphine (opioid) to Patient #22. Between June 25, 2012 and December 22, 2014, you prescribed oxycodone (opioid) to Patient #22. You prescribed these opioid medications in combination with clonazepam (benzodiazepine) from June 25, 2012 to December 16, 2014, temazepam (benzodiazepine) from November 26, 2012 to December 16, 2014, alprazolam (benzodiazepine) between September 9, 2013 and December 12, 2014, and lorazepam (benzodiazepine) between November 11, 2014 and December 16, 2014. The medication combination did not meet the standard of care.

**Specification 4:** Between June 25, 2012 and December 22, 2014, you prescribed morphine (opioid) to Patient #22. Between June 25, 2012 and December 22, 2014, you prescribed oxycodone (opioid) to Patient #22. You prescribed these opioid medications in combination with clonazepam (benzodiazepine) from June 25, 2012 to December 16, 2014, temazepam (benzodiazepine) from November 26, 2012 to December 16, 2014, alprazolam (benzodiazepine) between September 9, 2013 and December 12, 2014, and lorazepam (benzodiazepine) between November 11, 2014 and December 16, 2014. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 5:** Between June 25, 2012 and December 22, 2014, you prescribed morphine (opioid) to Patient #22. Between June 25, 2012 and December 22, 2014, you prescribed oxycodone (opioid) to Patient #22. You prescribed these opioid medications in combination with clonazepam (benzodiazepine) from June 25, 2012 to December 16, 2014, temazepam (benzodiazepine) from November 26, 2012 to December 16, 2014, alprazolam (benzodiazepine) between September 9, 2013 and December 12, 2014, and lorazepam (benzodiazepine) between November 11, 2014 and December 16, 2014. From June 25, 2012 to June 16, 2014, you prescribed Methylphenidate (stimulant) in combination with the morphine (opioid), oxycodone (opioid), clonazepam (benzodiazepine), temazepam (benzodiazepine), alprazolam (benzodiazepine), and lorazepam (benzodiazepine) to Patient #22. The medication combination did not meet the standard of care.

**Specification 6:** Between June 25, 2012 and December 22, 2014, you prescribed morphine (opioid) to Patient #22. Between June 25, 2012 and December 22, 2014, you prescribed oxycodone (opioid) to Patient #22. You prescribed these opioid medications in combination with clonazepam (benzodiazepine) from June 25, 2012 to December 16, 2014, temazepam (benzodiazepine) from November 26, 2012 to December 16, 2014, alprazolam (benzodiazepine) between September 9, 2013 and December 12, 2014, and lorazepam (benzodiazepine) between November 11, 2014 and December 16, 2014. From June 25, 2012 to June 16, 2014, you prescribed Methylphenidate (stimulant) in combination with the morphine (opioid), oxycodone (opioid), clonazepam (benzodiazepine), temazepam (benzodiazepine), alprazolam (benzodiazepine), and lorazepam (benzodiazepine) to Patient #22. Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 7:** Between June 25, 2012 and June 16, 2014, you prescribed Methylphenidate (stimulant). The medication was prescribed by you to treat PTSD. It is not standard care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.

**Specification 8:** Between June 25, 2012 and June 16, 2014, you prescribed Methylphenidate (stimulant). Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XIX: Failure to provide appropriate medical care to Patient #23**

**Specification 1:** Between May 1, 2009 and October 27, 2014, you prescribed amphetamine/dextroamphetamine (stimulant) to Patient #23. The medication was prescribed by you to treat PTSD. It is not standard care to use stimulants to treat PTSD. Your treatment did not meet the standard of care.

**Specification 2:** Between May 1, 2009 and October 27, 2014, you prescribed amphetamine/dextroamphetamine (stimulant) to Patient #23. Your documentation and

rationale was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 3:** Between March 25, 2002 and July 28, 2014, you prescribed clonazepam (benzodiazepine) to Patient #23. You continued the use of clonazepam (benzodiazepine) despite a history of alcohol dependence. Your treatment did not meet the standard of care.

