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**BEFORE THE STATE OF WISCONSIN
MEDICAL EXAMINING BOARD**

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
BARRY L. ROGERS, M.D., and	:	
MICHAEL E. TIEMAN, M.D.,	:	
RESPONDENTS	:	

The parties to this proceeding for the purposes of Wis. Stats., sec. 227.53 are:

Barry L. Rogers, M.D.
818 Inlet Road
Green Lake, Wisconsin 54941

Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, Wisconsin 53708

Dept. of Regulation & Licensing
1400 East Washington Avenue
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A hearing was held in the above-captioned matter on October 30-31, 1989, and on November 2, 1989. The respondent, Barry L. Rogers, M.D., appeared in person and by his attorneys, Bradway A. Liddle, Jr., and Richard Schmidt, Law Offices of Boardman, Suhr, Curry & Field. Judith Mills Ohm appeared on behalf of the complainant, Department of Regulation & Licensing, Division of Enforcement. Written arguments were submitted by the parties after the hearing in accordance with the briefing schedule established by the examiner. The hearing in the disciplinary proceeding filed against Michael E. Tieman, M.D., was held on March 20-21, 1989, and a proposed decision relating to that matter was filed with the Medical Examining Board on April 5, 1990.

Based upon the record herein, the examiner recommends that the Medical Examining Board adopt as its final decision in this matter, the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The respondent herein, Barry L. Rogers, M.D., 818 Inlet Road, Green Lake, Wisconsin, is a physician duly licensed and currently registered to practice medicine and surgery in the State of Wisconsin, pursuant to license #24248, which was granted on October 23, 1981.
2. Barry L. Rogers, M.D., respondent herein, specializes and is certified in general surgery. Respondent engages in the practice of medicine in Berlin and Ripon, Wisconsin.

3. Respondent herein, Barry L. Rogers, M.D., provided medical care and treatment for Cheryl M. Griggel from August 25, 1983, to September 7, 1983, at Berlin Memorial Hospital, Berlin, Wisconsin.

4. Cheryl M. Griggel, age 33, was admitted to Berlin Memorial Hospital, Berlin, Wisconsin, on August 25, 1983, for the delivery of her third baby. At the time of her admission, Ms. Griggel was employed as a nurse in the intensive care unit at Berlin Memorial Hospital. The patient was admitted to the hospital by her family physician, Dr. William C. Piotrowski. Dr. Rogers, respondent herein, assumed primary responsibility for the care of the patient.

5. On August 26, 1983, Dr. Rogers, assisted by Dr. Piotrowski, performed a transverse lower uterine segment Caesarean section on the patient, Cheryl M. Griggel, and delivered a viable, male infant. The patient's previous deliveries had also been by Caesarean section. Dr. Rogers stated in the operative report dated August 26, 1983, that the patient tolerated the procedure well and was returned to recovery in satisfactory condition. Dr. Rogers did not document any complications relating to the operation.

6. On August 26, 1983, the patient was afebrile and all other vital signs were stable. On August 26, the patient was given 4 doses of 75 mg. meperidine. A TENS unit was employed to alleviate pain.

7. On August 27, 1983, the first postoperative day, the patient was afebrile and all other vital signs were stable. On August 27, the patient was given 6 doses of 75 mg. Demerol. A TENS unit was employed to alleviate pain.

8. Dr. Rogers recorded in the progress notes for August 27, the following information regarding the patient: Lungs clear. Wound looks good. Moderate uterine cramping. No headache.

9. The nurses' notes for August 27, indicated that the patient was nauseated and complained of uterine cramps, back pain and gas pains.

10. On August 28, 1983, the second postoperative day, the patient was afebrile and all other vital signs were stable. On August 28, the patient was given 4 doses of 75 mg. Demerol, 2 doses of 60 mg. codeine, 1 dose of 5 mg. Valium and 1 dose of 10 mg. Valium for pain. A TENS unit was employed to alleviate pain.

11. Dr. Rogers' progress notes for August 28, stated regarding the patient: Abdomen slightly distended. Bowel sounds - tinkles. Lungs clear

12. On August 28, Dr. Piotrowski recorded the following information in the progress notes: Severe gas pains. Patient has aerophagia even when feeling well... Will pass NG tube - will keep in only temporarily to relieve aerophagia induce gas pain.

13. The nurses' notes for August 28, indicated that at or around 12:30 a.m., the patient had "severe gas pains"; at or around 1:20 a.m., the patient was "crying with pain", "extremely nauseated", and continued to have "gas pains"; at or around 2:00 a.m., the patient's abdomen was "greatly distended"; at or around 7:30 a.m., the patient complained of severe gas pains, her abdomen was "distended, tender to palpation and very firm" and the patient had "bowel sounds present"; at or around 11:00 a.m., the patient was "resting comfortably"; at or around 12:25 p.m., the patient was "unable to breathe. Very agitated."; at or around 6:45 p.m., that the patient "feels better ... abdomen soft"; and at or around 11:05 p.m., the patient complained of "abdominal discomfort" and the patient's abdomen was "soft and less distended".

THIRD POSTOPERATIVE DAY

14. On August 29, 1983, the third postoperative day, at or around 7:45 a.m., Dr. Rogers recorded the following in the progress notes regarding the patient: Left shoulder pain and abdominal pain with dyspnea; mild tachypnea, mild tachycardia... Lungs clear, abdomen soft. Will check chest x-ray - if clear, recheck ABG, if still hypoxemic, then proceed with lung scan.

15. The nurses' notes for August 29, indicated that at or around 12:05 a.m., 4:00 a.m., 6:30 a.m., and 10:15 a.m., the patient's abdomen was tender and/or distended; that during the morning the patient was unable to take deep breaths, and that at or around 3:05 a.m., 6:30 a.m., and 9:50 a.m., the patient complained of left shoulder pain and/or of abdominal pain.

16. A perfusion lung scan and x-rays (chest, PA and lateral) were taken for the patient, at or around 8:00 a.m., on August 29. The results of the perfusion lung scan indicated a normal lung scan. The chest, PA and lateral x-ray report stated: Chest, PA and lateral is compared to a previous examination of September 14, 1982. Films were taken more in expiration, since the patient could not take a deep breath, both diaphragms are elevated and there is crowding of the vessel markings at both bases. There is no evidence of infiltrate.... When compared to the old exam there has been no interval changes.

17. Two films (PA) of the chest x-rays taken for the patient on August 29, can be interpreted as showing no free air, and one film (lateral) can be interpreted as showing no free air, or at the very most, a minimal amount of free air.

18. Dr. Piotrowski's progress notes, at or around 7:20 p.m., stated the following regarding the patient: Better. Lung scan negative. Stop all constipatory and addicting drugs, if possible.

19. On August 29, 1983, the patient was given 4 doses of 75 mg. Demerol, 3 doses of 60 mg. codeine, and 3 doses of 5 mg. Valium for pain. A TENS unit was employed to alleviate pain. The patient's vital signs on August 29, 1983, as recorded in the patient's chart were as follows:

<u>Time</u>	<u>Temperature</u>	<u>Blood Pressure</u>	<u>Pulse (approx.)</u>
4:00 a.m.	99	150/76	99
Noon	100.8	120/52	95
8:00 p.m.	100.6	120/58	105

FOURTH POSTOPERATIVE DAY

20. On the morning of August 30, 1983, the fourth postoperative day, Dr. Rogers recorded the following information in the progress notes regarding the patient: Afebrile - feeling better except for occasional gas cramps. Lungs clear. Abdomen soft - active - bowel sounds. Wound looks good. ... Impression: Gradual improvement.

21. On the morning of August 30, 1983, Dr. Piotrowski recorded the following information in the progress notes regarding the patient: "Improved. However - bilateral shoulder pain this a.m." The nurses' notes for August 30, stated that the patient complained of right and left shoulder pain; that at or around 6:00 a.m., the patient "slept well"; at or around 9:40 a.m., the patient was "screaming out" with pain; at or around 10:30 a.m., the patient complained of "some nausea"; at or around 10:15 a.m., 12:00 p.m., 3:00 p.m., 4:20 p.m., and 8:25 p.m., the patient was "crying out; and that at or around 12:00 p.m., 3:00 p.m., and 11:30 p.m., the patient's abdomen was distended.

22. A KUB (kidney, ureter, bladder) portable x-ray was taken for the patient on August 30, 1983, at or around 11:15 a.m., as ordered by Dr. Rogers. The x-ray report stated, in part: "Air is seen in the large bowel and multiple small bowel loops which are normal in diameter. The stomach is seen to be distended with gas. ... Impression: Findings of unspecific ileus. The stomach is rather markedly distended. ... "

23. On August 30, 1983, Dr. Rogers' progress notes, at or around 11:30 a.m., stated the following regarding the patient: Extremely agitated. Gasping, swallowing lots of air. Bowel sound tinkling without rushes. No tenderness when distracted. KUB - stomach and small bowel filled with air. Impression: hysterical reaction to pain

24. On August 30, the patient was given 275 mg. of anaprox, 2 doses of 5 mg. Valium and 1 dose of 2.5 mg. methadone. A TENS unit was employed to alleviate pain. The patient's vital signs, as recorded in the patient chart were as follows:

<u>Time</u>	<u>Temperature</u>	<u>Blood Pressure</u>	<u>Pulse (approx.)</u>
4:00 a.m.	96.2	86/56	65
Noon	101.4	130/74	100
8:00 p.m.	98.4	98/40	100
Midnight	98	116/60	115

25. At or around 5:30 p.m., on August 30, 1983, Dr. Rogers' progress notes stated regarding the patient: Patient distended, extremely distraught. Occasional bowel sounds. Abdomen soft, tho great deal of voluntary guarding. Asking for narcotics and IV Valium to knock her out. Impression: Severe aerophagia, ileus. Large functional overlay. ... Will check KUB.

26. A KUB and an upright abdomen x-ray were taken for the patient at or around 5:30 p.m. The x-ray report stated: Large amounts of free peritoneal air are present. Air is seen in multiple small bowel loops which are not definitely distended. There is no air seen in the rectum.

27. Some of the films of the abdominal x-rays taken for the patient on August 30, can be interpreted as showing large amounts of free intraperitoneal air.

28. Dr. Rogers saw the patient on August 30, at or around 7:15 p.m. Dr. Rogers recorded in the progress notes that the patient's temperature was 98.4 degrees; the patient's blood pressure was 94/70; the patient's pulse was 96, and that the KUB showed marked intraperitoneal air. The progress notes also indicated that Dr. Rogers performed a paracentesis on the patient, at or around 7:15 p.m. Dr. Rogers indicated in the progress notes regarding the paracentesis, that there was rapid deflating of the abdomen; there was no odor to the escaping air, and that there was no fluid from the abdomen. The progress notes further stated: Abdomen soft. Minimum tenderness - no guarding and patient resting quietly with easy respiration. ... Impression - will follow white count and temperature closely for evidence of intraperitoneal infection/possible bowel perforation tho none apparent at present.

29. The patient's white blood count, at or around 8:00 p.m., was 11,500 with 65 bands and 30 segs. A white count value of 11,500 with 65 bands and 30 segs, is an elevated white blood count. At some point in time during the morning of August 30, the patient's white blood count was 3,300 with 1 band and 81 segs. A white blood count value of 3,300 with 1 band and 81 segs, is a low white count value.

30. An abdomen, portable cross table lateral x-ray was taken for the patient on August 30, 1983, at or around 8:50 p.m., as ordered by Dr. Rogers. The x-ray report stated: When compared to the previous exam, again reveals large amounts of free intraperitoneal air.

31. On August 30, 1983, at or around 10:00 p.m., Dr. Rogers gave a telephone order for medication, and at or around 11:30 p.m., the respondent gave a verbal order for medication.

32. At some point in time, on August 29, or August 30, 1983, the patient suffered a perforated viscus.

33. The risks to a patient if a patient suffers a perforation is peritonitis, and if the peritonitis is not treated, the risk is death.

34. On August 30, 1983, while providing medical care and treatment for Cheryl M. Griggel, Dr. Rogers, respondent herein, did not diagnose that the patient had suffered a perforation; the respondent did not assess the patient with diagnostic procedures to rule out a perforation, other than a paracentesis, and the respondent did not perform abdominal surgery.

FIFTH POSTOPERATIVE DAY

35. On August 31, 1983, the fifth postoperative day, Dr. Rogers saw the patient at or around 4:30 a.m. Dr. Rogers recorded in the progress notes: "Much quieter. Abdomen less distended, soft, nontender when distracted. Will recheck white blood count, KUB and amylase in a.m. Shift may be margination." Dr. Rogers did not examine the patient again until September 1, 1983.

36. On August 31, 1983, at or around 4:30 a.m., Dr. Rogers ordered that an amylase be done with the "a.m. blood work", and at or around 12:20 a.m., and 5:45 a.m., he gave telephone orders for medication for the patient.

37. The patient's white blood count, taken at or around 6:00 a.m., was 18,100 with 39 bands and 56 segs. A white count values of 18,100 with 39 bands and 56 segs, is an elevated white blood count.

38. A KUB x-ray (abdomen, cross table lateral) was taken for the patient on August 31, 1983, at or around 7:30 a.m. The x-ray report stated: When compared to the previous exam, large amounts of free intraperitoneal air are still present.

39. The nurses' notes for August 31, indicated that at various times between 12:00 a.m., and 8:00 a.m., the patient's abdomen was distended and soft, and that the patient complained of abdominal pain and discomfort; that at or around 5:30 a.m., the patient "complained of being unable to breathe"; was taking "rapid shallow breaths"; requested pain medication, and that the patient stated "even the tightening of B.P. cuff makes abdomen hurt". The nurses' notes further stated, at or around 6:30 a.m., that the patient continued "to guard abdomen"; at or around 10:30 a.m., the patient appeared "comfortable - abdomen soft and non-distended"; at or around 1:50 p.m., the patient appeared "slightly tense & agitated"; at or around 2:30 p.m., the patient was "reluctant to move", and that between 6:00 p.m., and 8:30 p.m., and at or around 10:00 p.m., the patient complained of "left side pain and left shoulder pain".

40. On August 31, 1983, Michael E. Tieman, M.D., provided medical care and treatment for Cheryl M. Griggel at Berlin Memorial Hospital, at the request of Dr. Rogers. Dr. Tieman is a general surgeon.

41. The nurses' notes for August 31, indicated that at or around 8:00 a.m., the nursing staff communicated with Dr. Tieman regarding the patient, and that Dr. Tieman saw the patient at or around 9:00 a.m., and between 3:30 and 5:30 p.m., on August 31.

42. At or around 9:00 a.m., on August 31, 1983, Dr. Tieman saw the patient, Cheryl M. Griggel. Dr. Tieman recorded the following information in the progress notes regarding the patient: "Complains of pain in abdomen when taking breath - no chest pains or shortness of breath. Temperature 98.6 degrees consistently, vital signs stable ... Abdomen distended - quiet ... White blood count 18,100 with 56 segs and 39 bands. Amylase - 137. KUB ---". Dr. Tieman wrote an order for medication for the patient at or around 10:00 a.m.

43. On August 31, 1983, the patient was given 4 doses of 2.5 mg. methadone, and 1 dose of 25 mg. Thorazine for pain on August 31. A TENS unit was employed to alleviate pain. The patient's vital signs were as follows:

<u>Time</u>	<u>Temperature</u>	<u>Blood Pressure</u>	<u>Pulse (approx.)</u>
3:30 a.m.	98.8	138/62	100
Noon	98	112/60	110
8:00 p.m.	100.4	116/60	120

44. On August 31, Dr. Piotrowski recorded the following information in the progress notes regarding the patient: ... Very difficult functional problems aggravating physical problems.

SIXTH POSTOPERATIVE DAY

45. On September 1, 1983, the sixth postoperative day, Dr. Rogers recorded the following information in the progress notes regarding the patient: Persistent temperature spikes without chill or diaphoresis. Lungs clear. Abdomen distended - sore but not rigid... Impression: Slightly improved - look for source of fever. Dr. Rogers' progress note at 5:30 p.m., stated: Still moderate discomfort, tho improving. Abdomen distended but no peritoneal signs. Bowel sounds - active ... Impression - slightly improved. Dr. Rogers' progress note at 9:00 p.m., stated, in part: After demerol much more composed ... Abdomen soft tho very sore - she states all pain in muscle wall - no pelvic or uterine pain ... Impression - atelectasis - left lung ...

46. Chest x-rays (PA and lateral) were taken for the patient as ordered by Dr. Rogers. The x-ray report stated, in part: As compared to a previous exam of 8/29/83. There is free intraperitoneal air under both diaphragms... Both diaphragms are elevated and there is crowding of the vascular markings at both bases and some streak atelectasis at the left base. The costophrenic angles are sharp and there is no evidence of an infiltrate... the pulmonary vessels are unremarkable. Impression: Evidence of free intraperitoneal air, minimal streak atelectasis at the left lung base. No evidence of an infiltrate.

47. The chest x-rays (PA and lateral) taken for the patient on September 1, 1983, can be interpreted as showing free air.

48. On September 1, 1983, the patient's temperature at or around 4:00 a.m., was 101 degrees; at or around noon, 99.6 degrees; at or around 7:00 p.m., 103 degrees, and at or around midnight, 101 degrees. At or around noon the patient's pulse was 100; at or around 6:00 p.m., 140, and at or around 11:00 p.m., 110. The patient's blood pressure reading, at or around 4:00 a.m., was 126/62; at or around 8:00 p.m., 118/58 and at or around midnight, 132/70.

