

**BEFORE THE SOUTH DAKOTA  
BOARD OF MEDICAL EXAMINERS**

In the matter of  
the medical license of  
Harold J. Fletcher, M.D.  
Date of Birth: 03-30-38  
License Number: 0790

**STIPULATION  
AND ORDER**

IT IS HEREBY STIPULATED AND AGREED, by and between Harold J. Fletcher M.D. (“Respondent”), and the South Dakota Board of Medical Examiners (“Board”) as follows:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of South Dakota.
2. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter. Respondent is represented by John L. Wilds, 141 North Main Avenue, Suite 500/502, Sioux Falls, South Dakota 57104-6435. The Board is represented by Charvin Dixon, 1323 S. Minnesota Avenue, Sioux Falls, South Dakota, 57105.

**FACTS**

3. For the purpose of this stipulation, the Board may consider the following facts as true:
  - a. Respondent was licensed by the Board to practice medicine in the State of South Dakota on August 12, 1968. He has been continually licensed since that time. Respondent is also a practicing physician in St. Peter, Minnesota, at the Cornerstone Wellness Center. Respondent practiced in South Dakota as a surgeon and family practitioner until the mid-1990’s. Since that time Respondent has confined his practice to chelation therapy in South Dakota and Minnesota.
  - b. Minnesota Statute Section 148.171, Subdivision 6 states, “Collaborative management is a mutually agreed upon plan between an advance practice registered nurse and one or more physicians or surgeons licensed under Chapter 147 that designates the scope of collaboration necessary to manage the care of patients.” The Respondent did have a collaborative agreement with Nurse Practitioner #1 as required under Minnesota Statute Section 148.171.

**PATIENT #1**

- c. Patient #1 (YOB 1917) received 12 chelation treatments from September 8 through October 26, 2000. The Respondent’s records, in the form of the chelation therapy flow sheet, list

“macular degeneration” as one of the diagnosis. The physical exam and chelation therapy of Patient #1 was performed by Nurse Practitioner #1.

#### **PATIENT #2**

d. Patient #2 (YOB 1927) has a history of gout, hypertension and obesity and was first seen by Nurse Practitioner #1 on September 1, 1999. Respondent also saw Patient #2 on September 10, 1999, September 17, 1999 and June 23, 2000. A September 10, 1999 note in the file in Respondent’s handwriting state “Reviewed lab results, cholesterol 233, needs chelation.” Respondent did not sign the note. Patient #2 had 47 chelation therapy treatments from September 3, 1999 to July 25, 2000. The chelation therapy of Patient #2 was preformed by Nurse Practitioner #1.

#### **PATIENT #3**

e. Patient #3 (YOB 1931) was first seen by Nurse Practitioner #1 on February 1, 2001. Patient #3 had 16 chelation treatments from February 1 through May 16, 2001. A physical evaluation form was completed by Nurse Practitioner #1. The examination revealed peripheral edema, “wheezing,” and shortness of breath. The form stated the diagnosis as: “atrial fibrillation, obesity, hypertension, and asthma.” Examination showed Patient #3’s EKG was abnormal with atrial fibrillation and myocardial ischemia. Abnormal lab test results were also noted. Respondent changed Patient #3’s medication from Synthroid to Armor thyroid without documenting any rationale for the change. Respondent started Patient #3 on potassium without indication in writing any reason in the file. The administration of chelation therapy and physical exam of Patient #3 was performed by Nurse Practitioner #1. This Patient was using furosomile (Lasix) – therefore needed the potassium as Lasix removes potassium from his urine.

#### **PATIENT #4**

f. Patient #4 (YOB 1933) was seen on March 21, 2001 for complaints of heart fibrillation and peripheral neuropathy with pain and numbness in the feet. Patient #4 had 20 chelation treatments from March 21 through June 13, 2001.

g. On March 21, 2001, a physical evaluation form for Patient #4 was completed by Nurse Practitioner #1. The form stated the diagnosis as “peripheral vascular disease and hypertension.” The administration of chelation therapy and physical exam of Patient #4 was performed by Nurse Practitioner #1.