**Specification 4:** Between March 25, 2002 and July 28, 2014, you prescribed clonazepam (benzodiazepine) to Patient #23. Your documentation was insufficient to justify the medication used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**CHARGE XX: Failure to provide appropriate medical care to Patient #24**

**Specification 1:** Between July 26, 2010 and January 6, 2014, you prescribed methylphenidate (stimulant) to Patient #24. Your documentation and rationale was insufficient to justify the medication used in the treatment regimen of this patient who had a history of alcohol dependence and paranoid schizophrenia. Your treatment did not meet the standard of care.

**CHARGE XXI: Failure to provide appropriate medical care to Patient #26**

**Specification 1:** Between July 13, 2007 and January 13, 2015, you prescribed the benzodiazepine (temazepam) to Patient #26. Between March 7, 2008 and January 15, 2015 the benzodiazepine (diazepam) was prescribed to Patient #26. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). The medication combination did not meet the standard of care.

**Specification 2:** Between July 13, 2007 and January 13, 2015, you prescribed a benzodiazepine (temazepam) to Patient #26. Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient #26. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). There is no documentation that risk of adverse effects of these medications was discussed with the patient. This was relevant since the patient dropped his daughter and she sustained injuries as per documentation on March 24, 2014.

**Specification 3:** Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient #26. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). Between July 13, 2007 and January 13, 2015, you prescribed another benzodiazepine (temazepam). Your documentation was insufficient to justify the medications used in the treatment regimen of the patient. Your treatment did not meet the standard of care.

**Specification 4:** Between March 7, 2008 and January 15, 2015, a benzodiazepine (diazepam) was prescribed to Patient #26. Between July 2009 and June 10, 2014, you prescribed medication containing barbiturates (butalbital). Between July 13, 2007 and

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

**CHARGE XXII: Failure to provide appropriate medical care to Patient #27**

**Specification 1:** On August 28, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) for Patient #27, which was added to an existing combination of sedating medications including a benzodiazepine (diazepam), benzodiazepine (temazepam), antipsychotic (quetiapine), antihistamine (diphenhydramine), antihistamine (hydroxyzine), and opioid (tramadol). The suboxone was initiated on August 29, 2014. Adding suboxone to this combination of medications did not meet the standard of care.

**Specification 2:** On August 28, 2014, you prescribed suboxone: buprenorphine/naloxone (opioid/narcotic) for Patient #27 without discussing the risks and benefits of the medication with the patient and obtaining informed consent. Your failure to discuss the risks and benefits and obtain the patient's informed consent did not meet the standard of care.

**CHARGE XXIII: Professional misconduct.**

**Specification 1:** In November 2008, after a probationary pharmacist notified you of her concerns regarding a prescription you had written, you told her you were sick of pharmacists questioning your prescriptions, your clinical judgment, and your authority, or words to that effect. You also told her that if she did not want to fill the prescription then she could find the patient a new doctor and that you were going to speak with her supervisor about the situation; or words to that effect.

**Specification 3:** On multiple occasions in 2008, you entered the Pharmacy Service and told the Interim Pharmacy Chief to control her pharmacists, or words to that effect. Your comments were made regarding pharmacists who had questioned prescriptions you had written.

**Specification 4:** In about June 2009, you encouraged removal of the probationary pharmacist, based in part because the pharmacist had previously questioned and refused to fill several prescriptions that you had written.

**Specification 5:** On September 3, 2009, in an email submitted to the VISN 12 Pharmacy Executive, your Associate Chief of Staff and a pharmacy staff member, you referred to two pharmacists by name and described them as "overtly malignant" because, in your opinion, new pharmacists were following their lead in refusing to fill prescriptions.

**Specification 6:** In 2010, you informed a social worker, who you believed had questioned the medication you prescribed a patient, that if this happened again you would sue him for slander and he would be fired.

**Specification 7:** In 2012, you stated in the presence of a pharmacy staff member that someone in pharmacy had reported you to the Office of Inspector General and that you "do not appreciate it," or words to that effect.

