

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN HENRY HAGMANN, M.D.
License No.: 0101-226760

ORDER OF SUMMARY SUSPENSION

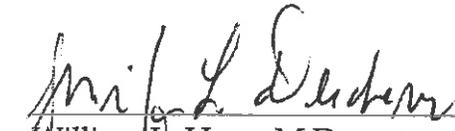
Pursuant to § 54.1-2408.1 of the Code of Virginia (1950), as amended ("Code"), a quorum of the Virginia Board of Medicine ("Board") met on March 12, 2015, by telephone conference call after a good faith effort to convene a regular meeting of the Board failed. The purpose of the meeting was to receive and act upon information indicating that John Henry Hagmann, M.D., may have violated certain laws and regulations relating to the practice of medicine and surgery in the Commonwealth of Virginia, as more fully set forth in the Statement of Particulars, which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under § 54.1-2408.1 of the Code, the Board concludes that a substantial danger to the public health or safety warrants this action and ORDERS that the license of John Henry Hagmann, M.D., to practice medicine and surgery in the Commonwealth of Virginia be, and hereby is, SUSPENDED. It is further ORDERED that a hearing will be convened forthwith to receive and act upon evidence in this cause, and that the Executive Director of the Board shall be authorized to execute this Order and all other documents, notices, and Orders on behalf of the Board necessary to bring this matter to hearing.

Upon entry of this Order of Summary Suspension, the license of John Henry Hagmann, M.D., will be recorded as suspended and no longer current.

Pursuant to § 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD

for 

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 3/12/2015

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN HENRY HAGMANN, M.D.
License No.: 0101-226760

STATEMENT OF PARTICULARS

The Virginia Board of Medicine ("Board") alleges that:

1. Dr. Hagmann may have violated Sections 54.1-2915.A(3), (11), (12), (13), (16) and (18) and 54.1-3303.A of the Code of Virginia (1950), as amended ("Code") and 18 VAC 85-20-29.A(1) and (3) of the Board of Medicine General Regulations ("Regulations"), in that, during his military course training programs, he exploited participants for his personal gain, thereby representing a danger to the health and welfare of his patients and the public. Specifically, by Dr. Hagmann's own admission, while conducting training courses for his business, Deployment Medicine International ("DMI"), in or about 2012 and 2013 in Virginia, the United Kingdom, Maryland and North Carolina, he authorized and allowed course participants, including medical students/military officers who he recruited from a uniformed services university in Maryland, to independently perform, on each other, invasive medical procedures. These procedures were not undertaken or provided in good faith for medicinal or therapeutic purposes, were undocumented and were not performed under adequate or appropriate sterile conditions. Examples of such procedures performed in these courses in or about July 2012 and 2013 include the following:

a. During an *Operational Medicine and Emergency Skills* ("OEMS")/*Procedures in Casualty Care* ("PCC") course conducted at Dr. Hagmann's training facility in Partlow, Virginia, his 32-acre farm, from approximately July 5-8, 2013, Dr. Hagmann instructed, authorized or allowed course participants, who were not licensed by the Virginia

Department of Health Professions, to perform invasive procedures on one another, as follows:

- i. A course participant initiated a Foley catheterization on Patient A, discussed in more detail below in Paragraph 6(a). When the course participant was unable to successfully catheterize the patient, Dr. Haggmann took over the procedure, changing the catheterization tubing.
 - ii. A course participant performed a Foley catheterization on Patient B.
 - iii. Patient C was administered a FAST I sternal intraosseous infusion. After making an incision down to the periosteum, Dr. Haggmann or a course participant removed the device with needle drivers, and according to Patient C, called for course participants who had never sutured a live person to use the opportunity to get some practice. Subsequently, when several of the course participants began suturing, Dr. Haggmann left the area, claiming that he could not bear to watch.
- b. During an OEMS/PCC course conducted in the United Kingdom in or about July 2012, attended by United States citizens who were medical students and/or members of the military, course participants performed the following invasive procedures on one another, as follows:
- i. Patient D performed a Foley catheterization on Patient E.
 - ii. Subsequently, Dr. Haggmann informed Patient D that he would receive ketamine (C-III), followed by "a procedure." Individual 1, a uniformed services university student acting as the DMI OEMS course coordinator who was present, stated that, subsequent to the administration of ketamine and midazolam (C-IV),

Patient D was catheterized by Patient E, followed by an intravenous (“IV”) insertion by course participants. Individual 1 stated that Patient D was not told, prior to receiving ketamine and midazolam, what procedure would be performed, so that the effects of medication(s) on his post-procedure recollection could subsequently be assessed.