49. The nurses' notes for September 1, stated regarding the patient that, at or around 3:30 a.m., the patient continued to complain of "shoulder discomfort"; at or around 6:00 a.m., "complained of left shoulder discomfort", abdomen "soft, only slightly distended", and "occasional bowel sounds heard"; between 7:00 a.m. and 11:00 a.m., the patient was "comfortable", and did not request medication; at or around 12:30 p.m., the patient complained of "severe gas pain", patient's abdomen "slightly distended"; at or around 3:30 p.m., "patient's spirits up"; at or around 6:30 p.m., "needs encouragement to move", and at or around 11:00 p.m., "sleeping soundly".

50. On September 1, the patient was given 3 doses of 2.5 mg. methadone, 2 doses of 25 mg. Thorazine and 1 dose of 100 mg. Demerol for pain and/or for agitation. A TENS unit was employed to alleviate pain. The patient's white blood count was not taken on September 1.

SEVENTH POSTOPERATIVE DAY

51. On September 2, 1983, the seventh postoperative day, Dr. Rogers recorded the following information in the progress notes regarding the patient: Afebrile. Vital signs stable. Feels much better - good attitude ... Abdomen distended but much softer... minimum tenderness ... white blood count normal.. Impression - much improved - continue IVs, sips liquid.

52. The nurses' notes for September 2, stated regarding the patient that, at or around 12:00 a.m., "moves slowly"; at or around 3:00 a.m., "patient comfortable"; at or around 7:30 a.m., "moves about slowly but more comfortably"; at or around 4:00 p.m., "complained of pain"; at or around 8:15 p.m., "appears fairly comfortable"; at or around 9:15 p.m., "complains of pressure in abdomen"; at or around 10:25 p.m., "abdomen very distended ... upper abdomen soft and tender to touch. Lower abdomen more firm. Bowel sounds present"; and at or around 11:30 p.m., "complained of pain".

53. The patient's white blood count on September 2, was 5,800 with 15 bands and 64 segs. The patient's temperature ranged from, at or about 98.4 degrees to at or about 99 degrees. The patient's blood pressure readings were 120/62, at or around 8:00 a.m.; 120/60, at or around noon, and 124/60 at or around 8:00 p.m. There were no x-rays taken for the patient on September 2.

54. On September 2, the patient was give 1 dose of 75 mg. Demerol, 1 dose of 25 mg. Demerol, 1 dose of 25 mg. Thorazine, and 1 dose of 275 mg. anaprox for pain and discomfort. A TENS unit was employed to alleviate pain.

55. Michael E. Tieman, M.D., provided medical care and treatment for the patient on September 3, 1983 and September 4, 1983. Dr. Rogers was away from the hospital because of personal reasons.

56. On September 3, 1983, the eighth postoperative day, Dr. Tieman recorded the following information in the progress notes regarding the patient: Feeling some better... Afebrile, vital signs stable - chest clear ... Abdomen moderately distended - bowel sounds present... Plan: increase activity, add potassium to IV fluids....

57. On September 3, the patient's temperature spiked at 100.4 degrees, at or around noon. The patient's blood pressure reading was 120/58, at or around 8:00 a.m.; 128/50, at or around 4:00 p.m., and 130/64, at or around midnight. The patient's white blood count was not taken on September 3, and there were no x-rays taken for the patient.

58. On September 3, the patient was given 1 dose of 25 mg. Thorazine, 1 dose of 275 mg. anaprox, and 2 doses of 25 mg. Demerol for pain and agitation. A TENS unit was employed to alleviate pain.

59. On September 4, 1983, the ninth postoperative day, Dr. Tieman recorded the following information in the progress notes regarding the patient: Feeling a little better ... Afebrile, vital signs stable... Abdomen still distended - soft and nontender... Bowel sounds active ... Plan: Mycostatin. Clear liquids, discontinue IV and TENS....

60. The patient's temperature was below normal most of the day. The patient's blood pressure reading, at or around 4:00 a.m., was 134/60; at or around noon, 130/58, and at or around 8:00 p.m., 112/66. The patient's white blood count was not taken on September 4, and there were no x-rays taken for the patient. The patient was given 1 dose of 275 mg. anaprox, 3 doses of 25 mg. Thorazine, and 1 dose of 25 mg. Demerol for pain and agitation.

61. The nurses' notes for September 4, stated regarding the patient that, at or around 9:50 a.m., 4:30 p.m., and 6:40 p.m., the patient's abdomen was distended and/or bowel sounds were present; at or around 5:30 p.m., 7:30 p.m., and 10:40 p.m., the patient complained of "gas pains"; and that at or around 9:50 a.m., 1:30 p.m., 4:30 p.m., 6:00 p.m., 8:00 p.m., and 10:40 p.m., the patient was up walking with assistance. The nurses' notes also indicated that at or around 10:45 p.m., Dr. Rogers was notified of the patient's "increased abdominal distension", and that "orders were taken". The physician orders contained in the patient chart indicates that Dr. Rogers gave an order at or around 10:45 p.m.

TENTH POSTOPERATIVE DAY

62. On September 5, 1983, the tenth postoperative day, Dr. Rogers resumed primary responsibility for the care and treatment of the patient.

63. On September 5, chest x-rays (PA and lateral) were taken for the patient. The x-ray report stated: A large amount of indistinct density is noted adjacent to the elevated left hemidiaphragm. This has increased in extent since the prior study of 9/1/83. Free intraperitoneal air is again seen beneath both hemidiaphragms. Additional densities are noted in the perihilar regions, and could represent early pulmonary edema, or subsegmental atelectasis. Clinical correlation is requested.

64. On September 5, several abdominal x-rays were taken for the patient. The supine and erect abdomen x-ray report stated: The massive amount of free intraperitoneal air is again visualized. Several other air-distended loops of small and large bowel are also apparent, which have associated air fluid levels. The abnormal gastrointestinal findings obscure the visceral outlines. The cross table lateral abdomen x-ray report stated: There is a massive amount of free intraperitoneal air. In addition, there are copious air fluid levels associated with gaseous distention of small and large bowel loops

65. The patient's temperature was below normal on September 5. At some point in time during the day, the patient's white blood count was 15,200 with 45 bands and 42 segs. The patient was given 1 dose of 275 mg. anaprox, at or around 1:00 a.m., 1 dose of 25 mg. Thorazine, at or around 2:00 a.m., and 1 dose of 275 anaprox, at or around 1:20 p.m.

66. Dr. Rogers' progress notes for 4:00 p.m., stated the following regarding the patient: Seen this morning ... massive abdominal distension and rales ... x-ray - large air fluid level ... WBC 15,000s with some shift. Temperature subnormal, though pulse strong. Blood pressure 120/80. Abdomen wall tender in epigastrium tho not rigid and no tenderness laterally. Impression: Persistent intraperitoneal air with large amounts of probable 3rd space fluid. Will tap air and fluid for abdomen to allow better pulmonary toilet for suspected pneumonia, and for culture to be sure not missing a low grade peritonitis from an occult gastric perforation.

67. On September 5, 1983, at or around 4:30 p.m., Dr. Rogers performed a paracentesis on the patient. The operative report stated, in part, that there was "prompt return of foul liquid, green material. A total of approx. 1200 cc was drained out as well as a marked amount of gas. Gram stain showed poly-microbial infection, gram positive cocci and rods, and gram negative rods."

68. On September 5, at or around 7:20 p.m., Dr. Rogers performed a "right hemicolectomy with endileostomy and mucous fistula". The operative report dictated by Dr. Rogers on September 5, 1983, indicated that at the conclusion of the operation, the patient was in serious but stable condition; that the preoperative diagnosis was perforated viscus, and that the postoperative diagnosis was "perforation of cecum on antimesenteric border with thrombosis of pericecal veins with diffuse peritonitis and multiple loculated areas of fluid".

69. On September 6, 1983, the eleventh postoperative day, a portable supine chest x-ray was taken for the patient, at or around 12:10 a.m. The x-ray report stated that the findings were consistent with pulmonary edema, or possibly wide-spread subsegmental atelectasis. The report indicated that the findings had deteriorated considerably since the prior study. A portable chest x-ray was taken for the patient at or around 6:45 a.m. The x-ray report indicated that pulmonary edema was suspected and that some subsegmental atelectasis persisted within both lower lung fields.

70. At or around 3:30 a.m., the patient's white blood count was 10,100 with 64 bands and 35 segs. The patient's temperature spiked at 100.2 degrees, at or around 11:00 a.m.

71. At or around 4:45 p.m., a portable chest x-ray was taken for the patient. The x-ray report indicated that the pulmonary findings had worsened considerably in the interval since the prior study earlier on the same date.

72. At or around 10:30 p.m., Dr. Rogers recorded the following information in the progress notes regarding the patient: "Impression -- suspect ARDS with gases, chest x-ray with clinical history. Feel patient will need prolonged ventilation and may be difficult to wean. Will transfer to Madison per mobile ICU in a.m., unless significantly improved". The discharge report dictated by Dr. Rogers on September 6, 1983, stated that the patient's "respiratory effort was poor and she could not be weaned from the ventilator". The report further stated that the patient was being transferred to the University of Wisconsin, because of "anticipated difficulty with weaning and suspected ARDS".

73. On September 7, 1983, the twelfth postoperative day, Dr. Rogers' progress note at 7:00 a.m., stated, in part: Temperature 100.4 degrees, blood pressure 110/50, pulse, 120-130 ... respiration shallow ... respiration much poorer ... white blood count 8,800. Dr. Rogers' progress note for 10:00 a.m., stated, in part: "Impression: serious but stable to slightly improved". At some point in time after 10:00 a.m., the patient was transferred to the University of Wisconsin Hospital and Clinics, Madison, Wisconsin, as ordered by Dr. Rogers.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to sec. 448.02 (3), Wis. Stats., and sec. MED 10.02 (2) (h) Wis. Adm. Code.

2. Respondent's conduct in providing medical care and treatment to Cheryl M. Griggel fell below the minimum standards of competence established by the medical profession, in that the respondent failed to timely and adequately diagnose and treat the patient for a perforated viscus.

3. Respondent's conduct in providing medical care and treatment to Cheryl M. Griggel posed an unacceptable risk to the patient which a minimally competent physician would have avoided or minimized.

4. Respondent's conduct in providing medical care and treatment to Cheryl M. Griggel is practice and conduct which tend to constitute a danger to the health, welfare and safety of the patient, and therefore, constitutes unprofessional conduct as defined in sec. 448.02 (3) Wis. Stats., and sec. MED 10.02 (2)(h) Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the respondent herein, Barry L. Rogers, M.D., be and hereby is **REPRIMANDED**.

IT IS FURTHER ORDERED that the license of Barry L. Rogers, M.D., be and hereby is, limited for a period of one year on the following terms and conditions:

1. Respondent shall participate in and successfully complete 30 hours of continuing medical education in the subject area of postoperative complications, satisfactory to the Board, in addition to the continuing medical education otherwise required by law. Respondent shall submit a copy of each course curriculum to the Medical Examining Board for its approval.
2. Respondent shall provide to the Medical Examining Board, within 12 months of the effective date of this Order, evidence of participation in and completion of the continuing medical education programs referred to in par. #1 above.
3. Respondent shall be supervised by a physician to be appointed by the Board, in regards to his postoperative care and treatment of his patients. Respondent shall meet with the supervising physician every three months for purposes of permitting the supervising physician to examine the respondent's medical records and to review the postoperative care provided by the respondent to his patients. The supervising physician shall submit detailed reports to the Board every three months regarding his/her review of the respondent's medical records and practice.
4. Respondent shall permit the supervising physician referred to in par. #3, above, to observe the respondent in his practice, if the supervising physician deems it necessary, and the physician shall work with the respondent to apprise respondent of aspects of respondent's practice that could use improvement in terms of diagnosing and treating postoperative complications.
5. The supervising physician referred to in par. #3 and #4, above, shall report to the Board any deficiencies in the respondent's practice which are found during the physician's review of the respondent's practice. The Board will determine, with regard to any deficiencies discovered by the supervising physician, if further investigation of the reported deficiency is warranted, and whether the review of the respondent's practice should be extended beyond the one year period.
6. Respondent shall appear before the Medical Examining Board, at the option of the Board, for an oral exam on the subject area of postoperative complications, at or prior to, the end of the one year license limitation period.

IT IS FURTHER ORDERED that the respondent's motion to dismiss this action, be and hereby is, **DENIED**

This order is effective 30 days after signing by the Medical Examining Board, or its designee.

OPINION GUIDE

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OPINION

I. GENERAL OVERVIEW

The Complaint filed in this matter alleges that Dr. Rogers engaged in unprofessional conduct in that the medical care and treatment which the respondent provided for Cheryl M. Griggel constituted a danger to the health, welfare and safety of the patient, in violation of sec. 448.02 (3) Wis. Stats., and sec. MED 10.02 (2)(h) Wis. Adm. Code.

The evidence presented at the hearing consisted of the testimony of four witnesses and the information contained in 19 Exhibits. Dr. Charles Aprahamian testified at the request of the complainant, and Drs. J. David Lewis and Sanford Mackman testified at the request of the respondent. Dr. Rogers testified as an adverse witness during the presentation of the complainant's case, and he testified on his own behalf during the presentation of his defense.

Exhibits #1-19 were introduced by the complainant. Exhibit #1 is a copy of the patient's medical chart, Exhibits #2-18 are copies of x-ray films taken for the patient during her hospitalization at Berlin Memorial Hospital in August, 1983, and Exhibit #19 is a copy of Dr. Charles Aprahamian's curriculum vitae.

II. FACTUAL ANALYSIS

The findings of fact are based primarily upon the patient's medical records, which consist of the patient chart (Ex. #1), and copies of x-ray films (Exs. #2-18). Several findings are based, in part, upon the testimony of Dr. Rogers (FF: 2,3,4,27,32,37,40). Additional findings are based, in part, upon the testimony of Dr. Aprahamian, Dr. Lewis and/or Dr. Mackman (FF: 17,27,29,32,33,34,37,47).

The evidence presented at the hearing indicates that on August 25, 1983, Cheryl M. Griggel was admitted to Berlin Memorial Hospital for the delivery of her third baby. On August 26, 1983, Dr. Rogers, assisted by Dr. Piotrowski, performed a transverse lower uterine segment Caesarean section on the patient and delivered a viable, male infant. Dr. Rogers did not document any complications relating to the operation.

The first two postoperative days, the patient was afebrile and her vital signs were stable. The patient was given medication and a TENS unit was employed to alleviate pain.

Third Postoperative Day

On the morning of August 29, the third postoperative day, the patient complained of left shoulder pain and of abdominal pain. According to Dr. Rogers' progress notes for August 29, the patient was in pain and was having breathing difficulties. The progress notes stated regarding the patient's condition: "left shoulder pain and abdominal pain with dyspnea, mild tachypnea and mild tachycardia". The results of a perfusion lung scan taken for the patient on August 29, indicated a normal lung scan. The chest, PA and lateral x-rays taken for the patient did not show changes in the patient's condition when compared to a previous examination of the patient on September 14, 1982. According to Dr. Aprahamian (Tran. p.65-66) and Dr. Mackman (Tran. p.252,256), the films of the chest x-rays taken for the patient on August 29, can be interpreted as showing no free air or at the most minimal free air.

The patient's temperature on August 29, spiked at 100.8 degrees around noon and remained elevated to approximately 100.6 degrees throughout the afternoon. The patient was given medication for pain throughout the day.

Fourth Postoperative Day

On the morning of August 30, 1983, the fourth postoperative day, the patient showed signs of gradual improvement; however, the patient continued to experience left shoulder pain and in addition, right shoulder pain. The patient also complained of abdominal pain. According to the nurses' notes the patient's abdomen was distended and soft to touch.

A KUB x-ray was taken for the patient around 11:15 a.m. The x-ray report indicated that there was air in the large bowel and that the stomach was markedly distended with gas. The x-ray report also indicated findings of "unspecific ileus". (Exhibit #1, p.151).

Around 11:30 a.m., on August 30, Dr. Rogers indicated in his progress notes that the patient was extremely agitated, gasping and swallowing lots of air, and that the KUB showed the patient's stomach and small bowel were filled with air. Dr. Rogers recorded his impression in the progress notes, indicating that the patient was having a "hysterical reaction to pain".

The patient's temperature on August 30, spiked at 101.4 degrees at or around noon. The patient was given medication for pain throughout the day. Dr. Rogers recorded in the progress notes at or around 5:30 p.m., "Impression: Severe aerophagia, ileus. Large functional overlay. ... Will check KUB".

A KUB x-ray was taken for the patient around 5:30 p.m. The KUB x-ray report indicated that there were large amounts of intraperitoneal air present in the patient's small bowel. (Exhibit #1, p.152).

Around 7:15 p.m., Dr. Rogers performed a paracentesis on the patient. The progress notes recorded by Dr. Rogers indicated that the patient's abdomen deflated rapidly; that the escaping air did not have an odor, and that there was no fluid from the abdomen. Dr. Rogers noted that the patient's white blood count and temperature would be followed closely for evidence of intraperitoneal infection/possible bowel perforation.

The patient's white blood count at some time during the morning of August 30, was 3,300 with 1 band and 81 segs. At or around 8:00 p.m., on August 30, the patient's white blood count was 11,500 with 65 bands and 30 segs. The lateral x-ray taken for the patient around 8:50 p.m., showed a large amount of free intraperitoneal air. According to the patient chart, Dr. Rogers gave orders for medication around 10:00 p.m., and 11:30 p.m. on August 30, 1983.