**Specification 8:** Sometime between 2010-2012, you made a comment in the presence of the then Mental Health Service Line Manager that a particular physician assistant would not be working there much longer if he continued to question or attempted to change medication for patients.

**Specification 9:** On June 7, 2013, you emailed a physician assistant and stated in pertinent part that you take personal issue with the physician assistant changing medications on your Veterans. In bold font, you stated, "I expect this practice to stop immediately." You continued by stating, "This will be the last time I address this issue."

2. In reaching this decision, I have carefully considered the entire evidence file and your written replies to the proposed removal notice. You did not provide an oral reply.
3. I have also considered other factors including your years of service, your past work record, the seriousness of the sustained offenses, notoriety of the offenses, impact on the VA's reputation, and whether there are any mitigating or extenuating circumstances which would justify mitigation of the proposed penalty. I have concluded that the sustained charges against you are of such gravity that mitigation of the proposed penalty is not warranted, and that the penalty of removal from employment and revocation of clinical privileges is appropriate and within the range of reasonableness.
4. Since the reason for the action as stated in the notice of proposed removal and revocation of clinical privileges involves a question of professional conduct or competence, you have the right to appeal both of these decisions to the Disciplinary Appeals Board (DAB) and to request a formal hearing before the Board. Your request for a formal hearing must be submitted in writing in conjunction with your appeal. The appeal must be submitted through the Office of Human Resources Management, Employee Relations and Performance Management Service (051) to the Under Secretary for Health, 810 Vermont Ave., N.W., Washington, DC 20420, so as to be received no later than 30 calendar days after your receipt of this decision. The Office of Human Resources Management (051) may be contacted via telephone at (202) 461-5983 or fax (202) 495-5200.
5. **IMPACT OF DECISION REGARDING CLINICAL PRIVILEGES:** In finding that the removal and revocation of clinical privileges are based on substandard care, professional misconduct or professional incompetence, the medical center is required to file a report with the National Practitioner Data Bank (NPDB) regarding the revocation of your clinical privileges (and the summary suspension of your privileges) with a copy to the State Licensing Board (SLB) and other SLBs in all states in which you are licensed, in accordance with VHA Handbook 1100.17. However, please be advised that such reporting requirement is not effective until you have exhausted your entitlements pursuant to VA Handbook 5021, Part V, Chapter 1.

6. **IMPACT OF VOLUNTARY SURRENDER OF PRIVILEGES:** Should you surrender or voluntarily accept a restriction of your clinical privileges, or resign or retire from your position with the Department of Veterans Affairs prior to the effective date of your separation, your fair hearing and appeal rights regarding privileges will be limited to a hearing on whether you took such action while under investigation for professional incompetence, professional misconduct or substandard care.
7. **REPORTING TO STATE LICENSING BOARDS:** It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated, voluntarily or otherwise, whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) in accordance with VHA Handbook 1100.18.
8. If you believe that this action is based on discrimination because of your race, color, religion, sex, national origin, age or disabling condition, you may file a complaint of discrimination with VA in accordance with Office of Resolution Management (ORM) discrimination complaint procedures. Should you elect to do so, you may appeal this action by contacting ORM at 1-888-737-3361 within 45 calendar days of the date you receive this letter.
9. A copy of VA Directive 5021, Part V, Chapter 1 is enclosed to provide you with necessary information regarding an appeal to the Disciplinary Appeals Board. A further explanation of your appeal rights may be obtained by consulting Randy Spahos, VISN 12 Human Resources, 414-384-2000, ext. 47747.



Denise M. Deitzen  
Network Director, VISN 12

Enclosure: *VA Directive 5021, Part V, Chapter 1*

# Executive Summary

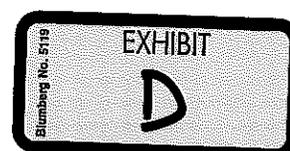
The Chief Medical Officer (CMO) of Veterans Integrated Service Network (VISN) 12 charged an external clinical team to conduct an unprotected focused clinical review of alleged inappropriate prescribing of medications by Dr. David Houlihan, Chief of Staff and Psychiatrist at Tomah VAMC. The clinical review team was comprised of three VA psychiatrists, all outside of VISN-12. The review team was coordinated by a Psychiatrist/Chief Mental Health Officer outside of VISN12.

