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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
Christine E. Langemo, MD, Respondent.	:	LS0307292MED

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 16TH day of FEBRUARY, 2005.

Board Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	PROPOSED FINAL DECISION AND ORDER
CHRISTINE E. LANGEMO, M.D. RESPONDENT	:	Case No. LS 0307292 MED

The parties to this action for purposes of Wis. Stats. § 227.53 are:

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Agency

Medical Examining Board
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Procedural History

A hearing in the above captioned matter was held on February 17 and 18, 2004, before Administrative Law Judge William A. Black. The Division of Enforcement appeared by attorney Gilbert C. Lubcke. Attorney Sarah J. Elliott appeared on behalf of Christine E. Langemo, M.D. Based on the entire record in this case, the undersigned administrative law judge 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. Christine E. Langemo, M.D., Respondent herein, N4448 Jordan Center Road, Argyle, Wisconsin, 53504, was born on 12/27/59 and is licensed and currently registered to practice medicine and surgery in the state of Wisconsin, license #33086, said license having been granted on 4/29/92.

2. Respondent is trained as a family practice physician but at all times relevant to this complaint was employed and practicing as an emergency room physician at the Monroe Clinic Hospital.

3. Andrew Meier, the patient herein, was born on 7/25/96.

4. On 11/25/96, the patient's father took him to his primary pediatrician for a routine checkup and immunizations. The patient had had a cold and stuffy nose for a couple of days and was more fussy than usual. The pediatrician's examination disclosed that the patient was afebrile, his lungs were clear and his abdomen was soft and nontender with positive bowel sounds. The pediatrician diagnosed a viral syndrome and elected to delay administering the immunizations.

5. The patient remained fussy on 11/26/96.

6. On 11/27/96, following the patient's afternoon nap, the patient's mother noted two small spots of blood in his stool when she changed his diaper. He also had developed diarrhea. When she attempted to feed him, he vomited and continued to vomit with each attempt to feed him thereafter. He continued to have diarrhea. He became more fussy as the day went on with more crying episodes and he became more difficult to console.

7. On the evening of 11/27/96, the patient's mother contacted by telephone the emergency room at the Monroe Clinic Hospital. The emergency room referred her to the pediatrician on call and she spoke with him by telephone at approximately 2100 on 11/27/96. She reported the patient's symptoms to her pediatrician and also reported that the patient had a low grade fever. The pediatrician recommended that she give Tylenol for that she spoon feed Pedialyte every 15 minutes.

8. The patient remained fussy throughout the night of 11/27-28/96 and continued to vomit.

9. The patient remained fussy and continued to cry and to vomit on the morning of 11/28/96. At 1643 on 11/28/96 the patient's mother and father took him to the emergency room at the Monroe Clinic Hospital with continuing complaints of vomiting, diarrhea and fever. Respondent was the emergency room physician staffing the emergency room at the time of the patient's arrival.

10. The emergency room nurse obtained a medical history from the patient's mother. The patient's mother reported that the patient was fussy and had had diarrhea for 2 days with 4 to 5 watery diarrhea stools the prior day but no incidents of diarrhea on the day of the emergency room visit. The patient's mother noted that the patient's diarrhea had been brownish-reddish in color and the nurse observed a small amount of the brownish-reddish diarrhea in the patient's diaper at the time of his admission to the emergency room. The patient's mother also reported that the patient had begun vomiting the prior day and was continuing to vomit with 3 episodes of vomiting earlier

on the day of the emergency room visit. The patient's mother reported that the patient had had a fever the previous evening. The nurse noted that the patient was awake, active, alert and smiling when she assessed him in the emergency room. The nurse's assessment disclosed that the patient's lungs were equal and clear bilaterally and he had bowel sounds in all 4 quadrants.

11. Respondent obtained a medical history from the patient's mother and spoke with the emergency room nurse about her findings. Respondent ascertained from the patient's mother that the patient began to develop loose stools on 11/25/96 but did not have diarrhea. On 11/26/96 and 11/27/96, the patient had diarrhea with 5 stools on 11/27/96 and 1 stool on 11/28/96 prior to the patient's arrival in the emergency room. The respondent was told by the patient's mother that the patient's stool might have blood in it. The respondent also ascertained from the patient's mother that the patient had been vomiting since 1500 on 11/27/96 and had vomited at least 6 times on 11/27/96 and 3 times since awakening on 11/28/96. Respondent was told by the patient's mother that she had been giving Tylenol every 4 hours to control the patient's fever.