Based upon the evidence, the patient suffered a perforated viscus at some point in time on August 29, or August 30, 1983. The evidence establishes that the respondent did not diagnose on August 30, that the patient had suffered a perforation; the respondent did not assess the patient with diagnostic procedures to rule out a perforation, other than performing a paracentesis, and the respondent did not perform abdominal surgery on the patient.

Fifth Postoperative Day

On August 31, the fifth postoperative day, Dr. Rogers saw the patient at or around 4:30 a.m. Dr. Rogers recorded in the progress notes that the patient was "much quieter. Abdomen less distended, soft, nontender when distracted" Dr. Rogers also noted that a KUB x-ray, an amylase, and a test to determine the patient's white blood count values were to be completed sometime during the morning of August 31. Based upon the evidence presented at the hearing, Dr. Rogers did not examine the patient again until September 1. Dr. Rogers gave telephone order for medication for the patient around 12:20 a.m. and 5:45 a.m.

The patient's white blood count taken at or about 6:00 a.m., on August 31, was 18,100 with 39 bands and 56 segs. Based upon the evidence presented at the hearing, a white count value of 18,100 with 39 bands and 56 segs, is an elevated white blood count value. (Tran. p. 104,240). A KUB x-ray was taken for the patient around 7:30 a.m. The x-ray report indicated that there was a "large amount of intraperitoneal air still present". (Exhibit #1, p.153).

Dr. Michael E. Tieman saw the patient on August 31, around 9:00 a.m. Dr. Tieman reported in the progress notes that the patient complained of pain in her abdomen when taking deep breaths, and that she had no chest pains or shortness of breath. Dr. Tieman further stated in the progress notes that the patient had a temperature of 98.6 degrees consistently; the patient's abdomen was distended and quiet; the patient's vital signs were stable; the patient's white blood count was 18,100 with 56 segs and 39 bands and the amylase was 137. Dr. Tieman also wrote in the progress notes, the letters "KUB -----" (the line denotes an arrow pointing to the right), but he did not record any information in the progress notes relating to the KUB x-ray.

The nurses' notes for August 31, indicated that the nursing staff communicated with Dr. Tieman regarding the patient around 8:00 a.m., and that Dr. Tieman saw the patient at or about 9:00 a.m., and sometime between 3:30 and 5:30 p.m., on August 31, 1983.

Sixth Postoperative Day

Dr. Rogers' progress notes for September 1, indicate that the patient was slightly improved; that the patient's abdomen was distended; that there were no peritoneal signs present; that he would look for the source of the patient's fever, and that his impression was that the patient had atelectasis in her left lung.

The x-ray report for the chest x-rays taken on September 1, stated that, as compared to the chest x-rays taken on August 29, there is free intraperitoneal air under both diaphragms. According to Drs. Aprahamian, Lewis and Rogers, the September 1, chest x-rays can be interpreted as showing free air. (Ex.#1, p.154; Tran. p.47,77-78,214).

Seventh Postoperative Day

Dr. Rogers' progress notes for September 2, indicate that the patient was afebrile, felt much better, and was "much improved". Dr. Rogers noted that the patient's abdomen was distended but much softer, and that the patient's white blood count was normal. According to the patient chart, the patient's white blood count on September 2, was 5,800 with 15 bands and 64 segs. (Ex. 1, p.128). There were no x-rays taken for the patient.

On September 3 and September 4, Dr. Michael E. Tieman provided medical care and treatment for the patient; Dr. Rogers was on vacation on those two days.

Tenth Postoperative Day

On September 5, the patient's temperature was subnormal. At some point in time during the day, the patient's white blood count was 15,200 with 45 bands and 42 segs.

Several abdominal x-rays were taken for the patient on the morning of September 5. (Exhibits 15,16,18). Based upon the evidence presented at the hearing, the abdominal x-ray films can be interpreted as showing free air (Exhibit #1, p.155; Tran. p.80-81, 290-291). Some time during the day, before 4:00 p.m., several chest x-rays were taken for the patient (Exhibits 14,17). Based upon the evidence, the films of the chest x-rays can be interpreted as showing free air. (Exhibit #1, p.155; Tran. p.80-81, 289).

Dr. Rogers' progress notes for September 5, indicate that the patient had persistent intraperitoneal air, and that he was going to "tap air and fluid for abdomen to allow better pulmonary toilet for suspected pneumonia, and for culture to be sure not missing a low grade peritonitis from an occult gastric perforation". (Tran. p.41,42).

Dr. Rogers performed a paracentesis at or around 4:30 p.m., and a "right hemicolectomy with endileostomy and mucous fistula", at or around 7:20 p.m. (Exhibit #1, p.6,23,26,27,42).

The facts relating to the patient's care on September 6 and September 7, 1983, are as noted in the proposed findings of fact.

There is no evidence in the record relating to Ms. Griggel's treatment after she was transferred from Berlin Memorial Hospital to the University of Wisconsin Hospital and Clinics (other than the reference to the fact that Dr. Aprahamian reviewed the patient's records from the hospital prior to testifying at the hearing. Tran. p.61). The Complaint alleges (paragraph #58) that the patient died on November 12, 1983, and that the final anatomic diagnosis was that the patient died from respiratory failure and overwhelming sepsis.

III. LEGAL ANALYSIS

1. Unprofessional Conduct

The Complainant alleges in paragraphs 59-61 of the Complaint that:

- 1) Respondent's conduct in providing medical care and treatment to Cheryl M. Griggel fell below the minimum standards of practice established in the profession because the Respondent failed to timely and adequately diagnose and treat the patient for a perforated viscus.
- 2) Respondent's conduct created the unacceptable risk that the patient's perforated cecum would not be timely and adequately identified and treated, thus exposing the patient to risks to which a minimally competent physician would not expose a patient.
- 3) Respondent's conduct, as set forth in this Count of this Complaint, is practice and conduct which tend to constitute a danger to the health, welfare and safety of the patient and therefore constitutes unprofessional conduct as defined in section 448.02(3), Wis. Stats., and section MED 10.02(2) (h), Wis. Adm. Code.

Section 448.02 (3) Wis. Stats., grants authority to the Medical Examining Board to investigate allegations of unprofessional conduct, to conduct a hearing, if the board finds there is probable cause to believe that a person is guilty of unprofessional conduct, and to discipline a person if, after a disciplinary hearing, the board finds the person guilty of unprofessional conduct.

Section MED 10.02 (2) (h) Wis. Adm. Code reads as follows:

(2) The term "unprofessional conduct" is defined to mean and include but not to be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

The Wisconsin Supreme Court, in Gilbert v. Medical Examining Board, 119 Wis. 2d. 168, 349 N.W.2d 68 (1984), discussed the standard which the Medical Examining Board must consider in determining whether a physician's conduct in providing medical care and treatment to a patient constitutes unprofessional conduct. According to Gilbert, supra at page 205, the Medical Examining Board must determine: 1) whether a physician's conduct in providing medical care and treatment to a patient fell below the minimum standards of competency established by the medical profession, and 2) whether the physician's conduct posed an unacceptable risk to the patient which a minimally competent physician would have avoided or minimized.

A. Minimum Competence

The complainant alleges that the respondent's conduct in providing medical care and treatment to Cheryl M. Griggel fell below the minimum standards of practice established in the profession, because the respondent failed to timely and adequately diagnose and treat the patient for a perforated viscus (Complaint, par. 59). The respondent denies that his conduct in providing care and treatment to the patient fell below the minimum standard of practice established by the medical profession. (Answer, par.2; Tran. p.159, lines 24-25; p.160, lines 1-9).

1. Opinion of Expert Witnesses

At the request of the parties, several physicians testified at the hearing regarding the minimum standard of competence established by the medical profession pertaining to the diagnosis and treatment of visceral perforations.

Dr. Charles Aprahamian testified at the request of the complainant. Dr. Aprahamian stated that in his opinion, based upon his review of the patient's medical records, including the x-rays, the respondent's conduct in providing medical care and treatment to Cheryl M. Griggel fell below the minimum standards of competence for a surgeon practicing in 1983 (Tran. p.62). Dr. Aprahamian testified that:

- 1) The respondent failed to recognize the importance of the intra-abdominal free air and to act properly on August 30.
- 2) The respondent failed to recognize the importance of the information obtained with the paracentesis on August 30.
- 3) The respondent failed to react when given the possibility of a perforation.
- 4) The respondent failed to recheck the patient on August 31.
- 5) The respondent failed to recognize the presence of free air on September 1, that was not found on August 29.
- 6) The respondent failed to recognize the changes in the white count reported on September 2.
- 7) The respondent failed to appreciate the real significance of the intra-abdominal air on September 5.

Drs. J. David Lewis and Sanford Mackman testified at the request of the respondent. Drs. Lewis and Mackman testified that in their opinion, the respondent's conduct in providing medical care and treatment to Cheryl M. Griggel did not fall below the standard of minimum competence established by the medical profession. (Tran. p.179, lines 19-25; p.180, lines 17-21; p.190, lines 16-25; p.180-191; p.237,248-249).

2. Analysis of Expert Testimony

1. Intra-Abdominal Free Air on August 30

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent failed to recognize the importance of the intra-abdominal free air and to act properly on August 30, and that the respondent's conduct was below the minimum standards of competence established by the medical profession.

Expert Opinion

Dr. Aprahamian testified that in his opinion, Dr. Rogers' failure to recognize the importance of the intra-abdominal free air and to act properly on August 30, was conduct which fell below the minimum standards of competence established by the medical profession (Tran. p.62-68).

Dr. Aprahamian's opinion is based upon his conclusion that the films of the x-rays taken for the patient on August 30, (Exhibits 6-10), can be interpreted as showing free air, and that the films of the x-rays taken for the patient on August 29, can be interpreted as showing no free air, or at the most minimal free air. Dr. Aprahamian's opinion is that the free air shown on the August 30, x-ray films was "brand new air" in the sense that either it was not present at the time the x-rays were taken for the patient on August 29, or that, if the films of the August 29, x-rays could be interpreted as showing free air, the free air is minimal compared to the "marked increased" in the amount shown on the films of the x-rays taken on August 30 (Tran. p. 64-65).

Dr. Aprahamian testified that the "presence of free air on 8-30 on this patient is a pathologic condition, and is, in terms of bridge, is a demand bid to do something. And he did not appreciate the presence of that free air. He had access to films taken on 8-29, chest x-ray, and there is no free air on that chest x-ray. And so, now this is brand new air, and I think any minimally trained individual would have accepted this free air as pathologic rather than air that was present from the time of surgery." Dr. Aprahamian further testified that if one were to interpret Exhibit #3 (which is a film of an x-ray taken for the patient on August 29), as showing free air, "it's not a great deal of air. It's a small amount of free air. And even if this were free air, which I don't believe was, then the picture the next day shows a marked increase in the amount of air". (Tran., p.64-65).

Dr. Aprahamian testified that "from August 25 to August 30, the patient had a variety of abdominal complaints which were being seen by Dr. Rogers and assessed by Dr. Rogers. But on August 30, there was sufficient concern on his part to obtain an x-ray at or about 11:30. ... On viewing that film he describes that there is gas in the stomach and that there's gas in the small intestine, and there's no mention made of free air. He then subsequently rechecks the patient at 5:30 in the evening. Between that 11:30 and the 5:30 there's a temp elevation to 101.4 There's increase in abdominal pain. There is blood pressure of 90 over 55. The abdomen is distended. And he wants to recheck the film. ... At or around 7 o'clock when these pictures were taken, there is clear evidence of free air in the abdominal cavity -- abundant free air in the abdominal cavity. He performs a paracentesis, which is insertion of an angiocath, a 14-gauge angiocath, and he removes considerable air" (Tran. p.63-64).

Dr. Lewis testified that in his opinion, Dr. Rogers recognized the "existence" of the free air on August 30 and August 31. Dr. Lewis stated that Dr. Rogers "documented that he felt that there was free air present". (Tran. p. 185, lines 9-17). Dr. Lewis did not offer an opinion as to whether Dr. Rogers recognized the "importance" of the free air shown on the August 30, x-ray films. Dr. Lewis also testified that in his opinion, Dr. Rogers did not diagnose on August 30, that the patient had suffered a perforation. (Tran. p.225, lines 16-25; p.226, lines 1-4).

Dr. Mackman testified that Dr. Rogers recognized the "presence" of free air on August 30. (Tran. p.241, lines 9-10). Dr. Mackman did not offer an opinion as to whether Dr. Rogers recognized the "importance" of the free air shown on the August 30, x-ray films.

Respondent's Testimony

Dr. Rogers testified that he recognized the free air on both August 30 and August 31, and that he understood the possible implications and possible consequences of that free air. Dr. Rogers stated that he looked at the x-rays under the circumstances and felt that there was free air on August 29, and that it was not from a perforation (Tran. p.156, lines 7-17).

Analysis

Dr. Aprahamian's opinion that the respondent failed to recognize the importance of the intra-abdominal free air shown on the x-rays can be summarized as followed: 1) the abdominal x-rays taken for the patient on August 30, can be interpreted as showing free air; 2) the chest x-rays taken for the patient on August 29, can be interpreted as showing no free air, or at the very most minimal free air, and 3) the respondent failed to act properly in response to the presence of free air shown on the August 30, x-ray films.

The evidence presented at the hearing establishes that there were abdominal x-rays taken for the patient on August 30 (Ex. 6-10), and that several chest x-rays were taken for the patient on August 29 (Ex. 2-4). The evidence also establishes that between 5:30 p.m. and 6:00 p.m., on August 30, Dr. Rogers compared the abdominal x-rays and the chest x-rays. Dr. Rogers testified that he compared "the whole series of x-rays", and that he put all the films up and went over "all the film at that point, in sequence". (Tran. p.28, lines 7-19; p.29; p.33, lines 17-25; p.138, lines 15-25).

First, in reference to the abdominal x-rays taken for the patient on August 30 (Ex. 6-10), the evidence establishes that some of the x-rays can be interpreted as showing large amount of free intraperitoneal air.

Dr. Aprahamian testified that there was clear evidence of abundant free air in the abdominal cavity shown on the x-rays taken for the patient at or around 7:00 p.m., on August 30 (Tran. p.64, lines 15-17).

Dr. Lewis testified that on August 30, there was evidence of a "significant amount of free air present on the x-rays" (Tran. p.194, lines 13-16). Dr. Mackman testified that Exhibit #7, shows a 'large amount of air and it has to be suspicious for free intraperitoneal air, but could conceivably be air entrapped in a grossly distended loop of intestine". Dr. Mackman stated that Exhibits #8 and #9, show findings of "quite probable free intra-abdominal air", and that he could not tell if Exhibits #6 and 10, showed free air because of the quality of the films. (Tran. p.253-257). Dr. Mackman further testified that the amount of air on at least some of the x-ray films from August 30, is a "massive amount". (Tran. p.255, lines 10-16).

Dr. Rogers testified that when he looked at the abdominal x-rays taken on August 30, and compared them to the x-rays taken on August 29, he concluded that the patient "clearly had free air in the evening --- on Tuesday evening. And she had lots of free air ...". (Tran. p.28, lines 13-25). Dr. Rogers stated that the patient "had this x-ray that showed a massive amount of free air". (Tran. p.40, lines 13-15; p.168, lines 10-14; p.169, lines 1-2). Also, Dr. Rogers' progress note for August 30, at 7:15 p.m., stated "KUB showed marked intraperitoneal air".

In addition, the x-ray report for the KUB and upright abdominal x-rays, and the lateral x-ray taken for the patient on August 30, indicates that the films revealed "large amounts of free intraperitoneal air". (Ex. #1, p.152).

Second, in reference to the chest x-rays taken for the patient on August 29, the evidence establishes that two x-rays (Ex. #2 and 4) can be interpreting as showing "no free air", and that one x-ray (Ex. #3) can be interpreted as showing no free air, or at the most a minimal amount of free air.

In reference to Exhibits #2 and #4, Dr. Aprahamian testified that in his opinion, there is no evidence of free air shown underneath the diaphragm, on Exhibits #2 and 4. (Tran. p.66, lines 7-12). Dr. Lewis did not offer a specific opinion regarding the presence or absence of free air in reference to Exhibits #2 and #4. Dr. Mackman testified that he did not see any evidence of free air on Exhibit #2. Dr. Mackman further stated that he did not personally see anything that he would read as free air, on Exhibit #4, but that he didn't believe that a minimally competent physician could make a "statement one way or another whether or not there was free air on that x-ray ... there could be free air but it's not very clear in that film ..." (Tran. p.252). Dr. Mackman testified at a deposition in 1986, regarding the August 29, x-rays, stating that "the chest x-ray taken on the 29th, which is lateral and AP x-ray, shows no, or at the very most minimal, amount of free air". (Tran. p.256, lines 8-16). Dr. Rogers stated that Exhibits #2 and #4, did not provide any additional information regarding whether there was free air (Tran. p.29, lines 22-25; p.30, lines 12-13, 17-19, 24-25; p.31, lines 9-17; p.32, lines 12-24; p.139, lines 4-17).

In reference to Exhibit #3, Dr. Aprahamian stated that "one could view this as free air. One could look at it as fortuitous shadows one upon another giving you the x-ray picture of free air. One would have to look at the other film that goes with this, and that other film might rule out free air and would make one think that this is more likely just fortuitous shadows. (Tran. p.65, lines 3-14; p.102, lines 21-25; p.103, lines 1-14). Dr. Aprahamian stated that a minimally competent physician who viewed Exhibits #2 and #4, would conclude that the likelihood of free air on Exhibit #3 is less likely, and that "what was perceived as free air is really fortuitous shadows one upon another, to give you the x-ray picture of free air". (Tran. p.65, lines 20-25; p.66, lines 16-22).