c. During an OEMS/PCC course held at a uniformed services medical university in Maryland in or about 2012, Dr. Hagmann conducted one or more “shock labs,” which involved withdrawing blood from medical students, monitoring them for hypovolemia, and then auto-transfusing their blood back to them.

d. During an OEMS/PCC course held from approximately July 13-20, 2013 at Dr. Hagmann’s training facility in Pink Hill, North Carolina, his 20-acre property, course participants performed invasive procedures on one another, as follows:

i. After watching a video on Foley catheterization, course participants were encouraged to “practice” on one another. When the course participants appeared hesitant, Dr. Hagmann volunteered to be the first “subject,” and made demeaning remarks to the men in the group for not volunteering. Subsequently, one female was catheterized and the four males in the group were catheterized, some of them twice.

ii. Individual 2, the first course participant chosen by Dr. Hagmann to catheterize a male patient, later stated that she performed the procedure without adequate instruction. Individual 2 further stated that she thought Dr. Hagmann intentionally withheld the necessary instruction because previously, she had been critical of the live tissue training portion of the course, and he was “trying to

embarrass [her]" in retaliation for the criticism.

2. Dr. Hagmann may have violated Sections 54.1-2915.A(3), (8), (11), (12), (13), (16), (17) and (18); 54.1-3303.A and 54.1-3408.A-B of the Code and 18 VAC 85-20-29.A(1) of the Regulations, in that, in the absence of proper training and supervision, and absent medicinal or therapeutic purposes within the course of his professional practice, he dispensed controlled substances to and instructed, authorized or allowed course participants, who were not licensed by the Virginia Department of Health Professions, to administer to or inject each other or themselves with ketamine; midazolam; lorazepam (C-IV); lidocaine (C-VI); benzocaine (C-VI); heparin (C-VI); Diamox (C-VI); prednisone (C-VI); dexamethazone (C-VI) and Viagra (C-VI). Further, Dr. Hagmann directed, authorized or allowed course participants to engage in "ketamine labs," "alcohol labs" or "studies," and "cognition labs," which involved the dosing of ketamine (a disassociative anesthetic) and consumption of alcohol, at times in combination or in quick succession, so that he could assess the effects of these substances on their cognition. None of these labs or studies was approved by an Institutional Review Board ("IRB"). Specifically:

a. In or about 2012, during the OEMS course(s) conducted at the uniformed services university in Maryland, students participated in a "ketamine lab," wherein they were injected with ketamine in order to observe its effects.

b. In or about July 2012 during the OEMS/PCC course in the United Kingdom:

i. Several course participants received morphine (C-II) or ketamine injections, administered by Dr. Hagmann or one of the course participants. ii.

After receiving ketamine, midazolam and IV fluid, Patient D was catheterized, as detailed above in Paragraph 1(b)(ii).

c. In or about July 2013, at the OEMS/PCC course in Partlow, Virginia, as part of a "cognition lab," course participants were asked to complete cognition tests prior to and after consuming approximately eight (8) ounces of bourbon in a span of approximately 20-30 minutes. According to Patient C, this lab was "part of training." Patient C further stated that, subsequently, participants were permitted or encouraged to "chase" the bourbon with beer.

d. In or about July 2013, at the OEMS/PCC course in Pink Hill, North Carolina:

i. As part of a "cognition lab," course participants were asked to complete cognition tests prior to and after consuming approximately eight (8) ounces of 80-proof rum within approximately ten minutes. Two participants each drank an additional approximate four (4) ounces of rum.

ii. Approximately one hour or less after consuming rum as part of the "cognition lab," several course participants were injected with ketamine to allow them to feel the effects. Regarding four participants who consumed alcohol (rum) and received ketamine injections:

- Patient F experienced a negative reaction to the ketamine and began crying. Lorazepam was administered in an effort to calm her down. Subsequently, despite the fact that Dr. Hagmann was the only licensed health care provider present, he did not monitor Patient F's condition or offer follow-up care. Instead, Individual 2 cared for Patient F by placing her in the recovery position.
- Patient G became nauseous almost immediately after receiving ketamine (having consumed approximately twelve (12) ounces of rum within the

previous hour) and began vomiting. Dr. Haggmann and another course participant, who was inebriated, discussed performing a penile nerve block on Patient G. Individual 2 twice informed Dr. Haggmann and the other course participant that she did not think it was appropriate for him to perform a penile nerve block on Patient G, who was incapable of giving informed consent. Subsequently, two other course participants approached Individual 2 and stated that they had not agreed with the proposed procedure, and Patient G later stated that he was glad that Patient 2 had interceded on his behalf.