The focus of this review was to assess the medical records of patients who were prescribed opioids or suboxone by Dr. Houlihan. The team reviewed computerized medical records of 27 randomly selected charts from a list of patients who were treated by this provider and prescribed opioids or suboxone in 2014 (sample 13% for Dr. Houlihan).

The reviewers opined regarding each patient record on the following five core questions:

- 1) Did the provider meet generally accepted standards of clinical practice?
- 2) Was the medical treatment provided by provider appropriate- including the drugs used, drug combinations and dosing of drugs prescribed?
- 3) Was there appropriate documentation to justify the treatment provided?
- 4) Did the provider practice within their scope for their specialty and practice?
- 5) Do you have concerns about any other aspects of care and/or patient safety?

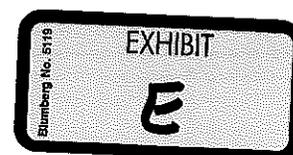
The review team determined that Dr. Houlihan met standard of care in only 8% of cases (Cases 21, 25). Reviewers found care provided was not appropriate in 84% of the cases (Cases 1, 2, 4-6, 8-20, 22-24, 26). Documentation was not adequate to support the care in 84% of the cases (Cases 1, 2, 4-6, 8-20, 22-24, 26; the same cases for which care was judged to be inappropriate). Dr. Houlihan was seen as practicing outside his scope in 28% of the cases reviewed (Cases 1-4, 7, 16, 18). In 48% of the cases, reviewers identified other significant concerns with Dr. Houlihan's care beyond the five core questions (1-2, 4, 6, 8-1, 13, 16, 19, 23). Concerns were identified in several aspects of practice, including inappropriate and unsafe use of opioids (80%; Cases 1-4, 6-13, 15-20, 22-24), psychostimulants (28%, Cases 4, 6, 8, 15, 18, 23, 25) and provision of unsafe combinations of drugs (84%; Cases 1-4, 7-13, 15-16, 18-20, 22-26). There was a pattern of continued prescribing of narcotic medications despite specific, written evidence in the medical record of adverse effects of medications (80%; Cases 1-4, 6-13, 15-20, 22-24). Examples of unsafe drug combinations include high dose benzodiazepines used along with opioids and/or hypnotics (76%; 1-4, 7-10, 12-13, 15-16, 18-20, 22-23, 25-26). The review also found inappropriate use of stimulants where there was questionable credible clinical indication to justify the use of stimulants (28%; Cases 4, 6, 8, 15, 18, 23, 25). There were multiple instances where the provider failed to appropriately monitor or assess adherence, leading to concerns regarding patient safety (76%; Cases 1-4, 6-13, 15-20, 24). There were several incidents of multiple benzodiazepines prescribed concomitantly (24%; Cases 1, 8-9, 13, 22, 26). There was



one incident in which a patient's child was seriously injured when dropped by the patient with no subsequent documentation of discussion of risks and benefits of sedating medications (Case 26). In several instances, Dr. Houlihan was prescribing more than one benzodiazepine in combination with stimulants and opioid/narcotic medications for patients whose records indicated active or concurrent substance abuse (16%; Cases 1, 8-9, 13).