12. The respondent examined the patient in the emergency room on 11/28/96.

13. The respondent's differential diagnosis was gastroenteritis, intussusception, appendix, Meckel's diverticulum, pyloric stenosis, and a secondary diagnosis of dehydration. The differential diagnosis did not include an inguinal hernia.

14. The respondent conducted the examination while the patient was being held supine on his mother's lap, not positioned on an examining table.

15. The respondent did not listen for the patient's bowel sounds.

16. The respondent did not perform a visual inspection of the patient's rectal area.

17. The respondent did not perform a visual inspection the patient's inguinal area.

18. The respondent visualized the patient's abdomen during her examination.

19. The respondent palpated the patient's abdomen with hand to patient skin contact during her examination.

20. The department stipulated that the respondent was not subject to discipline based upon a failure to diagnose.

21. The respondent noted that at the time of the examination, the patient was interactive, sleepy and in no acute distress.

22. The respondent recorded in the emergency room record that the patient's lungs were clear with good aeration and his abdomen was soft and nontender with no masses.

23. The respondent observed reddish-brown stool in the patient's diaper but noted no frank blood. The respondent was of the opinion that the stool in the diaper did have blood in it but she saw no indication that it had a currant-jelly appearance.

24. The respondent also examined the patient's fontanel, the membranes of the patient's mouth and lips and the patient's eyes for evidence of dehydration. The respondent also noted that the patient had tears. The respondent concluded that the patient was not dehydrated.

25. The respondent's diagnosis in the emergency room on 11/28/96 was viral gastroenteritis. She recommended that the patient return home and remain on clear liquids for 24 hours and then be given ½ strength formula for the next 24 hours and then return to full strength formula as tolerated. Respondent also recommended that the patient's mother follow-up with the patient's regular pediatrician the following morning.

26. The respondent told the patient's parents to return to the emergency room if the patient's condition worsened or if the patient developed signs of dehydration.

27. On the night of 11/28-29/96, the patient slept for brief periods of time but frequently woke up crying. At approximately 0630 on 11/29/96, the patient's mother observed some brown foul smelling emesis trickling out of the side of the patient's mouth. The patient's mother determined that they should take the patient back to the emergency room. While she was changing the patient's clothes, she noted that the patient was breathing abnormally and his eyes were fixed straight ahead. While in the car on the way to the emergency room, the patient stopped breathing. Attempts at resuscitation at the emergency room at the Monroe Clinic Hospital were unsuccessful and the patient was pronounced dead at 0714 on 11/29/96.

28. An autopsy was performed at 1100 on 11/29/96 which disclosed intussusception with 4.5 centimeters of the ileum telescoped into the cecum. The entire wall of the telescoped terminal ileum and cecum were markedly dark, edematous and friable consistent with ischemia. The patient's lungs were markedly congested and other organs showed generalized congestion. A blood culture taken from the right ventricle of the patient's heart grew Enterococcus Faecalis. (Admitted in Answer)

29. The respondent's assessment of the patient's medical condition in the emergency room on 11/28/96 as set forth above met the minimum standards of competence accepted in the profession and did not create an unacceptable risk to the patient in the following respects:

a. The respondent performed a minimally competent abdominal examination.

b. The respondent was not required to listen for bowel sounds because in the absence of any tenderness upon palpation of the abdomen the presence or absence of bowel sounds and their quality, would mean little in differentiating between diagnoses, especially owing to the fact that the patient had recently had a bowel movement.

c. The respondent was not required to perform a rectal evaluation in this instance given the patient's history and presenting symptoms.

d. The respondent was not required to visualize the patient's inguinal area because an inguinal hernia was not a part of her differential diagnosis and the department stipulated that she was not subject to discipline based upon a failure to diagnose, or based upon a failure to create a minimally competent differential diagnosis.

Conclusions of Law

1. The Medical Examining Board has jurisdiction in this matter pursuant to Wis. Stats. § 448.02(3).

2. Respondent's conduct as set forth in the Findings of Fact does not constitute unprofessional conduct contrary to Wis. Stats. § 448.02(3), and Wis. Admin. Code § MED 10.02(2)(h) by engaging in conduct that tends to constitute a danger to the health, welfare and safety of the patient.

Order

IT IS HEREBY ORDERED, that the disciplinary action against the respondent be and hereby is dismissed.

Opinion

The patient's parents brought four month old Andrew Meier, (patient) to the emergency room at the Monroe Clinic where the respondent worked on Thanksgiving Day, 11/28/96.

The patient had a history of a bilateral inguinal hernias, both which had been repaired on September 18, 1996.