- Patient H, who received ketamine after consuming rum, underwent a penile nerve block while intoxicated.
 - Patient W received three (3) doses of ketamine. Despite the fact that Dr. Haggmann was the only licensed health care provider present, he did not monitor this patient's condition or offer follow-up care. Rather, Patient W asked Individual 2 to stay up with him before retiring at approximately 3:45 a.m.
- iii. Subsequent to the incident with Patient G, on that same evening, Dr. Haggmann volunteered himself for a penile nerve block, which course participants performed on him.
- e. In or about July 2013, at the *Mission Performance at High Altitude* ("MPHA") course in Leadville, Colorado, conducted at a high altitude location in rented huts:
- i. As part of a "cognition lab" conducted on or about the evening of July 11, 2013, in which cognition was being studied at various altitudes, participants, who

were described by Patient C as “pressured” into participation, performed the same or similar cognition tests prior to and after consuming quantities of bourbon, as had the participants in the Virginia and North Carolina alcohol “labs.”

ii. Patient C stated that, as part of a “ketamine lab” conducted late in the evening on or about July 12, 2013, Patient J, a Dutch military commando attending the course, was administered a micro-dose of ketamine in order to “demonstrate the intoxicating effects of the drug,” or words to that effect.

iii. In or about the late evening of July 12, 2013, ketamine and midazolam were administered to Patient K to demonstrate, according to Patient C, the “calming effects of adding midazolam to micro-dose ketamine, and also to show the suggestibility of a patient dosed with this combination of drugs” (also witnessed by Individual 4). Prior to receiving the ketamine and midazolam, Patient K had expressed reservations about undergoing a tibial intraosseous infusion, which was known to be painful, but after receiving the medications, he was “easily manipulated into accepting the procedure,” according to Patient C. Although the procedure was not performed, the administration for the purpose of the infusion was.

f. In or about July 2013 at the MPHA course in Partlow, Virginia and/or Leadville, Colorado, Dr. Hagmann dispensed or administered Diamox, prednisone and dexamethazone for “working at altitude” testing and Viagra for “aerobic performance at altitude” testing to Patients J - T as follows:

- Patients J and K - Diamox and Viagra

- Patients L, O, P and S -Diamox
- Patients M and N - prednisone or dexamethazone and Diamox
- Patients Q and R - prednisone or dexamethazone, Diamox and Viagra
- Patient T - prednisone and Diamox

g. In or about July 2013, as shown in a DMI training video provided to the Department of Health Professions' investigator in or about July 2014, Dr. Hagmann authorized or allowed Individual 5 to administer Heparin to Patient I and subsequently withdraw blood from the patient.

h. Dr. Hagmann's July 2013 medication and dispensing logs for ketamine, lorazepam and midazolam indicate that he transferred these medications from Gig Harbor, Washington to Partlow, Virginia and dispensed or administered these medications to Patients F, K, R, U, V and W, or dispensed and instructed course participants, who were not licensed health care practitioners, to administer these medications to themselves or each other, as follows:

Date	Patient	Medication/dosage administered
7/7/13	Patient F	0.5 mg/ .25 ml lorazepam
7/8/13	Patient U	3mg/0.6 ml midazolam
7/10/13	Patient K	1 ml ketamine; 2mg/0.4 ml midazolam
7/10/13	Patient R	2 ml ketamine
7/18/13	Patient F	0.25 ml ketamine
7/18/13	Patient U	1 ml ketamine
7/18/13	Patient V	1 ml ketamine
7/18/13	Patient W	1.25 ml ketamine

3. Dr. Hagmann may have violated Sections 54.1-2915.A(17) and (18) and 54.1-3304 of the Code in that, in or about July 2012 and July 2013, he dispensed, as detailed in Paragraph 2, C-III and C-IV controlled substances (ketamine, midazolam and lorazepam) to patients/individuals without being licensed by the Board of Pharmacy, as required by Section

54.1-3302 of the Code.

4. Dr. Haggmann may have violated Sections 54.1-2915.A (17) and (18) and 54.1-3404.D of the Code in that he failed to maintain a dispensing log for morphine administered to DMI course participants, despite the fact that his drug invoices indicate that he purchased 50 units of injectable morphine sulfate on or about July 1, 2013 and an additional 50 units on or about November 7, 2013. Further, Dr. Haggmann admitted to the DHP investigator that he uses morphine in a course offered to participants from the Department of Energy and Individual 3 stated that at least one student was administered morphine during the July 2012 OEMS/PCC course in the United Kingdom (as detailed in Paragraph 2(b)(i)). Further, Dr. Haggmann failed to maintain a dispensing log for the “high altitude” medications he dispensed to patients in Virginia and/or Colorado in or about July 2013, as detailed in Paragraph 2(f).