**MEDICATIONS PRESCRIBED TO PATIENT A  
AT TOMAH VA IN 2014**

Medication Name		Drug Schedule
Generic	Brand	
amphetamine/dextroamphetamine	Adderall®	Schedule II Controlled Substance per Wis. Stat. §961.16(5)(a)
atomoxetine	Strattera®	Not Scheduled
baclofen	Kemstro®	Not Scheduled
buprenorphine/naloxone	Suboxone®	Schedule III Controlled Substance per Wis. Stats §961.18(5m)(a)
cholecalciferol (Vitamin D3)	Calciferol/Drisdol®	Not Scheduled
clonazepam	Klonopin®	Scheduled IV Controlled Substance per Wis. Stats. §961.20(2)(cn)
clonidine	Catapres-TTS®	Not Scheduled
codeine/acetaminophen	Tylenol®	Schedule III Controlled Substance Wis. Stats. per §961.16(2)(a)(4)
diazepam	Valium®	Schedule IV Controlled Substance per WI Stats. §961.20(2)(CR)
Diphenhydramine HCL	Benadryl®	Not Scheduled
duloxetine	Cymbalta®	Not Scheduled
butalbital, acetaminophen, and caffeine tablets USP	Fioricet®	Not Scheduled
hydroxyzine pamoate	Vistar®	Not Scheduled
lamotrigine	Lamictal®	Not Scheduled
magnesium Al Plus XS		Not Scheduled
metoprolol tartrate	Toprol®	Not Scheduled
omeprazole	Prilosec®	Not Scheduled
potassium chloride	K-LOR™	Not Scheduled
Quetiapine	Seroquel®	Not Scheduled
Sertraline	Zoloft®	Not Scheduled
Temazepam	Restor®	Schedule IV Controlled Substance per WI Stats. §961.20(2)(CR)
Tramadol	Ultram®	Schedule IV Wis. Stats. § 961.20(4)(e) (as of 8/18/14)
Ziprasidone	Geodon®	Not Scheduled
Zolpidem tartrate	Ambien®	Schedule IV Controlled Substance per Wis. Stats. §961.20(2)(p)



**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Nifty Lynn Dio – Bureau Assistant		<b>2) Date When Request Submitted:</b>  03/07/16  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  03/16/16	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Medical Examining Board – Council Member Appointment Matters 1) Council on Physician Assistants a. Reappointments i. Jeremiah Barrett	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board should make a corrected motion regarding the reappointment of Jeremiah Barrett to the Council on Physician Assistants.  a. Reappointments ii. Jeremiah Barrett – Reappointment until 7/1/2019 (First term 7/18/2012 – 7/1/2016) 1. Motion Language: to reappoint Jeremiah Barrett to the Council on Physician Assistants as an Educator Member for a term to expire on July 1, 2020.  Previously: i. Jeremiah Barrett – Reappointment until 7/1/2019 (First term 7/18/2012 – 7/1/2015) a. Motion Language: to reappoint Jeremiah Barrett to the Council on Physician Assistants as an Educator Member for a term to expire on July 1, 2019.			
<b>11) Authorization</b>			
<b><i>Nifty Lynn Dio</i></b> Signature of person making this request		<b><i>3/7/2016</i></b> Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Kimberly Wood, Program Assistant Supervisor-Advanced		<b>2) Date When Request Submitted:</b>  2/29/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  3/16/2016	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Medical Examining Board – Council Member Appointment Matters 1) Council on Physician Assistants a. Appointments i. Nadine Miller, PA-C	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board should determine how best to proceed in terms of appointing Nadine Miller, PA-C, to the Council on Physician Assistants, for a term to begin as of July 1, 2016 and expiring on July 1, 2020. Nadine Miller will replace Julie Doyle.  Potential Motion Language: to appoint Nadine Miller to the Council on Physician Assistants as a physician assistant member for a term to expire on July 1, 2020.			
<b>11) Authorization</b>			
<b><i>Kimberly Wood</i></b>		<b><i>2/29/2016</i></b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**Nadine Miller PA-C**

██████████  
**West Allis, ██████████**  
██████████  
██████████

**Work Experience**

*Oak Creek Urgent Care, Oak Creek, WI*

2007 - Present

Staff Physician Assistant in solo coverage Urgent Care. Responsibilities include evaluation and treatment of patient presentations from pediatric to geriatric age range. Procedures include suturing, foreign body removal and splinting. Also perform initial reading of EKG and x rays. Referral /consult with specialist and Emergency Department when appropriate.