The patient had a history of vomiting and diarrhea of greater than twenty four hours duration. The patient had recently been vomiting every time the parents attempted to feed him and had a history of fussiness and crying and was essentially inconsolable. The patient had been taken to his primary pediatrician on November 25, 1996 for a routine examination and immunizations. He had had a cold and stuffy nose for a couple of days and was more fussy than usual. The patient's pediatrician on November 25, 1996, diagnosed a viral syndrome and did not administer immunizations that day.

The patient's mother had been in contact with the patient's pediatrician by telephone on the evening of November 27, 1996, and the pediatrician had recommended Tylenol for fever and that the parents spoon feed Pedialyte every 15 minutes.

The respondent's diagnosis in the emergency room on November 28, 1996, was viral gastroenteritis. Her differential diagnosis was gastroenteritis, intussusception, appendix, Meckel's diverticulum, pyloric stenosis, and possibly dehydration. (RT p. 23)

The respondent recommended that the patient return home and remain on clear liquids for 24 hours and then be given ½ strength formula for the next 24 hours and then return to full strength formula as tolerated. Respondent also recommended that the patient's mother follow-up with the patient's regular pediatrician the following morning. She also told told the patient's parents to return to the emergency room if the patient's condition worsened or if the patient developed signs of dehydration.
The patient died on November 29, 1996 of intussusception. Not at issue in this case is whether the intussusception was diagnosable in the emergency room by the respondent on November 28, 1996.

The department stipulated that the respondent was not being held subject to discipline for the failure to diagnose.

Rather the complaint alleges that the respondent's examination of the patient was below the minimally accepted standard necessary to permit diagnosis of one or more of the conditions that were consistent with the patient's presenting symptoms and medical history.

The potential diagnoses recounted by the department's expert included intussusception, pyloric stenosis, volvulus, hernia, ileus associated with various causes, appendicitis, Meckel's diverticulum, metabolic abnormalities, bacterial gastroenteritis and viral gastroenteritis.[i]

The complaint alleges the minimum standard of examination as follows:

18. A minimally competent physician, to avoid or minimize the unacceptable risks to the patient, would have:

> a. Examined the patient's abdomen while the patient was on an examination table with his abdomen fully exposed to permit a thorough and reliable abdominal examination including a thorough and reliable assessment for abdominal distension, tenderness, the presence, quality and location of bowel sounds and the presence of abdominal masses.
>
> b. Performed a rectal evaluation to evaluate the source of the blood noted in the patient's stool.

Positioning of the patient and visualization and palpation of the patient's abdomen.

The respondent testified that she did visually assess the patient's abdomen (other than the inguinal area, which remained covered by a diaper) and palpated it, including deep palpation in all four quadrants for tenderness and masses. She did not elicit any tenderness or masses. (RT pp. 48-49)

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[i]It is noted, that the department is including a diagnosis, hernia, as part of its case in chief regarding the competency analysis of the respondent's examination. However, the respondent did not include inguinal hernia in her differential diagnosis. (Finding of Fact # 13). The department stipulated that the respondent was not subject to discipline based upon a failure to diagnose, and accordingly, the department also did not assert that the respondent failed to create a minimally competent differential diagnosis that should have included an inguinal hernia. Therefore, the condition of inguinal hernia and any examination for it or the lack thereof, should not be a part of the department's case, and the department is estopped from asserting it either evidentially or by argument.

The respondent testified that the patient's clothes were loose and the abdomen and the chest were fully exposed. She pushed the patient's clothes away from his body and was able to visualize the abdomen during her examination and could both see and feel it. (R.T. p. 43, 202, 203) (The majority of the expert witnesses, with the exception of one of the respondent's experts, Dr. Werlin, agreed that a basic abdominal examination must include visualization of the abdomen.)

The respondent did not visualize the inguinal area, but the patient did not demonstrate tenderness to indicate an inguinal hernia, and did not evidence a mass:

Q. All right. Would you have find an inguinal hernia
that was --
A. Well, the inguinal hernia --
Q. -- incarcerated?
A. The inguinal area was covered y the diaper. But he would have been tender, and yes, he would have felt the tenderness.
Q. And yet he did not demonstrate tenderness?
A. He was not tender. (RT p. 212)

The respondent admitted that she did not use a stethoscope to listen to bowel sounds. (RT p. 44) However, she may have felt bowel activity during her palpation of the abdomen. The patient did not fuss or cry during the palpation of his abdomen. (RT p. 56-57) The patient was not irritable during the examination. (RT p. 214)

The respondent also did not visually inspect or examine the patient's rectal area.