Dr. Aprahamian further stated in reference to Exhibit #3, that "if one were to accept this as free air, it's not a great deal of free air. It's a small amount of free air. And even if this were free air, which I don't really believe was, then the picture from the next day shows a marked increase in the amount of air." (Tran. p.65 lines 9-19).

Dr. Lewis testified in reference to Exhibit #3, that in his opinion, the x-ray film could reasonably be interpreted as showing free air. Dr. Lewis stated that "I don't know that I think there's free air there, but I can certainly see where that interpretation could be made." (Tran. p.185).

Dr. Mackman testified in reference to Exhibit #3, that "there can be some questionable evidence of free air. I wouldn't dispute it one way or another. ... I don't think that a minimally competent physician or a maximally competent physician could conclude that there was free air on that chest x-ray. It think it's questionable free air". (Tran. p. 252). Dr. Mackman testified at a deposition in 1986, that "the chest x-ray taken on the 29th, which is lateral and AP x-ray, shows no, or at the very most minimal, amount of free air" (Tran. p. 256, lines 8-16).

Dr. Rogers testified that in his opinion, Exhibit #3 shows free air under the diaphragm and shows a "huge bubble of air" trapped under the liver. (Tran. p.29, lines 22-25; p. 30 lines 12-13, 17-19, 24-25; p. 31, lines 9-17; p. 32, lines 12-24; p. 139, lines 4-17). Dr. Rogers testified that in retrospect what he was seeing and interpreting as free air was a "massively distended cecum that went on to necrose and perforated". (Tran. p.155,lines 2-11).

Third, based upon the evidence, it can be concluded that on August 30, the respondent did not diagnose that the patient had suffered a perforation; the respondent did not assess the patient with diagnostic procedures to rule out a perforation, other than by performing a paracentesis, and the respondent did not perform surgery on the patient to correct and repair the perforation.

Dr. Aprahamian testified that Dr. Rogers failed to recognize the importance of the intra-abdominal free air and to act properly on August 30. (Tran. p. 62, lines 11-12). Dr. Aprahamian testified that "free air means that the patient has a perforation until proven otherwise. And I believe it's below minimum competence for someone to see the free air and then not act accordingly". Dr. Aprahamian stated that to "act accordingly would have been to look for an explanation of that free air by doing a contrast study, gastric perforation versus colonic, or lavage, to see if there's any peritoneal fluid suggesting inflammation". (Tran. p.113, lines 24-25; p.114, lines 1-5).

Dr. Aprahamian further testified that on August 30, a minimally competent physician should have performed certain diagnostic tests to determine if the patient had suffered a perforation, or could have without additional tests, gone to the operating room and "explored the patient and fixed it". Dr. Aprahamian stated that the diagnostic tests which a minimally competent physician should have performed on August 30, to determine whether the patient had a perforation included: 1) an upper GI to determine if there was a hole in the stomach or in the duodenum from a perforated ulcer; 2) a barium .. contrast enema to determine if there was a hole in the colon; 3) a CT to determine if there was a problem on the CT that would have shown some abnormality warranting operative intervention; or 4) a peritoneal lavage, rather than a paracentesis (Tran. p.84, lines 22-25; p.85, lines 1-20).

Dr. Lewis testified that in his opinion, Dr. Rogers did not diagnose on August 30, that the patient had suffered a perforation (Tran. p.225, lines 16-25; p.226, lines 1-4). Dr. Lewis testified that there is no question that the patient suffered a perforation and would have been served well by an operation the night of August 29, or the morning of August 30 (Tran. p. 217, lines 4-15).

Dr. Lewis further testified that it would have been appropriate for Dr. Rogers to do diagnostic tests to rule out the presence of a perforation, but that trying to equate what tests should have been done in reference to minimum standards is very difficult. Dr. Lewis stated that Dr. Rogers did a paracentesis, and that he thought that was an appropriate test to evaluate the situation. (Tran. p. 218, lines 1-9). The evidence in this case, indicates that the paracentesis which Dr. Rogers performed on August 30, did not yield positive results, and that it did not provide valuable information for purposes of diagnosing that the patient had suffered a perforation.

Dr. Mackman testified that Dr. Rogers' failure to diagnose before September 5, that the patient had suffered a perforation did not fall below the minimum standards, and that Dr. Rogers did recognize that a perforation could have existed, but that according to his clinical judgment and the course of the patient, it was not very clear to him (Dr. Rogers) until on or about September 5, that the patient had a perforation (Tran. p. 244, lines 3-14).

Dr. Rogers testified that on August 30, he considered both the possibility of a perforation and postoperative air, and that after performing the paracentesis, he felt it was less likely that the patient had a perforation (Tran. p.35, lines 12-14; p.37, lines 1-6). Dr. Rogers further testified that he considered operating on the patient and decided not to operate. Dr. Rogers stated that after looking back at the x-rays, he concluded that the patient had free air before (on August 29). Dr. Rogers also stated that the patient did not exhibit signs of peritonitis, perforation or any abdominal process other than colon spasms and referred pain from colon spasm. Dr. Rogers testified that he felt that the air was more likely left over from the original surgery and that the better course of action was to observe the patient rather than to take her down to surgery at that point. (Tran. p. 40, lines 5-9, 13-24).

The evidence clearly establishes that Dr. Rogers did not assess the patient with diagnostic procedures to rule out a perforation, other than by performing a paracentesis, and that he did not perform surgery on the patient until September 5.

2. Paracentesis Performed on August 30.

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent failed to recognize the importance of the information obtained with the paracentesis on August 30, and that the respondent's conduct was below the standards of minimum competence established by the medical profession.

Expert Opinion

Dr. Aprahamian testified that in his opinion, Dr. Rogers failed to recognize the importance of the information obtained with the paracentesis on August 30 (Tran. p.62, lines 13-14; p.68, lines 23-25).

Dr. Aprahamian testified that "the particular technique of a paracentesis is to stick a needle or an angiocath into the peritoneal cavity and then to aspirate. And he obtained air, and there's a notation that it didn't smell, and concluded that it couldn't have been bowel gas, and that he failed to -- and he was unable to aspirate any peritoneal fluid, and hence concluded that there was no inflammatory response. I think that's a negative result, and a negative result on a paracentesis is not useful information. One would have to obtain a positive result." (Tran. p.69, lines 2-10).

Dr. Aprahamian stated that in this case the positive result from the paracentesis was that there was air, and that since Dr. Rogers "didn't get peritoneal fluid", Dr. Rogers needed to perform other diagnostic procedures, such as an upper GI series, a barium enema with a gastrograph or a CT, a lavage, or he could have operated. (Tran. p.69, lines 8-16).

Dr. Aprahamian further testified that:

"If the differential diagnosis is perforation versus post-op air, then one would have to have a proof positive test that would negate the presence of perforation. And having the paracentesis in a way was positive information that there was free air there. But it would not -- a physician ought not rely on just that part of the test. He didn't show that there was no fluid in the peritoneal cavity; just because he didn't collect any didn't mean that there wasn't any. And he needed to do a test that was going to prove conclusively that the perforation was either present or absent, and that wasn't done." (Tran. p.70, lines 5-20).

Dr. Lewis testified that Dr. Rogers' conduct in interpreting the paracentesis did not fall below the level of minimum competence, and that Dr. Rogers' interpretation of the paracentesis was one with which he would not agree, but represented a "potential interpretation of the results". (Tran. p.185, lines 20-25; p.186, lines 2-14).

Dr. Lewis testified that the paracentesis provided information that the air in the abdomen was under pressure, but that Dr. Rogers "misinterpreted" the information. Dr. Lewis stated that in his opinion, Dr. Rogers' description of the paracentesis, that the "air was coming out under pressure", indicates that the air was more than just postoperative air. Dr. Lewis stated that one would not expect postoperative air to be under pressure usually, and that one would have to come up with an explanation for the air being under pressure. Dr. Lewis indicated that his interpretation would be that the air was under pressure and, therefore, there was a perforation. Dr. Lewis stated that in his opinion, Dr. Rogers' interpretation was that "there was no odor to that air, and therefore his feeling that the air had not come out of the intestine is understandable. I don't agree with it, but I think it's understandable". (Tran. p.218, lines 8-25; p.219, lines 1-14).

Dr. Lewis stated that in his opinion, Dr. Rogers did the paracentesis "to see whether or not there was fluid present within the abdomen, as well as air. And he did not get a significant amount of fluid out and that is why the situation was misrepresented" (Tran. p.219, lines 20-24).

Dr. Mackman testified that, "It's a little hard for me to have much of an opinion on this fact, basically because it's something that I normally would not do. But under the circumstances where he felt that she had a lot of air in her abdomen that came from the time of her first operation or her caesarean section, it is reasonable then to make an assumption that relieving that air would have improved her clinical condition, which according to his medical records, it did, for a short period of time". (Tran. p.242, lines 15-22; p.260, lines 7-15).

Dr. Mackman testified in 1986, regarding Dr. Rogers' treatment of the patient on August 30, that a paracentesis is only of value when fluid is removed from the abdomen. Dr. Mackman stated, regarding the paracentesis, "it has no place if you do not remove fluid. So therefore, that test to help him make a diagnosis of whether he was dealing with free intraperitoneal air from surgery or pathological intraperitoneal air is again an absurdity (Tran. p.261, lines 19-25; p.262, lines 2-7). Dr. Mackman stated that the interpretation of a paracentesis is "only of value if it rules in fluid. It has no place, .. no value, nothing if it rules it out", and that "the presence of an odor is absurd, because again, only the presence of an odor rules a pathological process in. The absence of an odor doesn't rule a pathological process out. (Tran. p.262, lines 19-25; p.263, lines 3-11).

Respondent's Testimony

Dr. Rogers testified that the purpose of the paracentesis was to determine whether the source of the patient's free air was from a perforation or from postoperative air. Dr. Rogers stated that if the air was from a stitch through the bowel or a perforated viscus, he reasonably could expect to get fluid from the "patient's gutter". Dr. Rogers indicated that he did not obtain any fluid from the patient's gutter, and that the paracentesis was non diagnostic. (Tran. p.35, lines 18-25).

Dr. Rogers stated that after performing the paracentesis, he considered a bowel perforation to be less likely, and that the KUB x-ray taken after the paracentesis was to find out if a large amount of air had re-accumulated, if so, then his original hypothesis would have been wrong and he would have concluded that the patient had a perforation. Dr. Rogers stated that the KUB x-ray "revealed the same amount of free air as she'd had after I did the paracentesis". (Tran. p.37, lines 4-6; p.39, lines 3-19).

Dr. Rogers further testified that his diagnosis after he performed the paracentesis was that the patient's pain was due to intestinal spasm. Dr. Rogers stated regarding his diagnosis that: "She had run a fever the day before. I felt that with all the splinting and the lack of movement and stuff, that she had some atelectasis that would explain a low grade fever, and felt that the free air at this point was probably air that had been left from the time of surgery." (Tran. p.142, lines 12-17).

Dr. Rogers testified that he considered operating on the patient and decided not to operate. Dr. Rogers stated that after looking back at the x-rays, he concluded that the patient had free air before (on August 29). Dr. Rogers also stated that the patient did not exhibit signs of peritonitis, perforation or any abdominal process other than colon spasms and referred pain from colon spasm. Dr. Rogers testified that he felt that the air was more likely left over from the original surgery, and that the better course of action was to observe the patient rather than to take her down to surgery at that point. (Tran. p.40, lines 5-7, 13-24).

Analysis

First, the evidence establishes that the results of the paracentesis performed by Dr. Rogers on August 30, were negative.

Based upon the evidence, Dr. Rogers performed a paracentesis on the patient, at or around 7:15 p.m., on August 30. Dr. Rogers indicated in his progress note regarding the paracentesis, that: 1) there was rapid deflating of the abdomen; 2) there was no odor to the escaping air, and 3) there was no fluid from the abdomen. (Exhibit #1, p.36).

Dr. Aprahamian testified that the information reported by Dr. Rogers in his progress note for August 30, indicates that the results of the paracentesis were negative. Dr. Aprahamian stated that the positive result from the paracentesis was that there was air (Tran. p. 69, lines 8-11).

Dr. Lewis did not offer a specific opinion regarding whether the results of the paracentesis were positive or negative. Dr. Lewis stated regarding the results of the paracentesis, that Dr. Rogers' interpretation was that there was "no odor to the air", and that Dr. Rogers did not get a "significant amount of fluid out". (Tran. p.219, lines 11-13, 20-24).

Dr. Mackman testified that the results of the paracentesis on August 30, were negative in that Dr. Rogers did not obtain fluid and he did not believe that there was any odor to the air which escaped (Tran. p. 264, lines 17-21).

Dr. Rogers testified that "the paracentesis I did to see if I had a positive finding. .. it was negative". (Tran. p.36, lines, 7-9; p.156, lines, 18-24).

Second, the evidence shows that the negative paracentesis did not provide useful information for purposes of diagnosing that the patient had suffered a perforation, and that the respondent did not assess the patient with any diagnostic procedure, other than the paracentesis, to rule out a perforation.

Dr. Aprahamian testified that a negative paracentesis does not provide useful information and that one would have to obtain a positive result. Dr. Aprahamian stated that in this case, the only positive result was that there was air. Dr. Aprahamian stated that because Dr. Rogers did not get peritoneal fluid, he (Dr. Rogers) "needed to perform other diagnostic procedures, one of which would have been an upper GI series. The second would have been a barium enema with a gastrograph or a CT, or he could have done a lavage or could have operated." (Tran. p.69, lines 9-16).

Dr. Lewis testified initially that the paracentesis provided Dr. Rogers with information that "the air that was in the abdomen was under pressure", but that Dr. Rogers misinterpreted the information. Later, during cross examination, Dr. Lewis testified that it was his interpretation that the air in the patient's abdomen was under pressure, not necessarily, Dr. Rogers' interpretation. The evidence in this case does not indicate that Dr. Rogers ever considered whether the patient had suffered a perforation based upon his conclusion that the air in the patient's abdomen was under pressure.

Dr. Lewis testified that Dr. Rogers "described air coming out under pressure. My interpretation of that would be that that's not just postoperative air. You wouldn't expect postoperative air to be under pressure usually, and so you'd have to come up with an explanation for it to be under pressure. So I think that provided information." (Tran. p.218, lines 10-24). Dr. Lewis further stated that "when you close and leave air behind, it's not under pressure. ... my interpretation of the description when the paracentesis was done was that there was more pressure than I would expect, and so having done that, my interpretation would be that the air was under pressure and therefore, there was a perforation.

Dr. Lewis stated that "I think his interpretation, because there was no odor to that air, and therefore, his feeling that the air had not come out of the intestine is understandable. I don't agree with it, but I think it's understandable" (Tran. p.219, lines 1-14). Dr. Lewis testified that the fact that Dr. Rogers did not obtain fluid from the patient's abdomen led Dr. Rogers to decide that it was likely that the patient had not suffered a perforation (Tran. p.219, lines 15-25; p.220, lines 1-12).

Dr. Mackman testified that the paracentesis did have value to Dr. Rogers. Dr. Mackman stated that: "The value that it had was that at least at that point he didn't have anything where he had irrefutable evidence of peritonitis, and therefore at that point he was relying on his clinical judgment that this ... air was gotten there from the time of the surgical closure". (Tran. p. 264, lines 22-25; p. 265, lines 1-7).

Dr. Mackman testified at a deposition in 1986, regarding the paracentesis performed by Dr. Rogers on August 30, that a paracentesis is only of value when fluid is removed from the abdomen. Dr. Mackman stated that "it has no place if you do not remove fluid. So therefore, that test to help him make a diagnosis of whether he was dealing with free intraperitoneal air from surgery or pathological intraperitoneal air is again an absurdity". (Tran. p. 262, lines 2-7). Dr. Mackman further testified at the deposition that the interpretation of a paracentesis is "only of value if it rules in fluid. It has no place, ... no value, nothing if it rules it out", and that "only the presence of an odor rules a pathological process in. The absence of an odor doesn't rule a pathological process out" (Tr. p.262, Ln.19-25; p.263, Ln.3-11).

Dr. Rogers testified that the paracentesis did not have any value, because he did not collect intestinal fluid (Tran. p. 35, lines 21-25; p. 36, lines 1,9; p. 142, lines 5-10; p.156, lines 18-24).

Third, the evidence establishes that the respondent placed some significance on the fact that the paracentesis was negative.

Dr. Aprahamian testified that in his opinion, Dr. Rogers placed some significance on the fact that the paracentesis was negative. Dr. Aprahamian stated in reference to Dr. Rogers' progress note for August 30, that "His impression at the time of that visit and the time of the paracentesis was 'will follow white count with temp closely for evidence of intraperitoneal infection, possible bowel perforation, though none apparent at present'. (Tran. p. 69, lines 17-23).

Dr. Lewis testified that in his opinion, it is reasonable to say that Dr. Rogers was "looking to see whether or not there was other material within the peritoneal cavity that would reflect a perforation. And the fact that he didn't get it out is what led him to decide that ... it was ... likely that there wasn't a perforation". (Tran. p.220, lines 2-7).

Dr. Mackman testified in reference to the negative paracentesis that Dr. Rogers misinterpreted the results of the paracentesis to mean that it was a benign process, but that in "misinterpreting that he also used his clinical judgment in evaluating the patient at that point and felt that she had a benign abdomen". (Tran. p.264, lines 3-20; p.265, lines 8-22).