1994 - 2007

*Emergency Medicine Specialists, Milwaukee, WI*

Senior Physician Assistant with Emergency Medicine Group that grew to include staffing multiple locations; St. Michael Hospital, St Francis and Wheaton Franklin. Responsibilities include evaluation and treatment, admission and discharge of a variety of patients. Seek consult from Staff Emergency Physician when appropriate.

**Licensure:**

NCCPA Certified #951178  
Wisconsin Certified # 798-23

**Certifications:**

CPR, ACLS instructor

**Education:**

Bachelor of Science - Medicine May 1994  
University of Wisconsin - Madison

**Professional Affiliations:**

Member, Wisconsin Academy of Physician Assistants  
Member, American Academy of Physician Assistants

**References :**

Furnished upon request

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Dale Kleven</b> <b>Administrative Rules Coordinator</b>		2) Date When Request Submitted:  <b>3/2/16</b> Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>3/16/16</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>Legislation and Rule Matters – Discussion and Consideration</b> <b>1. Update on SB 568/AB 726 Relating to Board and Council Reorganization and Various Other Changes</b> <b>2. Update on SB 698 Relating to Duties and Powers of DSPS</b> <b>3. Update on AB 768 Relating to the Diagnosis and Treatment of Lyme Disease</b> <b>4. Update on AB 852 Relating to Informed Consent for Performance of Certain Elective Procedures Prior to the Full Gestational Term of a Fetus and Other Provisions</b> <b>5. Update on SB 712/AB 867 Relating to Creating a Medicolegal Investigation Examining Board and Other Provisions</b> <b>6. Update on SB 762 Relating to Licensure of Primary Spinal Care Practitioners</b> <b>7. News Article Relating to Telemedicine</b> <b>8. Update on Pending Legislation and Possible and Pending Rulemaking Projects</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  1. Senate Bill 568: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb568">http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb568</a> Assembly Bill 726: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab726">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab726</a>  2. Senate Bill 698: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb698">http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb698</a>  3. Assembly Bill 768: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab768">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab768</a>  4. Assembly Bill 852: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab852">http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab852</a>  5. Senate Bill 712: <a href="http://docs.legis.wisconsin.gov/2015/related/proposals/sb712">http://docs.legis.wisconsin.gov/2015/related/proposals/sb712</a> Assembly Bill 867: <a href="http://docs.legis.wisconsin.gov/2015/related/proposals/ab867">http://docs.legis.wisconsin.gov/2015/related/proposals/ab867</a>  6. Senate Bill 762: <a href="http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb762">http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb762</a>			
11) <i>Dale Kleven</i> Signature of person making this request		Authorization  <i>March 2, 2016</i> Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			

**State of Wisconsin  
Department of Safety & Professional Services**

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

HEADLINE: Doctor fined for improper Internet prescriptions for pain medication

BYLINE: By, Tony Leys

A Quad Cities doctor who admitted on national TV last year that he prescribed pain medication to unfamiliar patients via the Internet has agreed to pay a \$10,000 fine.

Dr. Paul Bolger, 44, reached a settlement with the Iowa Board of Medicine last week, according to documents released Wednesday.

Bolger was confronted last spring by a CBS News crew investigating sales of expensive painkilling creams to soldiers and veterans. A CBS reporter had entered his own information into a website, requesting medication for pain and scars. Two weeks later, he received the medication from a California pharmacy, with a notation that Bolger had written the prescription.

In an interview that aired last May, CBS reporter Jim Axelrod asked Bolger if he'd done something wrong by signing such prescriptions without interacting with patients. "I couldn't disagree with that," the doctor replied.

The Iowa Board of Medicine began investigating after the CBS report aired. In the settlement reached last week, Bolger agreed not to participate in telemedicine "until he demonstrates that he is able to do so in a safe manner and he receives prior written approval from the board."