**PATIENT #5**

h. Patient #5 (YOB 1923) was first seen on March 7, 2001, with a diagnosis of prostate cancer. Patient #5 had 20 non-chelation treatments from March 7 through July 21, 2001. A physical evaluation for Patient #5 was completed by another physician. The form stated the primary diagnosis noted as history of aortic valve replacement, cancer of the prostate and basal cell cancer. The file also noted Patient #5 as taking Coumadin.

i. Respondent failed to document his assessment of Patient #5. The non-chelation therapy of Patient #5 was performed by Nurse Practitioner #1. Nurse Practitioner #1 did the assessment.

**PATIENT #6**

j. Patient #6 (YOB 1930) was first seen on March 19, 2001. Patient #6 had 27 chelation treatments from March 19 through June 9, 2001. The physical examination form was completed by Nurse Practitioner #1; however, it was initialed by Respondent.

k. On March 19, 2001, Nurse Practitioner #1 documented that Patient #6 had an abnormal EKG. Respondent did not document that he performed any follow-up regarding this abnormal EKG. Lab tests revealed a relative neutrophilia of 83.7, an elevated LDH at 316 and mildly elevated glucose the Nurse Practitioner #1 did. Respondent did not document any of the above abnormal lab results or his assessment of Patient #6. The administration of chelation therapy and physical exam of Patient #6 was performed by Nurse Practitioner #1.

**PATIENT #7**

l. Patient #7 (YOB 1928) was first seen on August 29, 2000. The physical examination form was completed by Nurse Practitioner #1; however, it was initialed by Respondent. Patient #7 had 37 chelation treatments from August 29, 2000 through May 21, 2001.

m. On January 26, 2001, Respondent noted "pt c/o drifting to R when she walks, has had 18 chelation without relief-need to see chiropractor."

o. Respondent failed to document this assessment of Patient #7. The Nurse Practitioner did the assessment on Patient #7. The administration of chelation therapy and physical exam of Patient #7 was performed by Nurse Practitioner #1.

**PATIENT #8**

p. Patient #8 (YOB 1943) was first seen at the Cornerstone Wellness Center in July, of 2001. Nurse Practitioner #1 provided the consent forms to Patient #8 without Respondent's knowledge or approval. Respondent did not see Patient #8. On September 8, 2001, Nurse

Practitioner #1 mixed a chelation solution and inserted an IV administering the therapy. On September 15, 2001 Patient #8 returned for another treatment. Nurse Practitioner #1 had difficulty inserting the IV into his arm, so the treatment was not completed. In addition to mixing chelation solutions and administering IV treatments, it was reported that Nurse Practitioner #1's duties included consulting with patients, performing physicals, EKG's, lab work, drawing blood, obtaining signatures on consent forms for treatment and writing prescriptions.

### **STATUTES**

4. The Minnesota Board of Medical Practice viewed Respondent's practices as inappropriate in such a way as to require the Minnesota Board to discipline Respondent in Minn. Stat. §147.091, subd. 1(k) (unprofessional conduct); (o) (failure to maintain medical records) and (i) (failure to properly supervise a nurse practitioner) (2000), and Respondent agreed that the conduct cited above constituted a reasonable basis to justify the disciplinary action under the above statutes.

5. Discipline by another licensing agency is grounds for discipline in South Dakota pursuant to SDCL 36-4-30(24),

### **REMEDY**

5. Upon this stipulation and all of the files, records, and proceedings herein, and without any further notice or hearing herein, Respondent does hereby consent that until further order of the Board, made after notice and hearing upon application by Respondent or upon the Board's own motion, the Board may make and enter an order conditioning and restricting Respondent's license to practice medicine and surgery in the State of South Dakota as follows:

- a. Respondent is hereby REPRIMANDED for the conduct described in paragraph 3.
- b. Within three months from the date of the Order, Respondent shall develop, and submit for Board approval, a written protocol that discusses informed consent, delegation of activities to nurses and other health care professionals, interpretation of lab and EKG results, and the assessment tools used to determine the need for and effectiveness of chelation therapy.
- c. Respondent shall successfully complete a medical records management course, approved in advance by the Board. Successful completion shall be determined by the Board or its designee and must be accomplished within three months from the date of this Order.
- d. Respondent shall undergo a chart audits by a representative of the Minnesota Board as directed by the Minnesota Board.
- e. Respondent shall meet with members of the Minnesota Board as directed by that Board.

f. This Stipulation and Order will remain in effect for a minimum of one year. Respondent may petition the South Dakota Board for reinstatement of an unconditional license prior to one year, if notified by the Minnesota Board of successful completion of the chart audit under paragraph 5.d, and reinstatement of unconditional licensure by the Minnesota Board. Upon hearing the petition, the Board may continue, modify, or remove the conditions set out herein.

6. Within ten day of the date of this Order, Respondent shall provide the Board with a list of all hospitals and skilled nursing facilities at which Respondent currently has medical privileges, a list of all states in which Respondent is licensed or has applied for licensure, and the addresses and telephone numbers of Respondent's residences and all work sites. Within seven days of any change, Respondent shall provide the Board with the new address and telephone information. The information shall be sent to Charvin Dixon at his above address.

7. In the event Respondent resides or practices outside the State of South Dakota, Respondent shall promptly notify the Board in writing of the location of his residence and all work sites. Periods of residency or practice outside of South Dakota will not be credited toward any period of Respondent's suspended, limited, or conditioned license in South Dakota unless Respondent demonstrates that practice in another state conforms completely with Respondent's South Dakota license to practice medicine.

8. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the Board shall schedule a hearing before the Board. The Board shall mail Respondent a notice of the violation alleged by Board and of the time and place of the hearing. Respondent shall submit a response to the allegations at least three days prior to the hearing. If Respondent does not submit a timely response to the Board, the allegations may be deemed admitted.

At the hearing before the Board, the Board and Respondent may submit affidavits made on personal knowledge and argument based on the record in support of the positions. The evidentiary record before the Board shall be limited to such affidavits and this Stipulation and Order.

At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Respondent's practice, or suspension or revocation of Respondent's license.

9. In the event the Board in its discretion does not approve this settlement, this stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon not introduced in any disciplinary action by either party hereto except that Respondent agrees that should the Board reject this stipulation and if this case proceeds to hearing, Respondent will assert no claim that the

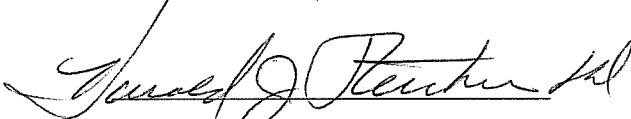
Board was prejudice by its review and discussion of this stipulation or of any records relating hereto.

10. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by South Dakota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the stipulation shall be the final order herein.

11. Respondent hereby acknowledges that he has read and understands this stipulation and has voluntarily entered into the stipulation without threat or promise by the Board or any of its members, employees, or agents. This stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this stipulation.

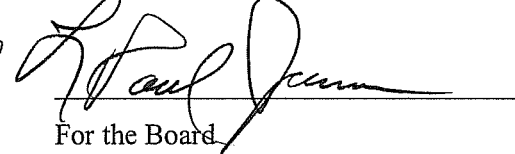
Dated: 6-24-03, 2003

Dated: 6-25-03, 2003



HAROLD J. FLETCHER, M.D.

*under Protest*




For the Board

**ORDER**

Upon consideration of this stipulation – and all the files, records, and proceedings herein, IT IS HEREBY ORDERED that the terms of this stipulation are adopted and implemented by the Board on this 25<sup>th</sup> day of June 2003.

SOUTH DAKOTA BOARD OF  
MEDICAL EXAMINERS



L. Paul Jensen

Executive Secretary

South Dakota Board of

Medical Examiners

Attachments:

- 1) Nurse Practitioner Affidavit
- 2) Clinic Protocol Document
- 3) Clinic Chelation Therapy Consent form
- 4) Resignation Letter to Cornerstone Clinic