WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	**FINAL DECISION AND ORDER**
WILLIAM B. LYLES, M.D., RESPONDENT.	:	0002457

Division of Legal Services and Compliance[1] Case Nos.
09 MED 197, 09 MED 305, 09 MED 335, 09 MED 399

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

William B. Lyles, M.D.
840 Willard Dr Ste 201
Green Bay, WI 54304

Wisconsin Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A disciplinary proceeding was commenced in this matter by the filing of a Notice of Hearing and Complaint with the Board on June 28, 2012. Prior to the hearing on the Complaint, the parties in this matter agreed to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent William Bradford Lyles, M.D. (dob March 7, 1959) is licensed in the State of Wisconsin to practice medicine and surgery, having license number 20-40554, first issued on November 6, 1998 and current through October 31, 2013. Respondent's most recent

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

address on file with the Wisconsin Department of Safety and Professional Services (Department) is 840 Willard Dr., Ste. 201, Green Bay, Wisconsin 54304.

2. On August 19, 2009, Respondent was disciplined by the Board in file no. 05 MED 175. He was reprimanded and ordered to make certain changes in his practice, and to take continuing education in specified areas. Respondent successfully completed the course: *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing*, sponsored by the University of South Florida School of Medicine on May 6-8, 2009, and received 24 hours of Category I continuing medical education, and an ethics course, and a charting course.

COUNT I

3. On and between November 7, 2006, and September 17, 2008, Respondent and his business partner, a licensed clinical social worker, provided care and treatment to patient D, a woman born in 1973.

4. During the course of therapy, this social worker provided the patient with a quantity of modafinil (Provigil®), a schedule IV medication, which had been turned in by another patient. The medication was in a pharmacy bottle, with the original patient's name removed. At the time the social worker gave this medication to the patient, it was not labeled for the patient, nor did it bear other labeling information specific to the patient.

5. During the course of this client's therapy, Respondent effectively delegated the prescribing of psychotropic medications to the patient to his social worker, including by allowing the social worker to provide sample medications (Invega®, Lamictal®, Lunesta®, Luvox®, Pristiq®, and Requip®) to the patient.

6. During this period, the patient was overprescribed dosages of individual medications, and prescribed multiple medications without adequate medical indication.

7. During the course of therapy, Respondent failed to ensure that the social worker charted all medications, including the quantities, provided.

8. Respondent also failed to require the social worker to provide appropriate information on the possible adverse effects of these medications, or the effects of interactions between the patient's medications.

9. On several occasions during the course of therapy, Respondent allowed the social worker to provide the patient with prescription orders for medication, which bore the signature of the Respondent. These prescriptions had been provided by Respondent, pre-signed in blank, and were then filled out by the social worker, on her own authority, and given to the patient to fill at a pharmacy.

10. Following termination of the professional relationship with the patient on September 23, 2008, Respondent's office sent additional samples of prescription-only medications, to the patient, on September 25, 2008 and October 16, 2008.

COUNT II

11. On and between April 17, 2007 and April 24, 2008, Respondent and his business partner, a licensed clinical social worker, provided care and treatment to patient S, a woman born in 1977.

12. During the course of this client's therapy, Respondent's care and treatment of the patient fell below the minimum standards for the profession in the following respects:

a. Respondent did not take and/or chart an adequate psychiatric history.
b. Respondent failed to properly assess the patient's condition and treatment needs, and effectively delegated ongoing assessment and medication management to the social worker.
c. Respondent prescribed inappropriately high doses of alprazolam and caused an iatrogenic sedative-hypnotic dependence syndrome.
d. Respondent's care and treatment caused the patient to have feelings of disgust, shame and insecurity, with behavioral impacts.
e. Respondent's care and treatment also led to the patient's distrust of, and resultant failure to seek, appropriate mental health treatment, thus potentially prolonging and worsening these negative emotions, as well as putting her at elevated risk for relapse of her substance dependence in the future.
f. Respondent prescribed other medications (fluoxetine, duloxetine, quetiapine, benzodiazepines, and stimulants) without proper evaluation and monitoring, and thereby unjustifiably increased the risk of both short- and long-term adverse consequences including development of serotonin syndrome, metabolic syndrome, and development of dependence on stimulants. The patient's alterations in mental status described during the period of time when she was taking these medications were caused or substantially worsened by the coadministration of these agents along with high-dose alprazolam.
g. Prescribing and/or managing medications is outside the expertise of social workers; Respondent authorized, encouraged, and/or tolerated such behavior as the supervising or collaborating psychiatrist.