5. Dr. Haggmann may have violated Section 54.1-2915.A(3), (13) and (16) of the Code in that he failed to obtain adequate or appropriate consent from Patients F, G, H and W, who were purported to have “consented” to the administration of ketamine and benzodiazepines while under the influence of alcohol, as detailed in Paragraph 2(d).

6. Dr. Haggmann may have violated Section 54.1-2915.A(3), (12), (13), (16), (18) and (19) of the Code and 18 VAC 85-20-29(3) and 18 VAC 85-20-100 of the Regulations, in that, from approximately July 5-8, 2013, he exploited, for personal gain and sexual gratification, Patients A and B, participants in his Partlow, Virginia DMI OEMS/PCC course, as follows:

a. After a course participant had difficulty passing a catheter through Patient A, Dr. Haggmann changed the tubing type or size and catheterized the patient. Later that day, Dr. Haggmann approached the patient and recommended a “private” prostate exam to determine a physical reason for the difficulty. At approximately 10:30 p.m. that evening,

Dr. Hagmann conducted a detailed physical examination of Patient A's penis, testicles and rectum, and the patient later stated to a uniformed services university investigating officer that the rectal exam "took longer than expected and made me feel uncomfortable," adding that Dr. Hagmann later asked if the patient "wanted to perform a digital rectal exam" on him.

b. Patient B was catheterized by another course participant, during which Dr. Hagmann noticed that the patient was uncircumcised. Subsequently, on or about the evening of July 8, 2013, after all other course participants had left the Partlow, Virginia premises, while consuming beer with Patient B, Dr. Hagmann "boast[ed]" about his proficiency with rectal exams and drove with Patient B to the warehouse on the property to practice "additional procedures." At the warehouse, Patient B, at Dr. Hagmann's request, performed a "femoral gas" on him, after which he requested that Patient B perform a focused pelvic trauma examination, including a penile and rectal examination, stating that he would talk Patient B through it. This examination was videotaped, according to Dr. Hagmann, for future training purposes; however, Patient B stated that the video has not been requested for course material. Further, while they both continued to consume beer, Dr. Hagmann questioned Patient B about the effect his uncircumcised penis had on masturbation and sexual intercourse and asked to photograph the patient's penis during various stages of manipulation of the foreskin, purportedly to use as a "training tool." Patient B, who stated that he was inebriated and felt that he could not refuse Dr. Hagmann's request, acquiesced and allowed him to examine, manipulate and photograph his penis.

7. Dr. Hagmann may have violated Section 54.1-2915.A(3), (13) and (16) of the Code

in that, on or about July 8, 2013, while he was under the influence of alcohol, he examined/treated Patient B as detailed in Paragraph 6(b), and, on or about July 9, 2013, he demonstrated a penile nerve block on a patient while under the influence of alcohol.

8. Dr. Hagmann may have violated Section 54.1-2915.A(3), (13) and (16) of the Code and 18 VAC 85-20-26.C of the Regulations in his care and treatment of Patients A - H and J - W, in or about 2012 and 2013, in that:

a. Prior to performing or instructing, authorizing or allowing others to perform invasive procedures on or administer controlled substances to these patients, Dr. Hagmann failed to obtain and/or record medical histories. Further, despite the fact that Dr. Hagmann was the only licensed health care provider at the DMI courses he offered, during some procedures Dr. Hagmann was not present, such as when Patient C was being sutured by course participants, as detailed in Paragraph 1(a)(iii).

b. Dr. Hagmann failed to monitor and/or record the monitoring of the patients' vital signs during the invasive procedures performed on them, and failed to maintain medical records for certain procedures, as follows:

i. During an OEMS/PCC course conducted at Dr. Hagmann's training facility in Partlow, Virginia, from approximately July 5-8, 2013:

- Patient A's Foley catheterization, as detailed in Paragraph 1(a).
- Patient B's Foley catheterization, as detailed in Paragraph 6(b).
- Patient C's FAST I sternal intraosseous infusion, as detailed in Paragraph 1(a).

ii. During an OEMS/PCC course conducted in the United Kingdom in or about July 2012:

- Patient D's Foley catheterization and IV treatment, as detailed in Paragraphs 1(b) and 2(b).
- Patient E's Foley catheterization, as detailed in Paragraph 1(b).

iii. During an OEMS/PCC course conducted in Pink Hill, North Carolina in or about July 2013:

- Patient H's penile nerve block, as detailed in Paragraph 2(d).

c. Regarding Patients F, G, H and W, Dr. Hagmann failed to provide follow-up care subsequent to their intoxication or adverse reactions caused by the administration of ketamine after consuming alcohol, as detailed in Paragraph 2.

d. Regarding Patients J, K, L, M, N, O, P, Q, R, S and T, Dr. Hagmann failed to record patient information regarding the administration, in or about July 2013, of "altitude" medications to these patients, to include Diamox, Viagra, prednisone and/or dexamethazone, including the medical indication for administration and the effects that these medications had on these patients, detailed above in Paragraph 2(f).

e. Regarding Patients F, K, R, U, V and W, listed in Dr. Hagmann's July 2013 dispensing logs for ketamine, lorazepam and midazolam, he failed to record patient information regarding the administration of these medications to these patients, including the medical indication for administration and the effect that these medication had on these patients.

9. Dr. Hagmann may have violated Sections 54.1-2915.A(3), (13), (16), (17) and (18), 54.1-3303.A and 54.1-3408.A of the Code and 18VAC85-20-26.C of the Regulations regarding Patient X, a 45-year-old male (as of March 17, 2005), who he treated, by his own admission, for pain management from approximately March 17, 2005 - February 19, 2014 at his Partlow,

Virginia course facility, at his Gig Harbor, Washington residence and/or telephonically, as follows:

- a. Despite the fact that Dr. Hagmann's initial March 17, 2005 medical record for Patient X, a Virginia resident, indicates that the patient requested on this date "refills of chronic medications for frequent episodes of paraspinous muscle spasm," as well as of Viagra, and that, on or about that date, he prescribed the patient Percocet (C-II), Viagra, baclofen (C-VI) and chlordiazepoxide (C-VI), Dr. Hagmann's medical record fails to note any related examinations, consultation findings or adequate rationale to support such prescribing.
- b. Beginning with Patient X's initial visit on or about March 17, 2005 and continuing through in or about February 2014, Dr. Hagmann failed to record the patient's blood pressure, weight, and other standard vitals, and failed to consistently perform and/or document adequate physical assessments and examinations of Patient X. Over the course of approximately nine (9) years, there are references in his treatment records to physical examinations on only three occasions: January 21 and June 21, 2008, wherein on both occasions Dr. Hagmann noted "Full PE WNL" and "Mild L lumbar paraspinous spasm not symptomatic but visible and palpable;" and May 12, 2012, wherein Dr. Hagmann noted: "Complete PE performed. NL. No neuro deficit, but spasm. "
- c. Despite the fact that Dr. Hagmann referred in his medical record to Patient X's back surgeries (April 2009 and September 2013) and physical therapy (January/February 2014) and noted this treatment in his statement to the Virginia Department of Health Professions' investigator, he failed to consult or coordinate the patient's care and treatment with other treatment providers.

d. Despite the fact that Dr. Hagmann treated Patient X for pain management for approximately nine years, prescribing him Percocet, chlordiazepoxide, tramadol (C-VI) and/or Mobic (C-VI), he failed to develop a comprehensive treatment plan and/or to adequately review and monitor the efficacy of Patient X's treatment, including monitoring and managing Patient X's usage of narcotic and benzodiazepine medications. Specifically:

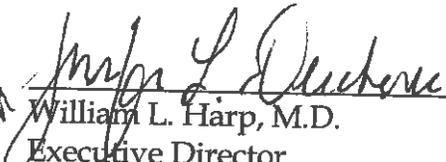
i. Dr. Hagmann failed to employ pain rating scales or other appropriate measures to determine the effect of prescribed medications on Patient X's activities of daily living.

ii. Dr. Hagmann did not have a pain management or similar contracts in place with Patient X, for whom he regularly prescribed narcotic and benzodiazepine medications.

iii. Dr. Hagmann failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether Patient X was taking his medications as prescribed and was otherwise compliant with his medication regimen. Further, despite the fact that Dr. Hagmann purported to "have assumed the role of medication 'gatekeeper'" for Patient X, he failed to consult or coordinate the patient's prescribed pain medication with other providers and/or record prescriptions from other providers in his medical record, which resulted in the patient obtaining approximately 330 dosage units of Percocet, 15 dosage units of hydromorphone (C-II) and 90 dosage units of hydrocodone-acetaminophen (Vicodin C-III) from approximately November 23, 2013 – January 23, 2014.

Please see Attachment I for the names of the patients and individuals referenced above.

FOR THE BOARD

for 

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

DATE: 3/12/2015