The board said Bolger prescribed medication without properly obtaining a medical history or interviewing the patients. It warned him that if he does so again, he could lose his medical license. In the CBS story, the doctor also admitted he didn't have a medical license in New York, from which the reporter ordered the medication. Bolger said the Internet company he worked for was only supposed to be sending him records from patients in states in which he is licensed.

"I'm not going to make excuses for what I was doing," Bolger told Axelrod. "It's not that I had bad intentions, it was that I was under the mistaken impression that patients such as yourself were being spoken with by a qualified medical provider - someone who's qualified to screen you, do an intake over the phone, and make sure you were safe to have these meds."

Bolger, who works at an "aesthetics and wellness center" in Davenport, did not immediately respond to a request for comment Wednesday. In his agreement with the board, he did not admit to breaking any laws, but said he decided to settle the case to avoid the expense and uncertainty of fighting with regulators.

After the CBS story aired last summer, he released this statement: "I have done everything I can to provide and promote high quality medical care here in the Quad Cities for many years, whether in the emergency room or at the clinic. That includes our military veterans who I've always dropped everything to care for. In looking back, I should have verified my understanding that the patients had been seen by qualified health care providers before I signed those prescriptions. I sincerely regret I did not live up to my own high standards."

February 11, 2016

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  2/24/2016	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  3/16/2016	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  FSMB Ethics and Professionalism – Draft Position Statements – Practice Drift, Duty to Report, Sale of Goods by Physicians and Physician Advertising, Compounding of Medications by Physicians - Stakeholder Review and Comment	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?  No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  The FSMB Ethics and Professionalism Committee is seeking review and comment on the following position papers: <ul style="list-style-type: none"> <li>• Practice Drift</li> <li>• Duty to Report</li> <li>• Sale of Goods by Physicians and Physician Advertising</li> <li>• Compounding of Medications by Physicians</li> </ul> The papers can be located here:  <a href="https://www.fsmb.org/Media/Default/PDF/draft_position_statements_FSMB_ethics_professionalism_committee.pdf">https://www.fsmb.org/Media/Default/PDF/draft_position_statements_FSMB_ethics_professionalism_committee.pdf</a>			

11)

**Authorization**

---

Signature of person making this request

Date

---

Supervisor (if required)

Date

---

Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  2/25/2016	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  3/16/2016	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Health Research Group Study Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?  No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Board Review.  <a href="http://www.citizen.org/documents/2300.pdf">http://www.citizen.org/documents/2300.pdf</a>			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Nifty Lynn Dio, Bureau Assistant On Behalf of Tom Ryan, Executive Director		<b>2) Date When Request Submitted:</b>  03/07/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  03/16/16	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Speaking Engagements, Travel, or Public Relations Requests <ul style="list-style-type: none"> <li>• Request to Speak With Atty. Patrick Koenen of Hinshaw &amp; Culbertson Regarding Telemedicine</li> </ul>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b> Dr. Simons,  Hi. I am an attorney practicing with the law firm of Hinshaw & Culbertson in Appleton, Wisconsin. I have been asked by the Health Law Section of the Wis. State Bar to give a webinar on "Telemedicine" and address some of the legal and clinical issues involved in it and lead a discussion on how lawyers can help guide doctors and other health care providers on how to safely practice TM from a legal standpoint (and get paid for doing it). In researching this subject I came across the FSMB "Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine". It was very helpful. I was wondering if you might have a few minutes to talk about that Report and provide me some of your thoughts on TM generally and in the state of Wisconsin. I think this will be a big issue in both medicine and law in our careers and am excited to talk about the issue. However, I would like to be informed and talking to someone with your unique perspective (Chair of DSPS & provider) would be valuable to me. I promise not to quote you (unless you agree or want me too), but am just looking for issues you see, perspective on present and future of TM and some of the barriers lawyers and doctors need to work on. If you can, please call me at [REDACTED]. Thanks! Pat Koenen			
<b>11) Authorization</b>			
<b>Nifty Lynn Dio</b>		<b>03/07/16</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			