COUNT III

13. On January 23, 2008, Respondent's business partner, a licensed clinical social worker, had an initial office encounter with client A, a girl born in October, 1991. At the time, Respondent was on medical leave, and the practice was being "covered" by another psychiatrist, who was there on a very limited basis. The social worker's office notes indicated that her initial clinical impression was that the client was bipolar with suicidal feelings, rule out ADHD; the delegee knew at the time that the client was being prescribed fluoxetine 40 mg for depression, by another physician. The social worker charted that she "collaborated" with the covering psychiatrist, who authorized her to give the client a starter package of Lamictal®. This was furnished to the client by the social worker, from Respondent's office's sample supply.

14. Client A had two subsequent sessions with the social worker after Respondent returned from medical leave, but at no time saw any other clinician, including any physician, in Respondent's office.

15. The social worker provided the client with samples of Lamictal® throughout the time that counseling services were provided to the client. Other than the initial starter package, the dispensing of this medication was not charted.

16. At no time did the social worker review any possible adverse effects of the medication with A or her parents, including the effect listed in the black box warning for this medication: a potentially disabling or life-threatening rash. The social worker did not review, with the client or her parents, the label precaution that treatment with antidepressants is associated with an increased risk of suicidal thinking and behavior in children and adolescents with major depressive disorder and other psychiatric disorders.

17. Respondent failed to properly assess the patient's condition and treatment needs, and delegated ongoing assessment and medication management to a social worker.

18. Prescribing and/or managing medications is outside the expertise of social workers; Respondent authorized, encouraged, and/or tolerated such behavior as the supervising or collaborating psychiatrist.

COUNT IV

19. On November 28, 2006, John Whelan, MD, evaluated SM, a man born in 1982. On that same date, he prescribed 60 temazepam 16 mg, 30 Adderall XR® 30mg. Respondent saw SM on 2/1/07, 5/29/07 and 11/5/07. Respondent commenced a medical leave on 11/16/07, returning to practice on 3/25/08. During Respondent's medical leave, his patients were managed by Dr. Edward Orman. Dr. Orman prescribed the following to SM:

Prescription	Fill Date
60 temazepam 15mg	12/10/07
60 temazepam 15mg	1/8/08
60 Adderall XR® 30mg	2/21/08
60 Adderall XR® 20mg	2/21/08
60 temazepam 15mg	2/21/08
60 temazepam 15mg	3/10/08

20. On or about the following dates, Respondent prescribed the following to patient SM, a man born in 1982:

RX #	Prescription	Fill Date
4371846	60 temazepam 15mg	4-9-08
2359548	60 Adderall XR® 30mg	5-2-08
2359549	60 amphetamine® 20mg	5-2-08
4371959	60 temazepam 15mg	5-7-08
2359610	60 Adderall XR® 30mg	5-30-08
2359611	60 Adderall® 20mg	5-30-08
4371959	*60 temazepam 15mg*	*6-3-08*

RX #	Prescription	Fill Date
2359676	60 Adderall XR® 30mg	7-7-08
2359677	90 Adderall® 20mg	7-7-08
2359745	60 Adderall XR® 30mg	8-5-08
2359746	90 Adderall® 20mg	8-5-08
2359814	90 Adderall® 20mg	9-3-08
2359815	60 Adderall XR® 30mg	9-3-08
2359871	60 Adderall XR® 30mg	9-26-08
2359872	90 Adderall® 20mg	9-26-08
2359950	60 Adderall XR® 30mg	10-28-08
2359951	90 Adderall® 20mg	10-28-08
4372612	60 temazepam 15mg	10-28-08
"	*60 temazepam 15mg*	*11-24-08*
2360010	60 Adderall XR® 30mg	11-25-08
2360011	90 Adderall® 20mg	11-25-08
4372612	*60 temazepam 15mg*	*12-15-08*
2360064	60 Adderall XR® 30mg	12-24-08
2360065	90 Adderall® 20mg	12-24-08
4372612	*60 temazepam 15mg*	*1-7-09*
2360124	90 Adderall® 20mg	1-22-09
2360125	60 Adderall XR® 30mg	1-22-09
2360180	60 Adderall XR® 30mg	2-18-09
2360181	90 Adderall® 20mg	2-18-09

[Italicized entries indicate a refill of a previously issued prescription.]