I find that the respondent did visualize and palpate the patient's abdomen. She recorded on her written record of the examination that the patient's abdomen was soft and non-tender with no masses. (Exh. 1) The record was dictated the same day as the patient's emergency room visit, right after the patient left and before the patient was brought back by the parents to the hospital the next day. (RT p. 208) Normal and expected chart entries that correspond with the respondent's testimony create the presumption that the act was done as charted and testified too. The department has not presented evidence of creating false or misleading chart entries in this instance.

The patient's mother's version is at odds with the respondent's version of the examination. The parents claim the respondent used a stethoscope on the patient's chest. (RT pp. 92-93, 118) The patient's mother does not recall the respondent using any other instrument. (RT. 95-96) However, the respondent testified that she used an otoscope to examine the ears, nose and throat of the patient. (RT p. 48) The written record of examination, (Exh. 1, p. 90) also records the results of the examination of the ears, throat and nose, which correspond to the respondent's testimony. Therefore, because it appears more probable than not that an otoscope was used this results in a lessening of the parent's credibility as to their recollections of the examination. I do not attribute this to bias, ill will or deliberate falsification, but rather, as explained below, their recollection of the patient's position during the examination most likely represents a layperson's general recollection as filtered by the passage of time, stress and lack of sleep.

The patient's mother described that the patient was held cradled in her left arm, with his feet coming across her lap:

Q. Can you describe for us Andrew's positioning at the time that Dr. Langemo conducted that examination?

A. I held Andrew on my left side.

Q. Were you still seated in the chair at this point?

A. Yes.

Q. Okay.

A. Cradled in my left arm with his head at my left shoulder, his torso going down the left side of me and my arm, with his feet coming across my lap.

Q. Okay. And I gather from that description that he was resting the back of his head on your arm up by your shoulder?

A. Yes.

Q. So he was sort of looking out and up at that point?

A. Yes.

Q. Over the -- over the course of Dr. Langemo's examination of the baby, can you describe for me how the baby's position changed, if it did?

A. I don't remember any change at all.

Q. Okay. So it twas the -- the baby was kept in the same position as you've just described?

A. Right.

Q. Was Andrew ever positioned out flat on his back resting on your legs like a table --

A. No.

Q. -- at any point during the course of that examination?

A. No.

Q. Was Andrew ever placed on the examination table during the course of Dr. Langemo's examination?

A. No.

Q. Did Dr. Langemo ever ask you to position the baby in any other position other than the way that you've described?

A. No.

Q. Did you ever indicate any reluctance to position the baby any differently?

A. No.

Q. And where was Dr. Langemo during the course of the examination that she conducted?

A. She was seated in a chair on my left side.

Q. Okay. So she was facing you?

A. Yes.

Q. Okay. But she was on your left?

A. Yes.

Q. And so Andrew then -- in -- in position Andrew would have been in your left arm between you and Dr. Langemo?

A. Yes. (RT pp. 90-93)

The mother also testified that the respondent did not expose the baby's abdomen, to her vision:

Q. Did you or Dr. Langemo ever move or raise the baby's shirt and lower the bib in such a way as to expose the baby's abdomen to your vision?

A. No. (RT p. 94)

The patient's father testified generally the same as the mother regarding the patient's positioning during the examination. (RT pp.116-119)

The respondent's version of the patient's position is that the child was supine on the mother's lap. Further the patient's clothes were unbuckled and she could visualize and palpate his abdomen:

Q. Okay. In terms of the placement of the child, did you examine the child with the child's head up against Mrs. Meier's shoulder with his legs draped over her lap?

A. No.

Q. What did you do?

A. Except when she carried him out, I never saw him held that high.

Q. How -- did you actually have her position the child for you?

A. When I came in the room, she had him in her left arm. And so then for the exam she just stretched out and we drew him down onto the flat surface of her lap.

Q. Okay. And was he then in a supine position on her lap?

A. Yeah.

Q. She testified that he was fully clothed except for his shoes. Is that consistent with your recollection?

A. The clothes were there but they were unbuckled. The bibs were unbuckled. So yes, everything was on except his shoes.

Q. Okay. And you saw the -- the photograph that's been marked as Exhibit --

A. Yes.

Q. -- 2. Were those the clothes that you recall him wearing?

A. Oh, that looks similar to what he was wearing.

Q. Okay. Were you able to visualize the child's abdomen during your examination?

A. Yes.

Q. And how did you do that?

A. Well, she had him for the exam -- we didn't start with the abdomen. But he was stretched out on the lap, and then the part about the abdomen. The bib was kind if in the way and I pushed it off to the side, and then you could see his abdomen and --

Q. Do you --

A. -- feel his abdomen.

Q. Do you recall whether you -- if it was – pushed it up from the top or from the bottom or which way?

A. I don't. I was paying attention to the abdomen, not the bib. I --

Q. Okay.

A. All I know is you could see his skin, you could feel his belly.

Q. Okay. And Mrs. Meier testified that the stethoscope -- that you placed the stethoscope between his bibs and his shirt. Is that accurate in your recollection?