Dr. Rogers testified that Dr. Aprahamian was incorrect in assuming that his decision that the patient had not suffered a perforation was based on the paracentesis. (Tran. p.157, lines 1-3).

Dr. Rogers stated that: "I'd looked at the x-rays ... I think she's got free air on Monday. What else can I do at the bedside to try and evaluate this. And my biggest concern was I put a stitch through the bowel. I know I've had trouble closing, and she was retching and pushing, and you know, this could be a perforation. And ... a good test of that was to put a needle in her abdomen and have her roll on her right side and see if fluid collected. The fact that I didn't get fluid out of it wasn't helpful. You know, if I'd gotten fluid, I would have been in the operating room Tuesday night also. I didn't. And because of the way I interpreted the x-rays I then felt that I would follow her along and chose that course of action." (Tran. p.157, lines 4-18).

Dr. Rogers further testified that his decision not to operate on the patient on August 30, was "not based so much on the paracentesis but -- as on his interpretation of the x-rays". (Tran. p.164, lines 21-23).

Dr. Rogers stated that "I looked at the x-rays and formed an opinion that there had been previously gas there when she wasn't septic or had the possibility of a perforation, and then did the paracentesis feeling if I did get fluid out or if the air re-accumulated to the extent that it was, then I need to go in and operate. As it was, I didn't get positive information, and it wasn't helpful in altering my thought patterns at that time". (Tran. p. 163, lines 10-23).

The evidence indicates that Dr. Rogers testified at a deposition in 1985, that the negative paracentesis and the lack of peritoneal signs after the paracentesis were the two most important factors in his decision not to operate on the patient on August 30. (Tran. p. 163, lines 24-25; p. 164, lines 1-17).

Dr. Rogers testified at the hearing that the answers he provided at the 1985 deposition regarding his decision not to operate were given in the "context of several pages of ... repeated questioning along that line relating to interpreting the x-rays", and that his decision not to operate was not based so much on the paracentesis, but on his interpretation of the x-rays. (Tran. p.164, lines 18-25; p. 165, lines 1-13).

Dr. Rogers testified that after performing the paracentesis he considered bowel perforation less likely, and that he considered postoperative air to be the more likely cause of the free air (Tran. p.37, lines 4-6; p.165, lines 14-25; p.166, lines 1-18).

As noted earlier, Dr. Arahamian testified that in his opinion, Dr. Rogers' progress note for 7:15 p.m., on August 30, indicated that he was going to follow the patient's white blood count and temperature closely for "evidence of intraperitoneal infection/possible bowel perforation tho none apparent at present". It is apparent from Dr. Rogers' progress note and from his testimony that after he performed the paracentesis he considered a perforation less likely, and that he relied upon the results of the negative paracentesis in deciding whether the patient had suffered a perforation.

Fourth, the evidence establishes that the respondent did not assess the patient with any diagnostic procedure, other than the paracentesis, to rule out the presence of a perforation.

Dr. Arahamian testified that because Dr. Rogers did not get peritoneal fluid, "he needed to perform other diagnostic procedures, one of which would have been an upper GI series. The second would have been a barium enema with a gastrograph or a CT, or he could have done a lavage or could have operated". (Tran. p.69, lines 9-16).

Dr. Lewis testified that it would have been appropriate for Dr. Rogers to do diagnostic tests to rule out the presence of a perforation, but that trying to equate what tests should have been done in reference to minimum competence is difficult. Dr. Lewis stated that Dr. Rogers did a paracentesis, and that in his opinion that was an appropriate test to evaluate the situation. (Tran. p.218, lines 1-9). The evidence in this cases indicates that the paracentesis which Dr. Rogers performed on August 30, was negative, and that it did not provide valuable information for purposes of diagnosing whether the patient had suffered a perforation.

3. Failure to React Given The Possibility of Perforation

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent failed to react when given the possibility that the patient had suffered a perforation, and that the respondent's conduct was below the minimum standards of competence established by the medical profession.

Expert Opinion

Dr. Aprahamian testified that Dr. Rogers failed to react when given the possibility that the patient had suffered a perforation. (Tran. p.62, lines 14-15; p.70, lines 21-25).

Dr. Aprahamian testified that Dr. Rogers' progress note for 7:15 p.m., on August 30, indicated that Dr. Rogers was going to follow the patient's white count and temperature closely; that subsequently Dr. Rogers was informed that "the patient had abdominal pain and the white count in fact had changed", and that Dr. Rogers saw the patient at 4:30 a.m., on August 31, and made the notation 'will recheck WBC and KUB in the morning'. Dr. Aprahamian further testified that in his opinion, Dr. Rogers knew at the time he wrote the 4:30 a.m., progress note on August 31, that the patient's white count had changed. (Tran. p. 70, lines 21-25; p.71, lines 1-7).

Dr. Aprahamian testified that the change in the patient's white count values on August 30, from 1 band and 81 segs to 65 bands and 30 stabs, indicates that "there was progression of the inflammation as evidenced by change in her white count; and the white count in this case would reflect peritonitis". Dr. Aprahamian stated that on August 30, "there is a temp elevation noted at 101. And on 8-29 there's a temp elevation noted close to 101, and that was a trend going up. I'll grant you that there was a low mark between the — those two high temps, but I think the trend was that it was going up, and the low temp may just reflect that the patient was having an abscess, one was now beginning to get some spiking temps that one would find with an abscess". Dr. Aprahamian further testified that on August 31, the patient had "some temps that were subnormal but then there was another one, 100.4." (Tran. p. 71, lines 10-20, 21-25; p. 72, lines 1-9). Dr. Aprahamian stated that given the patient's temperature course from August 29 through August 31, a minimally competent physician would have concluded that the "temps were up rather than down, and should reflect some ongoing inflammatory process." (Tran. p.72, lines 10-14).

Dr. Aprahamian stated that in his opinion, Dr. Rogers did not properly interpret the significance of the patient's temperature changes and white blood count values, because Dr. Rogers would have "either done the diagnostic procedures to verify the presence of the perforation or would have explored the patient". (Tran. p.72, lines 15-20).

Finally, Dr. Aprahamian testified that Dr. Rogers failed to recognize certain aspects of the patient's clinical condition in terms of making a proper diagnosis. Dr. Aprahamian stated that the patient's clinical course was that of abdominal discomfort requiring frequent doses of analgesics; that there were notations that the patient's abdomen was tender to nontender, and that Dr. Rogers either misinterpreted or failed to appreciate the symptoms. (Tran. p.72, lines 22-25; p.73, lines 1-5).

Dr. Aprahamian stated that the objective tests ordered for the patient, chest x-rays, abdominal films and blood tests, confirmed the presence of abnormality, and that "while the abdominal findings were difficult to evaluate and appreciate, I believe the chest x-ray and the abdominal films and the paracentesis clearly show that there was pathology going on. And these a minimally competent surgeon would have been able to act on". (Tran. p.74, lines 5-12).

Dr. Lewis testified that in his opinion, Dr. Rogers' conduct did not fall below minimum standards with respect to failing to react to the possibility of an existing perforation, and that Dr. Rogers documented "the potential of a perforation". Dr. Lewis stated that Dr. Rogers spent "considerable time and effort trying to document whether or not that was going on. I disagree with his interpretation of some of what was going on at the time, but I think that his actions as relates to that were above the minimum standards." (Tran. p. 186, lines 15-25; p. 187, lines 1-4).

Dr. Mackman testified that Dr. Rogers' conduct did not fall below the minimum level of care in reference to failing to react to the possibility of a perforation. Dr. Mackman stated that Dr. Rogers "in his medical records did recognize that a perforation could have occurred, so he didn't ignore that fact, but that Dr. Rogers and two other physicians examined the patient, and that their impression at the point of their care and management and evaluation of the patient was that the patient did not have perforation. And I don't believe that it's my place to second guess them, because I wasn't there to examine the patient". (Tran. p.242, lines 24-25; p. 243, lines 1-18).

Dr. Mackman further stated that Dr. Rogers' failure to recognize the perforation, up until September 5, did not fall below the minimum standards. Dr. Mackman stated that "The fact is that they did recognize that a perforation could have existed, but it -- according to their clinical judgment and the course of the patient, it was not clear to them until after it was very clear on or about the 5th". (Tran. p.244, lines 3-14).

Respondent's Testimony

Dr. Rogers stated that he did react when given the possibility of a perforation. Dr. Rogers stated that he went back and looked at the x-rays, did a paracentesis and called Dr. Piotrowski. Dr. Rogers stated that "the next morning I called my partner to bounce ideas off his mind. And I did react, but I made a wrong determination on my initial comparison on the x-rays, in retrospect". Dr. Rogers stated that the patient did not show the classic course of someone with a viscus perforation. (Tran. p.157, lines 19-25; p.158, lines 1-4).

Analysis

First, the evidence establishes that at the time Dr. Rogers saw the patient at 4:30 a.m., on August 31, he knew that the patient's white count had changed, and he knew that the patient's temperature spiked on August 29, and August 30.

Dr. Aprahamian testified that Dr. Rogers' progress note for 7:15 p.m., on August 30, indicated that Dr. Rogers was going to follow the patient's white count and temperature closely, and that subsequently Dr. Rogers was informed that the patient's white count had in fact changed. Dr. Aprahamian stated that in his opinion, at the time Dr. Rogers wrote the progress note at 4:30 a.m., on August 31, he knew that the white count had changed. (Tran. p.70, lines 21-25; p.71, lines 1-7).

The evidence indicates that Dr. Rogers recorded in his progress notes for 7:15 p.m., on August 30, that the patient's white blood count and temperature would be followed closely for evidence of intraperitoneal infection/possible bowel perforation. Dr. Rogers' progress note for 4:30 a.m., on August 31, indicated that the patient's white blood count, KUB and the amylase would be checked on the morning of August 31.

The evidence establishes that the patient's white blood count values on the morning of August 30 were 3,300 with 1 band and 81 segs, and that the patient's white count values, at or around 8:00 p.m., were 11,500 with 65 bands and 30 segs. (Exhibit #1; Tran. p.37, lines 12-16). The evidence also establishes that a white count value of 3,300 with 1 band and 81 segs is a low count value, and that a white count of 11,500 with 65 bands and 30 segs is an elevated count. (Tran. p.37, lines 12-19; p.50, lines 23-25; p.103, lines 24-25; p.104, lines 4-9; p.152, lines 22-24; p.199, lines 3-4).

Dr. Rogers testified that at the time he wrote the progress note for 7:15 p.m., on August 30, he was aware of the fact that the patient had a white count on August 30, of 3,300 with 1 band and 81 segs. (Tran. p.37, lines 12-16). Dr. Rogers stated that he did not know when he became aware of the results of the white count lab tests which were taken for the patient, at or around 8:00 p.m., on August 30 (11,500 with 65 bands and 30 segs), but that he was aware of the lab results when he saw the patient at 4:30 a.m., on August 31. (Tran. p.38, lines 24-25; p.39, lines 1-2; p. 41, lines 3-16).

Dr. Rogers stated regarding the lab results for the blood count taken at 8:00 p.m., that generally the white blood count lab results are called "up to the nurses", and that in this case, he didn't know whether the nurse relayed it to him verbally or gave the white count to him on a slip of paper, or whether he misunderstood at that time that the differential was 65 segs and 30 "lymphs". Dr. Rogers stated that a white count of 65 bands and 30 lymphs is a normal differential. Dr. Rogers further stated that "I think that there was probably a misunderstanding or a miscommunication that I didn't get at that point Tuesday night, the differential as being the left shift that it had. By 4:30 in the morning, reviewing the record, and by that time the official lab slip is up, and she had the left shift, by that time, you know, she looked good. And so then I went searching for other causes of .. that would cause that kind of shift in the white count". (Tran. p.152, lines 22-25; p.153, lines 1-13).

The patient's temperature readings on August 31, were 98.8 degrees, at or around 3:30 a.m.; 98 degrees, at or around noon, and 100.4 degrees, at or around 8:00 p.m. The patient's temperature readings on August 30, were 96.2 degrees, at or around 4:00 a.m.; 101.4 degrees, at or around noon; 98.4 degrees, at or around 8:00 p.m., and 98 degrees, at or around midnight. The patient's temperature readings on August 29, were 99 degrees, at or around 4:00 a.m.; 100.8 degrees, at or around noon, and 100.6 degrees, at or around 8:00 p.m.

Dr. Rogers testified that at the time he saw the patient at 7:15 p.m. on August 30, he was aware of the patient's temperature spikes on August 29, and August 30. Dr. Rogers stated that he was aware that the patient had a temperature spike of 100.8 degrees on August 29; that her temperature had decreased on August 30, to 96.2 degrees, and that the patient had a temperature spike of 100.4 degrees on August 30, at noon. (Tran. p.37, lines 24-25; p.38, lines 1-15; p.48, lines 11-19).

Second the evidence establishes that the patient's temperature and white blood count course reflected that the patient had an infection.

Dr. Aprahamian stated that given the patient's temperature course from August 29 through August 31, a minimally competent physician would have concluded that the "temps were up rather than down, and should reflect some ongoing inflammatory process". (Tran. p.72, lines 10-14).

Dr. Lewis testified that spiking temperatures are evidence of an infection. Dr. Lewis stated that the patient's temperature spikes on August 29, August 30, August 31, and September 1, are consistent with an infection, but not diagnostic of an infection. Dr. Lewis testified that in his opinion, the patient's temperature spikes "is corroborating evidence for the presence of infection, if that's what you're looking for".

Dr. Lewis further testified that any minimally competent physician who was following the patient closely for evidence of infection by watching her white blood count and temperatures and who was then confronted with the patient's white blood count and temperature spikes would not conclude that the patient had an infection. Dr. Lewis' opinion is not consistent with an opinion which he gave at a deposition less than a week before the hearing. Dr. Lewis testified at the deposition that "I don't think there's any question that the conclusion would be that there is an infection. The question is, what infection are we talking about?" (Tran. p.202-203;204, lines 1-2). Dr. Lewis stated that Dr. Rogers' progress note for August 30, at 7:15 p.m., indicated that Dr. Rogers would be following the patient closely for evidence of intraperitoneal infection.

Dr. Mackman testified that the patient's temperature from August 29, through September 1, were not typical of a classic peritonitis situation, because the patient never really had a "high fever" during that time period. (Tran. p. 240, lines 1-6). Dr. Mackman stated that the patient did have a fever on August 29, and August 30, but it was not "a diagnostic fever of anything". Dr. Mackman testified that "the fact that she had the temperatures doesn't mean she had peritonitis. In fact, it's most likely that it's not peritonitis. (Tran. p.269, lines 24-25; p.270, lines 1-13; p. 277-285). Dr. Mackman testified in 1986, that the patient's white blood count course, fever, tachycardia, tachypnea, and the massive amount of free intraperitoneal on August 30, was absolutely diagnostic of sepsis. (Tran. p.284-287).

Dr. Rogers testified that the patient's temperature readings on August 29, and August 30, are not "out of line with what someone normally has post-operatively when they're not coughing and deep breathing and then pretty typical range for a pulmonary fever". Dr. Rogers stated that he felt that the patient's temperature was "adequately explained by her lack of good pulmonary toilet and splinting because of the pain she was having". Dr. Rogers stated that he thought that the patient's temperature elevations of August 29 and August 30, were due to significant atelectasis, and that the atelectasis cleared with appropriate treatment. (Tran. p.38, lines 8-11, 12-23; p.43-44; p.153, lines 16-25). Dr. Aprahamian testified that the patient did not have significant atelectasis, and that he would "expect atelectasis to be sooner", and the "temps to be higher sooner with a tachycardia. And those things weren't present" (Tran. p.100, lines 16-25; p.101, lines 1-7).

In reference to the patient's white blood count values on August 30, Dr. Aprahamian testified that the changes in the patient's white count values, from 1 band and 81 segs. to 65 bands and 30 stabs, indicates that "there was progression of the inflammation as evidenced by changes in her white count, and that the white count in this case would reflect peritonitis". (Tran. p.71, lines 10-20). Dr. Aprahamian stated that in some people with a massive infection, they are not able to generate a white count, and their white count goes down. In this case, the evidence indicates that the patient had a low count (3,300), on August 30. (Tran. p. 103, lines 15-25; p.117, lines 2-10).

Dr. Lewis testified that the change in the white count from early on August 30, to late on August 30, and on August 31, reflects that a significant event took place in the patient's clinical course that in "retrospect I think is a reflection of her developing a perforation at that point. You can see changes like that as a result of pneumonia or, to a lesser extent, atelectasis or other event going on in a patient's clinical course". (Tran. p.197, lines 9-25; p.198, lines 17-25). Dr. Lewis stated that an elevated white blood count with a left shift can reflect an infection and that it can also reflect other stress. (Tran. p.197, lines 20-24). Dr. Lewis testified that a chemical peritonitis (versus a peritonitis resulting from infection) can also result in an elevated white count. (Tran. p.197, lines 17-19; p.199, lines 17-25; p. 200-202).

Dr. Lewis testified, less than a week before the hearing, that a minimally competent physician who suspected an infection and was confronted with the patient's white count should be able to reach the diagnosis of infection. (Tran. p.199, lines 1-25; p.201, lines 2-7,17-25). Dr. Lewis also testified at the deposition, stating that: "I don't think there's any question the conclusion is that the patient has an infection. The question is, what infection are we talking about". (Tran. p.203, lines 5-25; p.204, lines 1-20).