21. As of the date of the last prescription, above, the patient had not had a clinical encounter with Respondent since November 5, 2007. Respondent had an office visit with the patient on March 9, 2009, and subsequently issued the following prescriptions:

RX #	Prescription	Fill Date
4373065	120 lorazepam 0.5mg	3-9-09
2360226	60 Adderall XR® 30mg	3-16-09
2360227	60 Adderall® 20mg	3-16-09
4373065	*120 lorazepam 0.5mg*	*3-17-09*
"	*120 lorazepam 0.5mg*	*3-26-09*
"	*120 lorazepam 0.5mg*	*4-6-09*
2360310	60 Adderall XR® 30mg	4-13-09
2360311	90 Adderall® 20mg	4-13-09
4373065	*120 lorazepam 0.5mg*	*4-16-09*
"	*120 lorazepam 0.5mg*	*4-27-09*
4373296	120 lorazepam 0.5mg	5-22-09
2360437	60 Adderall XR® 30mg	6-12-09
2360438	90 Adderall® 20mg	6-12-09

22. Respondent successfully completed the course: *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing*, sponsored by the University of South Florida School of Medicine on May 6-8, 2009, and received 24 hours of Category I continuing medical education. In June, 2009, Respondent was informed of patient's arrest for having a

"meth lab" in his basement. Respondent discharged the patient based on misuse of benzodiazepines, Adderall XR®, and Adderall® because these were found in large quantities in the basement of the patient's home. A certified letter of discharge dated June 16, 2009, was sent to the Brown County Jail, where the patient was being held, as well as to the patient's house. Notwithstanding these facts, Respondent subsequently issued the following prescriptions to the patient:

RX #	Prescription	Fill Date
4402750	30 lorazepam 1mg	8-3-09
2202438	100 amphetamine combo 20mg	9-10-09
4402800	240 lorazepam 1mg	9-10-09
2202437	60 amphetamine ER 30mg	9-10-09

Respondent represents to the Board that he was treating the patient's wife during this time period, and believed that these prescriptions were appropriate, based upon her representations.

23. For reasons not documented in the chart, the patient was permitted to see a clinical social worker employed by Respondent on September 28, 2009. Respondent did not see the patient between March 9, 2009 and July 15, 2010. After September 28, 2009, the next visit the patient had with any other clinician in Respondent's office was with a clinical social worker, on February 22, 2010. On November 12-13, 2009, Respondent completed Case Western Reserve University School of Medicine's *Intensive Course in Medical Recordkeeping.* Notwithstanding these facts, Respondent issued the following prescriptions to the patient:

RX #	Prescription	Fill Date
4402822	150 lorazepam 1mg	10-1-09
2202508	90 amphetamine 20mg	10-16-09
2202509	90 amphetamine combo 20mg	10-16-09
4402800	*120 lorazepam 1mg*	*10-27-09*
4402890	150 lorazepam 1mg	11-19-09
2202570	60 amphetamine XR 30mg	11-19-09
2202571	90 amphetamine combo 20mg	11-19-09
4402929	150 lorazepam 1mg	12-16-09
4402984	150 lorazepam 1mg	1-20-10
2202703	90 amphetamine combo 20mg	1-20-10
2202704	90 amphetamine XR 30mg	1-20-10
4403023	150 lorazepam 1mg	2-18-10
2202851	60 amphetamine XR 30mg	3-19-10
2202852	90 amphetamine combo 20mg	3-19-10
4403067	120 lorazepam 1mg	3-19-10
"	*30 lorazepam 1mg*	*4-27-10*
4403146	150 lorazepam 1mg	5-4-10
4403219	150 lorazepam 1mg	6-24-10
2203115	60 amphetamine XR 30mg	7-15-10
2203116	60 amphetamine combo 30mg	7-15-10
4403244	150 temazepam 30mg (*see below*)	7-15-10

Respondent represents to the Board that he was treating the patient's wife during this time period, and believed that these prescriptions were appropriate, based upon her representations.

