STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH PROFESSIONS
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

FRED WOOLLEY STELSON, M.D.,
License No. 43-01-056585
_____/

File No. 43-09-112046

ADMINISTRATIVE COMPLAINT

The Department of Licensing and Regulatory Affairs, Bureau of Health Professions (Complainant) through its attorneys, Attorney General Bill Schuette, and Assistant Attorney General Graham Filler, files this Administrative Complaint against Fred Woolley Stelson (Respondent), alleging as follows:

1. The Board of Medicine (Board), an administrative agency established by the Public Health Code (Code), 1978 PA 368, as amended, MCL 333.1101 *et seq.*, grants the authority to discipline licensees under the Code through its Disciplinary Subcommittee (DSC).

2. Section 16221(a) of the Code authorizes the DSC to take disciplinary action against a licensee for a violation of a general duty, consisting of negligence or

failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results.

3. Section 16221(b)(i) of the Code authorizes the DSC to take disciplinary action against a licensee for incompetence, which is defined in section 16106(1) of the Code as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession whether or not actual injury to an individual occurs."

4. Section 16221(h) of the Code authorizes the DSC to take disciplinary action against a licensee for a violation, or aiding or abetting in a violation of Article 15 of the Code or of a rule promulgated under Article 15 of the Code.

5. 1996 AACS, Rule 338.1632 authorizes the DSC to take disciplinary action against a licensee for violating a final order issued by a disciplinary subcommittee, board, or task force.

6. Section 16226 of the Code authorizes the DSC to impose sanctions against a licensee, if after an opportunity for a hearing, the DSC determines that a licensee violated one or more provisions of the Code.

FACTS

7. Respondent has been licensed to practice medicine since 1990. On March 17, 2003, the Board of Medicine DSC issued an order pursuant to consent agreement, suspending Respondent's license after he admitted to having a sexual relationship with a patient.

8. On October 25, 2005, Respondent petitioned for the reinstatement of his license. On October 11, 2006, the Board of Medicine issued a final order granting reinstatement to Respondent, (see Attachment A).

9. As part of the terms of his reinstatement, Respondent was given a limited license that provided he work under the general supervision of a Board approved supervising physician for a period of one year. The Board's final order further provided that Respondent's medical license would automatically return to a full and unencumbered status after one year, provided Respondent satisfactorily complied with the terms of the order – including satisfactory performance evaluation reports from his supervisor. The Order further provided that reduction of the limitation period would only occur while Respondent was employed as a physician.

10. On September 22, 2008, Respondent began work at Pointe East, which is the psychiatric arm of Alpena Regional Medical Center. Dr. Carolyn Koppenol served as Respondent's supervising physician.

11. While at Alpena Regional, Respondent failed to follow general rules of prescribing narcotics by consciously disregarding the hospital's prescribing policy. Respondent prescribed Ritalin to patients, which was against hospital policy and against the instructions of his supervisor.

12. While working at Alpena Regional, Respondent was suspended from seeing patients for two weeks because he failed to update his patient records properly.

13. Respondent was known to fall asleep during meetings and even sleep on the hospital couch at times. Respondent claimed that he was not sleeping, but that he was doing transcendental meditation in the hospital. Respondent also claims his sleep apnea has caused him to have inconsistent sleeping patterns.

14. On November 6, 2008, Respondent treated D.B. (female, DOB initials used to protect patient confidentiality), a patient assigned to his ward at

Alpena Regional. D.B. had been admitted to the hospital because of extreme anxiety. Respondent diagnosed D.B. as having an adjustment disorder, with disturbed emotions, anxiety disorder, alcohol abuse, and a post-traumatic stress disorder.

15. On November 6, 2008, Respondent noted that despite D.B.'s grandiose and dramatic claims, she showed no evidence of delusions, nor was she being paranoid or psychotic. Respondent attributed D.B.'s exaggerations to a histrionic flare and D.B. was discharged on November 9, 2008.

16. Respondent ignored D.B.'s medical history when treating and quickly releasing her. Respondent's misdiagnosis directly led to D.B. not receiving proper antipsychotic or mood-stabilizing medications. Numerous experts and doctors diagnosed her as being acutely psychotic and documented her delusional claims (i.e. she claimed to have been being held hostage by Navy SEALS). One month before her admission to Alpena Regional, Bob May, D.O., had diagnosed D.B. as being acutely psychotic and a danger to herself.

17. Soon after Respondent treated and released D.B. from the hospital, D.B. was arrested on charges of assault less than murder. She was convicted of

aggravated assault in the 81st District Court on 02-23-09 and sentenced to six months in jail.

18. On January 14, 2009, Respondent treated J.P (male, DOB), who had been exhibiting mania and psychotic symptoms before being admitted to Alpena Regional. Before coming to the hospital, J.P. had been evaluated at the local AuSable Valley Community Mental Health, where he was evaluated as having severe aggression and severe psychosis. J.P. had physically threatened others on the date of his admission to the hospital. In evaluating J.P., Respondent noted on the patient chart:

> Today, on the day of his admission, he became agitated in the morning and grabbed his crippled father by his collar and pulled him up and scared him a great deal. Father says he has become mentally abusive at times which is not like him. He also became agitated and punched a hole in the ceiling this morning.

Respondent also wrote up a plan for treating J.P. According to Respondent's patient chart notes, he recommended J.P. be treated with milieu therapy and group therapy. Despite his findings and treatment recommendations, Respondent released J.P. less than 24 hours after admittance into the hospital.

19. On January 15, 2009, nurse M.M. filed a complaint against Respondent for unsafe practice regarding his discharge of J.P. M.M. specifically

alleged that Respondent discharged J.P. even while the patient exhibited dangerous, manic behavior.

20. On February 6, 2009, Respondent was terminated from his pro tems position at Alpena Regional. The facility terminated Respondent, in part, for his prescribing practices, bad recordkeeping, erratic behavior and misdiagnosing two patients.

21. Respondent violated the terms of his probation and the Board's October 11, 2006 Final Order when Respondent's Site Monitor at Alpena Regional reported violations during his pro tems position and eventually terminated his contract for these violations.

COUNT I

22. Respondent's conduct as described above constitutes negligence and/or failure to exercise due care, in violation of section 16221(a) of the Code.

COUNT II

23. Respondent's conduct and/or omissions as described above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT III

24. Respondent's conduct and/or omissions as described above constitutes a failure to comply with a Board's Final Order, contrary to 1996 AACS, R 338.1632, in violation of section 16221(h) of the Code.

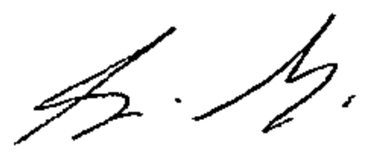
RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(7) of the Code, he has 30 days from receipt of this Administrative Complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Health Professions, Department of Community Health, P.O. Box 30670, Lansing, Michigan 48909, with a copy to the undersigned Assistant Attorney General. Further, pursuant to section 16231(8) of the Code, failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the Administrative Complaint and shall result in transmittal of the Administrative Complaint directly to the Boards' Disciplinary Subcommittees for imposition of an appropriate sanction.

THEREFORE, Complainant requests that this Administrative Complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of his licenses. If compliance is not shown, Complainant further requests that formal proceedings be commenced

pursuant to the Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*.

Respectfully submitted,

BILL SCHUETTE
Attorney General



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Dated: February 22, 2012

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