Dr. Mackman testified that the only high white count was on August 31, otherwise the white count was consistent with the non-complicated postoperative patient. (Tran. p.240, lines 8-20). Dr. Mackman stated that the white count and the differential would make one "very suspicious that there is an infection somewhere". Dr. Mackman testified in 1986, that the sequence of the white count and differentials on August 30 and August 31, is "absolutely diagnostic of sepsis". (Tran. p.274, lines 7-23).

Dr. Rogers testified that an elevated white blood count with a shift is consistent with the diagnosis of perforation, but it is also consistent with the diagnosis of endometritis, urinary tract infection, and pneumonia. (Tran. p. 50, lines 23-25; p.51, lines 1-6). Dr. Rogers further stated that he searched for other causes that would cause a shift in the patient's white blood count value. Dr. Rogers stated that pancreatitis is typically one of the things that "will cause that", and that "it will also cause a fever ... abdominal pain and an ileus". (Tran. p.152, lines 22-25; p.153, lines 1-15). Dr. Rogers testified that delivery is a very common cause of an elevated white count, and that white counts in the 15,000 to 18,000 range are frequently seen after pregnancy (Tran. p.144, lines 12-18).

Third, the evidence establishes that the respondent did not perform any diagnostic procedure, other than a paracentesis, to verify the presence of a perforation, and that he did not perform surgery on the patient until September 5.

Dr. Aprahamian testified that Dr. Rogers did not properly interpret the significance of the patient's temperature changes and white count values, because he would have "either done the diagnostic procedure to verify the presence of the perforation or would have explored the patient". (Tran. p.72).

The evidence in this case establishes that Dr. Rogers did not perform any diagnostic procedure, other than a paracentesis, to verify the presence of a perforation and that he did not operate on the patient until September 5.

Fourth, the evidence establishes that the respondent failed to recognize and appreciate certain aspects of the patient's clinical condition in terms of making a proper diagnosis of perforation.

Dr. Aprahamian testified that Dr. Rogers failed to recognize certain aspects of the patient's clinical condition in terms of making a proper diagnosis. Dr. Aprahamian stated that the patient's clinical course was that of abdominal discomfort requiring frequent doses of analgesics; that there were notations that the patient's abdomen was tender to nontender, and that Dr. Rogers either misinterpreted or failed to appreciate the symptoms. (Tran. p.72, lines 22-25; p.73, lines 1-5).

Dr. Aprahamian further testified that the patient's clinical condition was difficult to evaluate because of various reasons, but that a minimally competent surgeon would have been able to act based upon findings obtained from the objective tests, such as x-rays, blood tests, and the paracentesis. (Tran. p.73, lines 5-25; p.74, lines 1-12).

Dr. Lewis testified that the patient's general clinical situation was really quite complex. Dr. Lewis stated that the patient's condition was difficult to interpret for a variety of reasons, including: 1) the patient's reaction to pain and stress made it difficult to determine how much discomfort the patient was having; 2) the patient had just completed a pregnancy so that her abdominal wall had been stretched out significantly, therefore, it was difficult to evaluate muscle spasm, and 3) Ogilvie Syndrome normally happens in older people. (Tran. p.181-182).

Dr. Lewis further stated that the patient did suffer a perforation and that she did have a lot of pain but according to the chart, the patient's reaction to pain "appears to be out of proportion to the usual patient who has that experience". Dr. Lewis stated that when you have a patient who reacts that strongly to pain, it becomes difficult to interpret the significance of the pain. (Tran. p.207-213). Dr. Lewis further stated that if a minimally competent physician is faced with a complicated clinical picture, the physician would not place greater reliance on objective findings. Dr. Lewis stated that in such cases, a physician has to work with less information to make a decision. (Tran. p.213, lines 17-25; p.214, lines 1-8).

Dr. Mackman testified that Dr. Rogers got "off track because he made the assumption that a large amount of ... free intra-abdominal air was consistent with her clinical presentation and problem". (Tran. p.238, lines 1-4; p.239, lines 19-22). Dr. Mackman stated that the patient did not show the "clear cut" signs of peritonitis. (Tran. p.267).

The respondent's witnesses did not rebut the testimony of Dr. Aprahamian on this issue.

Dr. Lewis testified that in reference to physical findings, the "cardinal signs" of an existing peritonitis are pain and rigidity of the abdomen. Dr. Lewis stated that respiratory distress and "reluctance to move" are also associated with peritonitis. (Tran. p.176, lines 7-17). Dr. Lewis admitted that the patient had pain and that there were physical causes for the patient's abdominal pain. Dr. Lewis stated in reference to abdominal rigidity, that it is "almost impossible for a postpartum patient to exhibit abdominal rigidity". Dr. Lewis also admitted that the patient demonstrated respiratory distress, and that she was reluctant to move. (Tran. p.190, lines 11-15; p.192; p. 193, lines 1-14; p.213, lines 1-3).

Dr. Lewis further testified that the patient certainly demonstrated the signs and symptoms of peritonitis on August 29, and August 30, but that there was difficulty in interpreting those signs because of the circumstances. (Tran. p.190, lines 3-15).

Dr. Mackman testified that Mrs. Griggel did not present the typical or classic signs of peritonitis until September 5. Dr. Mackman stated that the "clear cut" classical signs of peritonitis are abdominal rigidity, rebound tenderness, direct tenderness, fever and leukocytosis. In reference to the physical findings, Dr. Mackman did not offer a specific opinion regarding whether the patient was experiencing pain. In this case, the evidence is clear that the patient was experiencing pain as reflected by the medication that was prescribed for the patient.

In reference to abdominal rigidity, Dr. Mackman did not offer a specific opinion regarding whether there was evidence in the patient chart which indicated that the patient exhibited abdominal rigidity. Dr. Mackman testified that in his opinion, a postpartum patient can exhibit rigidity. Dr. Aprahamian testified that a postpartum patient may not demonstrate as much rigidity as a patient who is not postpartum, and Dr. Lewis stated that it is almost impossible for a postpartum patient to exhibit abdominal rigidity. Dr. Lewis stated that any minimally competent physician knows that a postpartum patient has a lax abdominal wall and that a lax wall could affect the level of rigidity that a patient will exhibit. (Tran. p.239, lines 2-8; p.267, lines 14-22; p.74, lines 13-17; p.204-205). Dr. Mackman further testified that the patient had a lung scan done; that she had a tachypnea, and that she was gasping, and that "these things" could be consistent with respiratory distress. (Tran. p.269, lines 15-21).

Finally, Dr. Aprahamian testified that the fact that there was difficulty in assessing the patient's abdomen would dictate that one would do some other objective tests to determine if there was a problem. Dr. Aprahamian stated that the objective tests ordered were chest x-rays, abdominal films, and blood tests, and that in his opinion, the objective tests did confirm the presence of abnormality. (Tran. p.74, lines 3-5).

4. Failure to Recheck Patient on August 31.

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent's conduct did not fall below the minimum standards of competence established by the medical profession in regard to having failed to recheck the patient's white blood count values on August 31.

Expert Opinion

Dr. Aprahamian testified that "on the notes of 8-31, I believe that at 4:30 in the morning, he makes the note 'will recheck WBC, KUB in a.m.'. And I see no evidence that in fact he did. And had he done so, I think the changes in the temp would have been noted and the changes in the white count would have been noted, and I think one would have to ... come to the conclusion that the patient's course was that of a peritonitis rather than post-op free air." (Tran. p.75, lines 7-14).

Dr. Aprahamian further testified that "... there's a temp spike that went up. There's one that's noted at a little over 100. The temp had come down, but ... if one made a specific point of looking at the temp, the temperature chart, would note that there is a trend. Even though at that point in the daytime its low, by looking at the temp chart, one would have noticed that the prior temperatures were elevated." (Tran. p. 75, lines 17-23). In reference to the patient's white blood count values, Dr. Aprahamian testified that "It had gone from 9,600 to 11,500 to 18,100 and the shift had gone from 3 stabs to 65 to 39." (Tran. p. 75, lines 24-25; p. 76, line 1). Dr. Aprahamian stated that in his opinion, the fact that the "white count was going up is indicative of an inflammation, and the fact that there is a change in the shift would suggest that there's inflammation and it's progressive." (Tran. p.76, lines 3-9).

Dr. Aprahamian testified that Dr. Rogers should have checked the lab results on August 31, either by checking the results prior to leaving the hospital or by calling for the results after leaving the hospital, or Dr. Rogers should have identified someone who would check the lab results for him. (Tran. p. 76, lines 14-24). Dr. Aprahamian stated that if Dr. Rogers' goal was that Dr. Tieman would do the check for him, Dr. Rogers needed to "impress upon Dr. Tieman that his thought was that the patient had a possibility of perforation with peritonitis and that he needed to specifically look at the white count and if it were up, that was bad and one would have to act. That ... if that were the case, then the note of Dr. Tieman for 8-31 did not appreciate what was going on and I think reflects on Dr. Rogers." (Tran. p.77, lines 3-13).

Dr. Lewis testified that Dr. Rogers' failure to recheck the patient on August 31, did not fall below minimum standards, because Dr. Rogers turned the care of the patient over to Dr. Tieman on August 31. Dr. Lewis stated that "He had available an individual that he knew, who is a comparably trained surgeon, to whom he turns over care frequently; and number one, because of the events of the previous day would be in a better position to provide appropriate care. And number two, having a second opinion relative to the situation going on at that point was probably in the patient's best interest". (Tran. p. 187, lines 15-25).

Dr. Mackman testified that Dr. Rogers' failure to personally recheck the patient on August 31, was not below minimum standards, because Dr. Rogers turned the care of the patient over to a competent physician who was able to evaluate and care for the patient (Tran. p.244, lines 15-25; p. 245, lines 2-5).

Respondent's Testimony

Dr. Rogers testified that he did not believe that it was necessary for him to recheck the patient on August 31, because he had asked Dr. Tieman to "come to his own conclusions about it and to see what he thought of the x-rays ... ". (Tran. p. 158, lines 5-20). Dr. Rogers testified that although it was understood that Dr. Tieman would check on the patient on August 31, Mrs. Griggel was still his patient. (Tran. p.169, lines 1-21).

Analysis

Dr. Aprahamian's opinion that Dr. Rogers failed to recheck the patient on August 31, is based upon Dr. Rogers' progress note for August 31, recorded at or around 4:30 a.m., which indicates that the patient's white blood count and the KUB x-ray would be rechecked on the morning of August 31. Dr. Aprahamian stated that if Dr. Rogers had rechecked the patient's white blood count values and the KUB on August 31, the changes in the patient's temperature readings and the white blood count values would have been noted and a conclusion would have been reached that the patient's course was that of a peritonitis rather than post operative air (Tran. p. 75, lines 7-14).

Dr. Aprahamian testified that Dr. Rogers should have either: 1) checked the lab results prior to leaving the hospital, or called the hospital to obtain the lab results, or 2) identified someone who would recheck the lab results for him.

According to the evidence, the patient's white blood count value, at or around 6:00 a.m., on August 31, was 18,100 with 39 bands and 56 segs. The patient's white count values, at some point in time on August 30, was 3,300 with 1 band and 81 segs, and 11,500 with 65 bands and 30 segs., at or around 8:00 p.m.

The patient's temperature readings on August 31, were 98.8 degrees, at or around 3:30 a.m.; 98 degrees, at or around noon, and 100.4 degrees, at or around 8:00 p.m. The patient's temperature readings on August 30, were 96.2 degrees, at or around 4:00 a.m.; 101.4 degrees, at or around noon; 98.4 degrees, at or around 8:00 p.m., and 98 degrees, at or around midnight. The patient's temperature readings on August 29, were 99 degrees, at or around 4:00 a.m.; 100.8 degrees, at or around noon, and 100.6 degrees, at or around 8:00 p.m.

A KUB x-ray was taken for the patient on August 31, at or around 7:30 a.m.

First, the evidence establishes that Dr. Rogers did not personally check the lab results of the blood tests taken at or around 6:00 a.m.; that he did not look at the KUB x-ray taken for the patient at or around 7:30 a.m., and that he did not check the patient's temperature chart after 4:30 a.m., on August 31.

The evidence shows that the blood was drawn from the patient for the lab test, at or around 6:00 a.m., on August 31. The evidence does not establish when the lab results were completed, but it does establish that the results were available to Dr. Tieman when he saw the patient around 9:00 a.m. (Dr. Tieman's progress notes reflect that he was aware of the patient's white count values).

Dr. Rogers testified that he did not check the white blood count values on the morning of August 31; that he did not believe the lab results were available to him at that time, but that the white blood count results were available to him before he left the hospital. (Tran. p.41, lines 21-15; p.42, lines 9-12). Dr. Rogers also testified that he did not look at the KUB x-rays taken for the patient on the morning of August 31, and that he did not check the temperature chart, after 4:30 a.m., on August 31. (Tran. p.42, lines 15-23; p.43, lines 5-12). Dr. Rogers stated that, at the time he saw the patient at 4:30 a.m., he was aware of the patient's white blood count values of 11,500 with 65 bands and 30 segs. (Tran. p.41, lines 11-16).

Dr. Rogers testified that he stayed at the hospital throughout the night on August 30, and that he had been "up and around" on the wards and in contact with the nurses during the early part of the night (Tran.p.40, line 25; p.41, lines 1-8; p.143, lines 1-18).

Dr. Rogers testified that he did not recall how long he was at the hospital on August 31. The evidence indicates that Dr. Rogers gave a telephone order for medication, at or around 12:20 a.m.; saw the patient, at or around 4:30 a.m.; ordered, at or around 4:30 a.m., that an amylase be done with the "a.m. blood work", and gave a telephone order for medication, at or around 5:45 a.m.

Dr. Rogers stated that he talked with Dr. Tieman, at or around 7:15 or 7:30 a.m., on August 31, about the free air and about his concern about the amount of free air. (Tran. p.145, lines 6-11). Dr. Rogers testified that he signed out to Dr. Tieman "first thing in the morning before I went into surgery"; that he (Dr. Rogers) did a C-section and a trauma case, and then he went home (Tran. p.42, lines 3-6, 12-14; p.145, lines 1-5). Dr. Rogers testified that after he saw the patient at or around 4:30 a.m., he did not see the patient again until September 1. (Tran. p.145, lines 23-25; p.146, line 1).

Dr. Rogers testified that in his practice, the physician "on call" handles problems that come up or are identified and that the nurses are instructed to call the physician who is on call that day for any changes or problems. (Tran. p.169, lines 13-14,19-21).

The evidence shows that Dr. Tieman was involved in the care of the patient as early as 8:00 a.m. The nurses' notes for August 31, indicated that, at or around 8:00 a.m., Dr. Tieman communicated with the nursing staff regarding the patient. The evidence indicates that Dr. Tieman saw the patient, at or around 9:00 a.m. Dr. Tieman's progress notes indicates that the patient's white blood count values were 18,100 with 56 segs and 39 bands, and that the amylase was 137. Dr. Tieman did not record any information in the progress notes regarding the results of the KUB x-rays taken for the patient on the morning of August 31.

The evidence establishes that between 6:00 a.m. (the time the blood was drawn for the lab tests) and 8:00 a.m. (the time Dr. Tieman communicated with the nursing staff regarding the patient, Dr. Rogers was still at the hospital; however the evidence does not establish that the lab results were available to Dr. Rogers during that time period. The evidence does establish that the test results were available to Dr. Rogers at least by 9:00 a.m., and that he could have obtained the results in person prior to leaving the hospital or by telephone prior to or after leaving the hospital.

Second, the evidence does not establish that Dr. Rogers failed to identify someone who would check the patient's white count on August 31.

Dr. Aprahamian testified that Dr. Rogers should have checked the white count lab results or identified someone who would check the lab results for him.

In this case, the evidence establishes that Dr. Tieman provided medical care and treatment for the patient on August 31.

Dr. Aprahamian testified that if Dr. Rogers' goal was that Dr. Tieman would do the check for him, Dr. Rogers needed to "impress upon Dr. Tieman that his thought was that the patient had a possibility of perforation with peritonitis and that he needed to specifically look at the white count and if it were up, that was bad and one would have to act. That ... if that were the case, then the note of Dr. Tieman for 8-31 did not appreciate what was going on and I think reflects on Dr. Rogers". Dr. Aprahamian stated that Dr. Tieman's conduct reflected on Dr. Rogers, because Dr. Rogers identified Dr. Tieman to be his surrogate, and that "his surrogate dropped the ball, .. in that sense, he dropped the ball". (Tran. p.77, lines 3-13).

Dr. Aprahamian's opinion indicates that Dr. Rogers was required to convey to Dr. Tieman: 1) "his thoughts" that the patient had a possibility of perforation with peritonitis; 2) that he needed to specifically look at the white count, and 3) that if the white blood count "was up", Dr. Tieman needed to act.

Dr. Lewis testified regarding Dr. Tieman's knowledge of the patient's medical condition, stating that: "it is reasonable to expect him to know that she had been having postoperative difficulties and had an ileus, and had the paracentesis done, and that consideration of her perforation was part of the clinical activity for the previous 48 or 72 hours and that the situation had not yet resolved itself". (Tran. p.226, lines 5-25; p.227, lines 1-18).

In this case, the evidence does not establish that Dr. Rogers did not convey to Dr. Tieman, part or all of the information which Dr. Aprahamian referred to in his opinion.