24. On July 28, 2010, Respondent sent a new letter discharging the patient from care. Notwithstanding that fact, the following refillable prescription, which had been issued on or about July 15, 2010, was not canceled, and the patient was able to refill it:

RX #	Prescription	Fill Date
4403244	*150 temazepam 30mg*	*8-16-10*
"	"	*9-13-10*
"	"	*10-11-10*
"	"	*11-08-10*
"	"	*12-7-10*

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. By the conduct described in the Findings of Fact, William B. Lyles, M.D., engaged in unprofessional conduct pursuant to Wis. Admin. Code §§ MED 10.02(2)(a), (h), and (u), and MED 21.03(2) and (3).

3. Therefore, William B. Lyles, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. The license to practice medicine and surgery issued to William Bradford Lyles, M.D., (license number 20-40554) is SUSPENDED for 20 days, effective on the date of this Order.

3. The license to practice medicine and surgery issued to William Bradford Lyles, M.D., (license number 20-40554) is LIMITED as follows:

a. Effective the date of this Order, Respondent shall not prescribe, order, dispense, administer, or otherwise possess, without a prescription issued to him as a patient by another authorized prescriber, any controlled substance, nor shall he direct or request, directly or indirectly, a physician assistant or advanced practice nurse prescriber to prescribe, order, dispense, or administer any controlled substance.

b. Effective 30 days from the date of this Order, Respondent shall not concurrently treat any client of Cheryl K. Rotherham, LCSW.

c. Respondent shall certify, within 20 days of this Order, and annually thereafter, either that he has no sample prescription-only medications in his place of practice,

or, that he, or the facility with which he is associated, is in full compliance with Wis. Admin. Code ch. Med 17.

d. Respondent shall not engage in clinical solo practice. Respondent shall practice only in a work setting which shall assure that Respondent's practice is subject to frequent meaningful peer review. Respondent shall provide a copy of this Final Decision and Order and all other subsequent orders immediately to supervisory personnel at all settings where Respondent engages in practice, currently or in the future. Respondent shall report to the Board any change of employment status, residence, address or telephone number within five (5) days of the date of a change, and shall promptly answer any questions posed by the Department Monitor, the Board, or its designee, concerning his work setting.

e. No later than one year from the date of this order, Respondent shall demonstrate successful completion of a course or courses which have been preapproved by the Board or its designee, and which constitute a comprehensive review of psychiatric medications, including appropriate selection and dosing, interactions with both psychiatric and nonpsychiatric medications, and avoiding polypharmacy. The following course is preapproved as fully meeting this requirement, and Respondent may propose others: *Winter Seminar: Essential Psychopharmacology 2013*, offered by the Harvard Medical School, Department of Continuing Education, February 25-March 1, 2013.

4. William Bradford Lyles, M.D., shall pay COSTS of this matter in the amount of $18,500 within four years from the date of this Order, and at the rate of no less than $1,000 per quarter.

5. Proof of successful course completion, payment of costs (made payable to the Wisconsin Department of Safety and Professional Services), any notices or reports, shall be sent by Respondent to the Department Monitor at the address below:

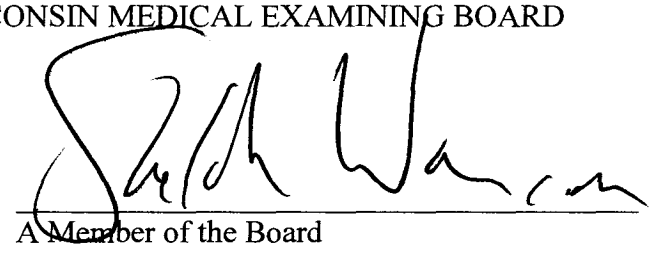
Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935, Madison, WI 53708-8935
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

6. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered or fails to submit proof of successful completion of the ordered education as set forth above, Respondent's license (no. 20-40554) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs and completion of the education.

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

8. The Order of the Board of August 19, 2009, shall remain in full force and effect, except for paragraph #1. The requirements of that paragraph are no longer warranted. Moreover, the obligation of Respondent's treating physicians to report to the Board is governed by Wis. Stat. § 448.115.

WISCONSIN MEDICAL EXAMINING BOARD

by: 

A Member of the Board

May 15, 2013
Date

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