The evidence indicates that Dr. Tieman was aware of the results of the white blood count tests which were taken for the patient on August 31, at or around 6:00 a.m. Dr. Tieman's progress notes for August 31, at 9:00 a.m., states that the patient's white blood count was 18,100 with 39 bands and 56 segs; that the patient's temperature was 98.6 degrees consistently, and that the results of the amylase test was 137. Dr. Tieman's progress note also made a reference to the KUB, but the note did not contain any information regarding the findings shown on the x-rays. It is not clear from the evidence whether Dr. Tieman obtained the information documented in his progress note relating to the patient's white count values, at the request of Dr. Rogers, or as a part of his usual practice in providing medical care to patients. According to Dr. Rogers, Dr. Tieman did not convey any information to him on August 31, regarding the patient's white count values or regarding his assessment of the patient. (Tran. p.145, lines 12-22).

Dr. Rogers testified that he talked with Dr. Tieman around 7:15 or 7:30 a.m., on August 31, regarding the free air and his concern about the amount of free air, and about "what was going on".

Dr. Rogers stated that on August 30, he considered as part of his differential diagnosis whether the patient had a viscus perforation with a resulting peritonitis, and that it was a big concern. Dr. Rogers stated: "that's why I discussed it with Dr. Tieman ... Although I had made an opinion and had come to the conclusion that it was free air, I really wanted to get his ideas on it as well. And ... but then her clinical course just was not that of one with feculent peritonitis". (Tr. p.153, Ln. 25; p.154, lines 1-10).

Dr. Rogers further testified that Dr. Tieman was "on call" that day, and that Dr. Tieman was going to "make rounds", "follow up on Cheri", and "make an evaluation". (Tran. p.42, lines 18-23; p.145, lines 6-11; p.168, lines 4-6). Dr. Rogers stated that he asked Dr. Tieman to look at the x-rays and see what he thought of them; and to "come to his own conclusions about it and to see what he thought of the x-rays ... ". (Tran. p.145, lines 12-17; p.158, lines 5-20). Dr. Rogers also stated that he sought Dr. Tieman's opinion on the cause of the "massive amount" of free air shown on the patient's x-rays. (Tran. p.42, lines 18-23; p.145, lines 16-17; p.167, lines 10-14; p.168, lines 1-4).

Finally, Dr. Rogers testified that his relationship with Dr. Tieman was such that they routinely alternated seeing the patients on the wards, and that the person "on call" handled the problems that came up or were identified that day. (Tran. p.169, lines 5-21).

In this case, there was no evidence presented, other than the testimony of Dr. Rogers, regarding what information Dr. Rogers conveyed to Dr. Tieman in reference to the patient's medical condition. Dr. Tieman did not testify at the hearing.

5. Failure to Recognize Presence of Free Air on September 1.

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent's conduct did not fall below minimum standards of competence established by the medical profession, in regards to having failed to recognize the presence of free air on September 1.

Expert Opinion

Dr. Aprahamian testified that Dr. Rogers failed to recognize the presence of free air on September 1, that was not found on August 29.

Dr. Aprahamian testified the chest x-rays taken for the patient on September 1, indicated that there was free air, whereas the x-rays taken on August 29, did not. Dr. Aprahamian stated in reference to the x-rays that "12 and 13 are the PA chest and a lateral taken on September .. 1st, 1983. On the PA view, there is clearly free air underneath the left diaphragm. On the lateral, there is a shadow which is similar to the ones seen on one of the previous lateral ones that may have been misinterpreted as free air. That still exists, but I think given the PA view and now what is seen here on the lateral, I think this air underneath the diaphragm is truly free air underneath the diaphragm; it is not fortuitous shadows. And on -- there is another area in which there is what I believe to be clear evidence of free air. (Tran. p. 77, lines 14-25; p. 78, lines 1-4).

Dr. Aprahamian further testified that a minimally competent physician who compared the September 1, chest x-rays to the x-rays taken on August 29, would have concluded that "there is a change and that there is free air that is ... on these films and not on prior ones. And the conclusion has to be that this a perforated viscus, either from stomach or colon.

Dr. Aprahamian testified that, if Dr. Rogers believed that the free air shown on the September 1, x-rays was postoperative air, Dr. Rogers' belief would not be a reasonable conclusion under minimum standards, because in his opinion, (Dr. Aprahamian) the x-rays showed "a fair amount of air". Dr. Aprahamian stated that "Any post-op air that's retained in the peritoneal cavity following surgery is a minimal amount in that it's frequently absorbed rather rapidly. And what one sees here is a considerable amount and it would be difficult to perceive how that got into the belly following surgery." (Tran. p. 78, lines 5-24).

Drs. Lewis, Mackman and Rogers did not offer specific opinions in response to Dr. Aprahamian's fifth criticism.

Analysis

First, in reference to the chest x-rays (PA and lateral) taken for the patient on September 1 (Exhibits #12 and 13), the evidence establishes that the x-rays can be interpreted as showing free air. The x-ray report (Exhibit #1, p.154) stated, in part, : "As compared to a previous exam of 8/29/83. There is free intraperitoneal air under both diaphragms ... Both diaphragms are elevated and there is crowding of the vascular markings at both bases and some streak atelectasis at the left base. The costophrenic angles are sharp and there is no evidence of an infiltrate ... the pulmonary vessels are unremarkable. Impression: Evidence of free intraperitoneal air, minimal streak atelectasis at the left lung base. No evidence of infiltrate ...".

Dr. Aprahamian testified that the PA x-ray clearly showed free air underneath the left diaphragm, and that the lateral x-ray shows "a shadow which is similar to the one seen on one of the previous lateral ones that may have been interpreted as free air." (Tran. p.77, lines 20-24). Dr. Aprahamian stated that "given the PA view and now what is seen here on the lateral, I think this air underneath the diaphragm is truly free air ...; it is not fortuitous shadows." (Tran. p.77, line 25; p. 78, lines 1-3).

Dr. Lewis testified that in his opinion, there was free air present on the chest x-rays taken for the patient on September 1, and that a minimally competent physician would recognize that there is free air on the x-rays. (Tran. p.214, lines 10-25).

Dr. Mackman did not offer an opinion regarding whether the chest x-rays taken on September 1, showed free air.

Dr. Rogers testified that he looked at the September 1, x-rays and that there was free air present on the x-rays. (Tran. p.47, lines 16-24).

Second, in reference to the chest x-rays taken for the patient on August 29, the evidence establishes that two x-rays can be interpreted as showing "no free air" (Exhibits #2 and #4), and one x-ray (Exhibit #3) can be interpreted as showing no free air, or at the most minimal free air. The opinions of Drs. Aprahamian, Lewis, Mackman and Rogers regarding the presence of free air on the August 29, chest x-rays were discussed previously herein (refer to p.22).

Third, the evidence does not establish that Dr. Rogers compared the September 1, chest x-rays to the August 29, chest x-rays.

Dr. Aprahamian testified that any minimally competent physician who compared the chest x-rays taken for the patient on September 1, to the chest x-rays taken for the patient on August 29, would conclude that "there is a change and that there is free air ... that are on these films and not on prior ones. And the conclusion has to be that this is a perforated viscus, either stomach or colon." (Tran. p.78, lines 5-12).

Dr. Rogers testified, in reference to whether he compared the September 1, chest x-rays to the August 29, chest x-rays, that he didn't know if he "put them all up on the board and reviewed them together or not". (Tran. p.47, lines 6-10). In reference to the September 1, chest x-ray report, Dr. Rogers testified that the report was not available to him on September 1. (Tran. p.47, lines 11-15). As noted previously, the x-ray report for the x-rays taken on September 1, indicated that "As compared to a previous exam of 8/29/83. There is free intraperitoneal air under both diaphragms ...".

The evidence establishes that Dr. Rogers looked at the August 29, x-rays on August 30, and that he looked at the September 1, chest x-rays, sometime on September 1. The evidence does not establish that Dr. Rogers ever compared the August 29, chest x-rays to the chest x-rays taken for the patient on September 1, or that he ever looked at the September 1, chest x-ray report. (Tran. p.28, lines 7-19; p.47, lines 16-24). Dr. Aprahamian did not offer an opinion regarding whether a minimally competent physician should have compared the two sets of x-rays, or whether such physician should have reviewed the September 1, chest x-ray report. No evidence was presented regarding Dr. Rogers' usual practice in reference to reviewing and comparing x-ray films or in reference to reviewing x-ray reports.

Based upon the evidence, it must be concluded that the respondent's conduct did not fall below minimum standards in regards to having failed to recognize the presence of free air on September 1.

6. White Blood Count Changes on September 2.

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent failed to recognize the significance of the white blood count changes on September 2, and that the respondent's conduct was below the minimum standards of competence established by the medical profession.

Expert Opinion

Dr. Aprahamian testified that the respondent failed to recognize the significance of the white blood count changes on September 2. Dr. Aprahamian's opinion is based upon the fact that Dr. Rogers' progress note for September 2, stated that the patient's white blood count was normal when according to Dr. Aprahamian, the blood count was abnormal. Dr. Aprahamian stated that "when one looks at the white count, there are 15 stabs and 64 segs, which is clearly abnormal". (Tran. p.79, lines 14-18). Dr. Aprahamian stated that the abnormal white blood count indicates that the patient still had an inflammatory process. (Tran. p. 79, lines 23-25).

Dr. Lewis testified that in his opinion, Dr. Rogers recognized that there were changes in the patient's white blood count. Dr. Lewis stated that: "There is no question that there was something going on with that patient at that point and I think the activities reflected that. Again, I think that there was misinterpretation, but that it's not a matter of not recognizing that there was something going on." (Tran. p. 188, lines 1-14).

Dr. Mackman testified that in his opinion, Dr. Rogers's conduct did not fall below minimum standards. (Tran. p. 246, lines 5-25). Dr. Mackman stated that the "white blood count is one thing, but the differential is another thing. And if you basically just looked at the white blood count, it wouldn't be too catastrophic." (Tran., p. 246, lines 16-18).

Respondent's Testimony

Dr. Rogers testified that the patient's white blood count and the differential improved over a period of time. Dr. Rogers stated: "If she had a spreading peritonitis, why did her white count come down to normal and why did the differential improve from 64 bands to 33 bands to 15 bands, which is a progressive improvement. The bands imply -- are what implies the acute infection and sepsis." (Tran. p.158, lines 21-25; p. 159, lines 1-7).

Analysis

Dr. Aprahamian testified that in his opinion, Dr. Rogers' progress note for September 2, records that the patient's white blood count was normal, when in fact, according to Dr. Aprahamian, it was abnormal. Dr. Aprahamian stated that the white count differential, "15 stabs and 64 segs" was clearly abnormal. (Tran. p.79, lines 10-25).

Dr. Rogers' progress note for September 2, reads in part as follows: Afebrile. Vital signs stable. Feels much better - good attitude ... Abdomen distended but much softer ... minimum tenderness ... white blood count normal ... Impression - Much improved - continue IVs, sips liquid. (Exhibit #1, p.39).

First, the evidence establishes that the patient's white blood count differential was abnormal.

The evidence in this case, indicates that the patient's white count values on September 2, were 5,800 with 15 bands and 64 segs. (Ex.#1, p.128).

Dr. Aprahamian's opinion that the patient's white count was abnormal on September 2, is based upon the white count differential which was "15 bands and 64 segs". Dr. Aprahamian stated that "when one looks at the white count, there are 15 stabs and 64 segs, which is clearly abnormal" (Tran. p.79, lines 10-18). Dr. Aprahamian further stated that the white count value, 5,800 is "normal if one took it in and by itself; when one looks at 3,300, 11,500, 18,100, and 5,800, one wonders why it fell to 5,800, and is the patient pooping out and is unable to generate a white count. One looks at the differential, and the differential consistently shows a shift to the left". (Tran. p.104, lines 20-25; p.105, lines 1-3).

Dr. Lewis testified that the white blood count became "normal as of September 2," and then became "abnormal again after that". (Tran. p.188, lines 15-25; p.189, lines 1-7). Dr. Lewis did not offer a specific opinion regarding whether the differential (15 bands and 64 segs) was abnormal.

Dr. Mackman did not offer a specific opinion regarding whether the patient's blood count differential was normal or abnormal. Dr. Mackman testified that the white count is one thing, but the differential is another. Dr. Mackman stated that "if you basically just look at the white count, it wouldn't be too catastrophic". (Tran. p.246, lines 14-18). Dr. Mackman testified that, in this case, there were nonsurgical causes that could account for the white blood count and shift. Dr. Mackman stated that atelectasis would cause an increased blood count and that in his opinion, Ms. Griggel had atelectasis. (Tran. p.247, lines 1-22).

Dr. Aprahamian testified that atelectasis could cause an increase in the white blood count, but "not necessarily in that amount; and I would expect to see atelectasis to be sooner and I would expect the temp to be higher sooner with a tachycardia. And those things weren't present". Dr. Aprahamian stated that the patient may have had a "small atelectasis, but not a significant one to account for that white count fluctuating that much". (Tran. p.100, lines 17-25; p.101, lines 1-7).

Dr. Rogers testified that the white blood count was normal on September 2, and admitted on cross-examination that the "differential was not normal". (Tran. p.168, lines 7-13). Dr. Rogers' opinion regarding the blood count differential emphasizes that the differential showed "progressive improvement". (Tran. p.158, lines 21-25; p.159, lines 1-7).

Second, the evidence establishes that the abnormal white blood count on September 2, indicated that the patient had an inflammatory process.

Dr. Aprahamian testified that the patient's abnormal white count indicated that the patient still had an inflammatory process. (Tran. p.79, lines 23-25).

Drs. Lewis, Mackman and Rogers did not offer a specific opinion regarding whether the white blood count differential on September 2, indicated that the patient had an on-going inflammatory process. Dr. Mackman testified that the sequence of the white blood count values and differentials from August 29, through September 2, "would make one suspicious that there is an infection somewhere". (Tran. p.274, lines 4-8).

7. Intra-Abdominal Air on September 5.

Determination

Based upon the evidence presented at the hearing, it must be concluded that the respondent failed to appreciate the real significance of the intra-abdominal air on September 5, and that the respondent's conduct was below the minimum standards of competence established by the medical profession.

Expert Opinion

Dr. Aprahamian testified that Dr. Rogers failed to appreciate the real significance of the intra-abdominal air on September 5. Dr. Aprahamian stated that the September 5th x-rays demonstrates intra-abdominal air and that Dr. Rogers did not recognize that the patient had peritonitis after looking at those x-rays. Dr. Aprahamian stated that a minimally competent physician who looked at the x-rays taken for the patient on September 5, would have diagnosed from the x-rays that the patient had suffered a perforation. (Tran. p.80, lines 1-4; p.81, lines 20-24).

Dr. Aprahamian testified in reference to Dr. Rogers' progress note for September 5, stating that: "In looking at that note, one is left with the impression that ... his mind was going; here is free air; the free air is bad because it's impacting on the patient's ventilation; therefore, I'll take out the free air so that the patient can breathe better. And only as an aside did he plan on checking for -- to see if there was a perforated viscus." (Tran. p. 80, lines 1-10).

Dr. Lewis testified that Dr. Rogers's conduct was not below minimum standards, because Dr. Rogers operated on the patient on September 5. Dr. Lewis stated that "I think it's fairly obvious that he recognized that there was a problem at that point and that there had been a perforation and he acted on it appropriately." (Tran. p. 189, lines 8-17).

Dr. Mackman testified that Dr. Rogers operated on the patient on September 5, because he diagnosed peritonitis." (Tran. p. 247, lines 23-24; p. 248, lines 1-3).

Respondent's Testimony

Dr. Rogers testified that Dr. Aprahamian's opinion that he did not appreciate the significance of the intra-abdominal air on September 5, and in essence failed to diagnose the peritonitis on that day, is a "gross misrepresentation". Dr. Rogers testified that: "I saw Cheri in the morning, and we're extremely busy, it being Labor Day and through the emergency room, and -- but you know, was trying to do ten different things at once, and ordered x-rays and go back and look at the x-rays and then see someone else. And no, I appreciated the significance of that x-ray and I took Cheri down and did a paracentesis to confirm what kind of fluid it was and took her to surgery that same afternoon" (Tran. p.159, lines 11-23).

Analysis

Dr. Aprahamian's opinion that Dr. Rogers failed to appreciate the real significance of the intra-abdominal air on September 5, is based upon the fact that Dr. Rogers did not diagnose from the x-rays that the patient had suffered a perforation. According to Dr. Aprahamian, the September 5, x-rays "demonstrates intra-abdominal air". (Tran. p.80, lines 1-5).

First, the evidence establishes that some of the abdominal and chest x-rays taken for the patient on September 5, can be interpreted as showing free air.

The evidence shows that several chest and abdominal x-rays were taken for the patient. Dr. Rogers testified that he ordered abdominal x-rays "sometime earlier in the day". The nurses' notes indicate that the patient was taken for x-rays sometime during the morning of September 5, and again at some time between 3:00 p.m. and 4:30 p.m.

In reference to the abdominal x-rays (Exhibits 15,16,18), the evidence establishes that the films of the x-rays can be interpreted as showing free air. Dr. Aprahamian testified that Exhibit #15, shows evidence of a "small amount of free air in selected areas"; that in Exhibit #16, there is "what looks like air ... outside the GI tract in the left quadrant below the diaphragm and also in the right upper quadrant, both of which suggest an abscess", and that Exhibit #18, shows "abundant free air in the peritoneal cavity". (Tran. p.80, lines 24-25; p.81, lines 1-8, 16-18).

Dr. Mackman stated regarding Exhibit #15, that there is "probably free air; that Exhibit #16, is a "clearer picture of free air", and that Exhibit #18, shows a "huge amount of free air". (Tran. p.290, lines 4-17; p.291, lines 1,10-13,23-24). Drs. Lewis and Rogers did not offer a specific opinion regarding whether the abdominal x-rays showed free air.

In addition, the report for the supine and erect x-rays states that "The massive amount of free intraperitoneal air is again visualized". The report for the lateral x-ray states that "there is a massive amount of free intraperitoneal air" (Exhibit #1, p.155-156).

In reference to the chest x-rays (Exhibits #14,17), the evidence establishes that the x-rays can be interpreted as showing free air. Dr. Aprahamian testified that Exhibit #14, shows some evidence of free air underneath the right diaphragm, and that Exhibit #17, which is a lateral x-ray, suggests that there is some air outside the GI tract underneath the diaphragm. (Tran. p.80, lines 14-23; p.81, lines 9-15).

Dr. Mackman testified that Exhibit #14 shows "some intra-abdominal air". (Tran. p.289, lines 16-21). Dr. Mackman stated in reference to Exhibit #17, that there is no clear evidence of free air under the diaphragm. (Tran. p.291, lines 3-9, 14-16; p.292, lines 1-4). Drs. Lewis and Rogers did not offer a specific opinion regarding whether the chest x-rays show free air.

In addition, the chest x-ray report stated that "free intraperitoneal air is again seen beneath both hemidiaphragms". (Exhibit #1, p.155).

Second, it can be concluded that a minimally competent physician who looked at the x-rays taken for the patient on September 5, would have diagnosed from the x-rays, that the patient had suffered a perforation.

Dr. Aprahamian testified that in his opinion, a minimally competent physician who looked at the x-rays taken for the patient on September 5, would diagnose from the x-rays that the patient had suffered a perforation. (Tran. p.81, lines 20-14).

Dr. Lewis testified that in his opinion, any minimally competent physician who had followed the patient's course throughout her hospitalization, and who read those x-rays would conclude that the patient had either a perforation or some other significant intra-abdominal problems at that point. (Tran. p.221, lines 9-14).

Dr. Mackman testified that he believed that on September 5, with "that massive amount of free air", any physician would have diagnosed a perforation. (Tran. p.292, lines 10-20).

Third, the evidence establishes that on September 5, Dr. Rogers looked at the September 5, x-rays, at some point in time, prior to performing the paracentesis.

Dr. Rogers testified that he ordered abdominal x-rays "earlier in the day" on September 5. Dr. Rogers stated that he did not know when he looked at the abdominal x-rays, but that it was sometime before 4:00 p.m. (Tran. p.53, lines 8-13). Dr. Rogers stated that his progress note for September 5, at or around 4:00 p.m., contains information which he learned after looking at the x-rays. Dr. Rogers' progress note stated, in part: "persistent intraperitoneal air with large amounts probable third space fluid". (Tran. p.53, lines 15-19).

The evidence indicates that Dr. Rogers performed a paracentesis on the patient, at or around 4:30 p.m., on September 5.

Fourth, the evidence establishes that Dr. Rogers did not diagnose from the September 5, x-rays that the patient had suffered a perforation.

Dr. Aprahamian testified that Dr. Rogers made the diagnosis of perforation after he "put in a lavage catheter and aspirated peritoneal contents and air" (Tran. p.81, line 25; p.82, lines 1-5). Dr. Aprahamian stated that in his opinion, Dr. Rogers' primary intent in performing the paracentesis was to remove the air for improving pulmonary toilet rather than for diagnosing perforated viscus". (Tran. p.82, lines 19-25; p.83, lines 1-3). Dr. Aprahamian stated that his opinion is based upon Dr. Rogers' progress note for September 5. Dr. Aprahamian stated that:

"..in his note one gets the impression that he knew the x-rays had been taken and had read the pictures. His impression is 'persistent intraperitoneal air with large amounts of probable third space fluid. Will tap air and fluid from abdomen and allow for pulmonary toilet for suspected pneumonia and culture to be sure not missing a low-grade peritonitis from an occult gastric perforation'. And the very next note is an op note. I'm led to believe that in fact he inserted the peritoneal dialysis catheter and removed air and removed the fluid and came to the conclusion that in fact the patient had a perforation, and on the basis of that went to the operating room. (Tran. p.82, lines 7-18).

Dr. Lewis testified that in his opinion, there was sufficient evidence on September 5, before the paracentesis was done, such that any minimally competent physician should have diagnosed that the patient had suffered a perforation (Tran. p.223, lines 9-12; p.224, lines 9-25; p.225, lines 1-8).

Dr. Mackman testified that he believed "that on the 5th with that amount of free air that any physician would have diagnosed a perforation, and I think ... that's very likely the reason why the patient was taken to surgery. (Tran. 292, lines 10-20).

Dr. Rogers testified that the September 5, x-rays caused him to reconsider the diagnosis of perforation; that he then did a paracentesis in order to determine whether in fact there was a perforation, and that the paracentesis revealed large amounts of fluid, which led him to perform surgery on the evening of September 5. (Tran. p.53, line 25; p.54, lines 1-9).

B. Unacceptable Risks

The complainant alleges that Dr. Rogers' conduct in providing medical care and treatment to Cheryl M. Griggel constituted a danger to the health, welfare and safety of the patient, in that the respondent's conduct created the unacceptable risk that the patient's perforated cecum would not be timely and adequately diagnosed and treated, thus exposing the patient to risks which a minimally competent physician would not expose a patient.

In Gilbert, supra pp. 196-197, the Wisconsin Supreme Court indicated that the term "danger" refers to unacceptable risks caused by a course of treatment utilizing accepted medical standards. The Court further stated that the testimony (of an expert witness) must "unequivocally indicate that a minimally competent physician would have chosen a different course of treatment which would have avoided or minimized the unacceptable risks".

In determining whether Dr. Rogers' conduct in failing to diagnose and treat the patient for a perforated viscus constituted a danger to the health, welfare or safety of the patient, it is essential to review the evidence in light of whether the respondent's conduct posed an unacceptable risk of danger to the health, welfare or safety of the patient.

Dr. Aprahamian testified that the risk to the patient created as a result of Dr. Rogers' failure to diagnose and treat the patient for a perforated viscus is that the perforation was not timely diagnosed and treated. Dr. Aprahamian stated regarding the risk to the patient that: "I believe that had the patient been diagnosed on 8-30 as having a perforated viscus and was operated on .. 8-30, the patient's ultimate course would have been different. Since there was failure to make the diagnosis on 8-30, the delay from 8-30 until 9-5 posed an unacceptable risk to the patient". (Tran. p.83, lines 4-12). Dr. Aprahamian further testified that:

The morbidity and mortality of a perforation is increased from the time the perforation occurs and then the establishment of a peritonitis. And with the establishment of peritonitis, the patient's normal body mechanisms are thrown off kilter, and as a result of that the patient's morbidity/mortality increases the longer there is a delay in making the diagnosis and initiating treatment.

Dr. Aprahamian further testified that in his opinion, a minimally competent physician on August 30, would have diagnosed the patient's perforated viscus or at least assessed the patient with diagnostic procedures that would have ruled in or out the perforated viscus. Dr. Aprahamian stated that: "Having identified it would have made sure that the patient underwent a surgical procedure to correct and repair the perforation. Each day that the diagnosis was missed I think was increasing the patient's risk for a morbidity/mortality". (Tran. p.83, lines 20-25; p.84, lines 1-6; p.120, lines 17-25).

Dr. Lewis testified that the risks to a patient from a perforation is significant, and that in this case the patient demonstrated just how significant the risks can be. Dr. Lewis stated that a patient can eventually die as a result of a perforation, and that patients certainly develop peritonitis and sepsis frequently. (Tran. p.195, lines 14-25; p.196, lines 1-3; p.215, lines 8-11).

Dr. Lewis further stated that if a physician acts on the presence of free air as though it is a perforation, and it turns out to be postoperative air, the risks associated with another operation are significantly greater than zero (Tran. p.196, lines 4-19; p.215, lines 12-25; p.216-217).

Dr. Lewis stated that "there's no question that this lady had a perforation and would have been served well by an operation the night of the 29th or the morning of the 30th. That would have been preferable with this patient. But if you have a complicated clinical situation and you .. have to then say, well, how many women is it reasonable to operate on and find out there's no perforation there for every person that you do operate on with a perforation. And that's the decision that Dr. Rogers was trying to make at this point, whether or not the signs that we've been talking about were sufficient to justify the risk of the operation. And his decision was that they weren't". (Tran. p.217, lines 2-15).

Dr. Mackman testified that the risks associated with a perforation depend upon whether or not the perforation seals off and is treated properly, in such cases there could be no risk. Dr. Mackman stated that if a perforation does not seal off and there is "continual seeding of the peritoneal cavity, it could be lethal". (Tran. p.271, lines 5-10).

The evidence clearly establishes that the patient would have benefitted from surgery on August 29 or August 30. Dr. Aprahamian testified that a minimally competent physician would have diagnosed the patient's perforated viscus or at least assessed the patient with diagnostic procedures that would have ruled in or out the perforated viscus. Dr. Aprahamian stated that having diagnosed a perforation, a minimally competent physician would have performed surgery to correct and repair the perforation. The evidence in this case clearly establishes that the patient suffered a perforation on August 29, or August 30, and that Dr. Rogers did not diagnose or treat the patient for the perforation until September 5. The evidence also establishes that the risk to a patient, if a patient suffers a perforation is peritonitis and if the peritonitis is not treated, the risk is death.

Based upon the evidence, it must be concluded that the respondent's conduct in failing to diagnose and treat Cheryl M. Griggel for a perforated viscus, posed an unacceptable risk which a minimally competent physician would have avoided or minimized.

2. Appropriate Discipline

The purposes of imposing discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct, and to promote the rehabilitation of the licensee. State v. Aldrich, 71 Wis.2d 206 (1976). Punishment of the licensee is not a proper consideration. State v. MacIntyre, 41 Wis.2d 481 (1969).

This examiner recommends that the Medical Examining Board reprimand the respondent for his conduct in failing to diagnose and treat the patient, Cheryl M. Griggel for a perforated viscus. The reprimand of the respondent is recommended in this case to insure protection to the public. The evidence in this case clearly establishes that the respondent's conduct in providing medical care and treatment to Cheryl M. Griggel constituted a danger to the health, safety and welfare of the patient. This examiner does not recommend suspension or revocation of the respondent's license, because the respondent's conduct in this case involves the treatment of one patient and involves one aspect of his practice, that is, his ability to recognize postoperative complications.

In addition, this examiner concurs with the recommendations of the complainant that the respondent's license be limited; that the respondent be required to obtain education on the subject area of postoperative complications, and that the respondent be supervised by a Board appointed physician for a period of one year. The respondent has indicated that if discipline is to be imposed by the Board, the recommendations of the complainant regarding discipline are acceptable to him. (Tran. p.314-317; Closing Argument and Post Hearing Brief of Respondent, p.17).

IV. PROCEDURAL MATTERS

The respondent filed a motion to dismiss this action based upon the grounds that he was denied due process of law by the Board's failure to allow him to attend his own hearing. (refer to respondent's Closing Argument and Post Hearing Brief, p. 4-6).

The respondent states that on March 22, 1989, the Board met to consider a Stipulation and proposed Final Decision and Order submitted by the parties. Respondent states that paragraph 10 of the Stipulation provided in part, that "the attorney for the parties ... may appear before the Medical Examining Board and argue in favor of acceptance of this Stipulation". Respondent states that the Stipulation would have allowed him to retain his license, albeit in limited form. Respondent states that he nor his attorney were advised of the "hearing" so as to appear in support of the Stipulation, and that a subsequent request by his attorney to appear before the Board was rejected.

The complainant argues that respondent's motion should be denied, because respondent has not been denied any of his due process rights. (refer to Complainant's Rebuttal To Respondent's Argument And Brief, p. 1-5)

First, the respondent has failed to set forth facts sufficient to support a favorable ruling on his motion.

Respondent filed a document referenced "Closing Argument and Post Hearing Brief". The respondent did not file affidavits or other verified documents in support of his motion.

The respondent states that he was not informed that the Medical Examining Board was going to consider the Stipulation and proposed Final Decision and Order, at its March 22, 1989, meeting. The respondent's statement is not consistent with the affidavit filed by the complainant in opposition to the respondent's motion, (refer to Complainant's Rebuttal To Respondent's Argument and Brief, and attached Exhibits). Since respondent's failed to file affidavits or other verified documents in support of his position, considerable weight must be given to the affidavit filed by the complainant. The affidavit filed by the complainant (Exhibit D, #1), clearly indicates that respondent was fully aware that the Board, in all likelihood, was going to consider the Stipulation at its March 22, 1989, meeting. It is apparent from the facts presented in the complainant's affidavit that the respondent, for whatever reason, waived his right to appear before the board to speak in support of the Stipulation.

Second, the respondent argues that the Board's meeting on March 22, 1989, at which the Board considered the Stipulation filed by the parties, "arguably" constituted a Class 2 proceeding under sec. 227.01 (3)(b) Stats., thereby entitling him to a ten-day notice and an opportunity to be heard, or alternatively, he was entitled to a hearing under sec. 227.42 (1) Wis. Stats.

The complainant argues that the Board's March 22, 1989, meeting was not a "class 2 proceeding", and that the respondent was not entitled to a hearing under sec. 227.42 (1) Stats., on the Board's "contemplation and subsequent decision of whether to accept or reject the stipulation".

In reference to whether the Board's March 22, 1989, meeting constituted a "class 2 proceeding", under sec. 227.01 (3)(b) Stats., the complainant argues that: 1) there was not a substantial interest asserted by one party and denied or controverted by another party since the parties expressly agreed to a stipulated resolution of the matter, and 2) a substantial interest of a party was not determined or adversely affected by a decision or order after a hearing required by law, because no hearing had been held.

In reference to whether the respondent was entitled to a hearing under sec. 227.42 (1) Stats., the complainant argues that: 1) the respondent does not assert, nor does the evidence in the record indicate, that he filed a written request with the Board for a "hearing" on the Board's deliberation of the Stipulation, and 2) there is no dispute of material fact with regard to the Stipulation, since it was an agreed-upon resolution of the case against the respondent.

This examiner concludes that the complainant's arguments on the issue of whether the respondent was entitled to a hearing under Ch. 227, Stats., is most persuasive. There is no legal basis upon which it can be concluded that the Board's March 22, 1989, meeting constituted a "class 2 proceeding", in reference to the Board's consideration of the Stipulation and proposed Final Decision and Order submitted by the parties, and there is no legal basis upon which to conclude that the respondent was entitled to a hearing under sec. 227.42 (1) Stats., on the Board's deliberation of the Stipulation. The respondent's arguments are not supported by case law, and do not represent a reasonable interpretation of the statute.

Third, the respondent argues that the basic notion of "fairness" inherent in the Fifth and Fourteenth Amendment as well as Article 1, sec. 1, of the Wisconsin Constitution, demands that at the least, minimal procedural safeguards be instituted. Respondent states that one of the most basic aspects of due process is the right to be heard.

The complainant argues that respondent was granted a "meaningful" opportunity to be heard; that the respondent waived his right to be heard by opting not to appear at the hearing scheduled for March, 1989, and that the respondent waived his due process rights by signing the Stipulation which expressly provided that the respondent freely, voluntarily and knowingly waived certain due process rights.

Complainant relies upon State ex rel. Michalek v. LeGrand, 77 Wis. 2d 520, 533-34, 253 N.W.2d 505 (1977), to support its position that the respondent has been granted a meaningful opportunity to be heard. Complainant referred to the six elements identified by the Wisconsin Supreme Court in LeGrand, in reference to what constitutes a "meaningful" opportunity to be heard. The six elements identified are as follows: (1) Timely and adequate notice detailing the reasons for a proposed deprivation of rights; (2) An effective opportunity to defend by confronting any adverse witnesses and by presenting arguments and evidence orally; (3) Retained counsel, if desired; (4) An impartial decision maker; (5) A decision resting solely on the legal rules and evidence adduced at the hearing, and (6) A statement of reason for the decision and the evidence relied on.

On the issue of whether the respondent was afforded a "meaningful" opportunity to be heard, this examiner is persuaded by the arguments of the complainant.

The record, including the affidavit of the complainant, indicates that a disciplinary proceeding was commenced before the Medical examining Board against the respondents, Barry L. Rogers and Michael E. Tieman, by the filing of a Disciplinary Complaint on September 2, 1988. A hearing constituting a class 2 proceeding under Ch. 227 Stats., was scheduled to held on March 20-23, 1989. The complainant appeared at the hearing and proceeded with the hearing relating to the disciplinary action filed against Dr. Michael E. Tieman. Neither the respondent, Barry L. Rogers, nor his attorney appeared at the hearing held on March 20-23, 1989.

This examiner concludes, based upon the facts in the record, and the legal authority discussed herein, that the respondent has been provided with a meaningful opportunity to be heard. The respondent was provided with opportunities to be heard: 1) at the March 22, 1989, meeting of the Medical Examining Board; 2) at the disciplinary hearing held on March 20-23, 1989, and 3) at the hearing held on October 30-31, and November 1, 1989. Respondent waived his opportunity to be heard at the March 22, 1989, meeting of the Medical Examining Board, and at the hearing held on March 20-23, 1989, by electing not to appear.

This examiner recommends to the Medical Examining Board that the respondent's motion to dismiss this action be denied for the reasons set forth herein.

Dated at Madison, Wisconsin this 22nd day of June, 1990.

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Hearing Examiner