A. Well, not between 'em. Under the shirt and under the bibs. I would have had to reach up. She said under the strap. And that's true. His chest was not bare. I had to -- I was under the shirt, but I was also under the bibs. And you had to reach up. (RT pp. 201-202)

The respondent created a firm surface for palpation by supporting the patient's back with one hand while palpating with the other:

Q. And then you had earlier testified that you palpated at all four quadrants. Can you describe how you were able to achieve a firm surface, if you were, b doing it on the mom's lap?

A. She had him stretched out on her lap. And then you just -- with the one hand you palpate the abdomen and the other you support the back, and you just go through the four quadrants. It's

not a very big area on a infant that size. And if her legs aren't enough support, you've got your hand there, too, but I mean the whole thing is – I feel like that is a good support. (RT p. 205)

The respondent also testified that the mother told her that the patient's vomiting and diarrhea were getting better and that the patient was consolable, not inconsolable as she testified. The patient also looked consolable to the respondent. (RT p. 214)
In considering the two versions of the patient's examination as recounted by the respondent and the parents, it appears that they are more similar than the parties may assert. Certainly a portion of the patient's body was on the mother's lap. There appears to be a difference in judgment and recollection between the witnesses only as to the degree of supinity of the patient on the mother's lap.

Mother's version-

A. Cradled in my left arm with his head at my left shoulder, his torso going down the left side of me and my arm, with his feet coming across my lap.

Respondent's version-

A. When I came in the room, she had him in her left arm. And so then for the exam she just stretched out and we drew him down onto the flat surface of her lap.

Comparing the two versions above, it is possible to read the mother's version of events as an incomplete or very generalized remembrance of the event as described by the respondent.

Almost eight years after the fact, it is certainly reasonable to expect that explicit specific positional parsings would become elusive to recall and explain. Moreover, it seems more probable than not that on the day of the examination, a mother who presents with a child who has been acutely and distressingly ill for several days may not be focusing on mentally recording an exact clinical review of the examination procedures at the time they occur. Rather, after the fact, one can recall general impressions, or suggestions by others, or may make certain portions of the examination to take such precedence as to push other portions from memory.

In providing care to their child, the parents were sleep deprived during the night before taking the patient to the emergency room:

Q. Having received that advice from Dr. Dueler, can you explain for us how Andrew responded over the remainder of that evening and into that night?
A. Well, there was no improvement. He cried through most of the entire night. We -- Andrew and I attempted to get a few minutes of sleep here and there by me laying him face down on -- on my belly. We were belly to belly. I would give him his Pedialyte every 15 minutes, which never stayed down. I would gave him his Tylenol, which didn't stay down. And that's how we went through the entire course of the night.
Q. Okay. Was there any time during that night when he did fall asleep for any extended period of time?
A. Just very, very short periods. Five minutes, ten minutes at a time. Not very long.
Q. And how did he respond when you continued to attempt to administer the -- the Pedialyte at 15-minute intervals?

A. He would vomit.
Q. And then on the next morning of November 28, 1996, can you explain to me what Andrew's situation was when he awoke and you awoke that morning?
A. My husband initially got up with Andrew, allowing me to get a couple hours of sleep.
Q. Do you know about what time your husband got up?
A. I want to say between 6:30 and 7:00 --
Q. Okay.
A. -- a.m.
Q. And then what time did you eventually get up?
A. I believe it was around 9:00 a.m. (RT pp. 78-79)

This factor of the lack of sleep coupled with the stress of the Thanksgiving holiday certainly could reasonably affect the parents' perception of the events and their ability to recall specific details that occurred during the examination.

It was certainly a difficult time for the parents in this matter. However, my review of the record leads to the conclusion that it is more probable than not that the respondent examined the patient in the manner in which she testified, supine on the mothers lap, and visualized and palpated the patient's abdomen. This fact determination is based upon the parent's recollection versus the respondent's recollection and based upon the respondent's chart entries. Insufficient evidence has been presented to establish that it is more probable than not that the parent's version is correct.

Inspection of the patient's stool

When the respondent inspected the patient's stool, its appearance was consistent with gastroenteritis:

Q. -- did your inspection of the content of the diaper confirm or -- or --
A. Yeah, it did.
Q. -- make you question?
A. Yeah. It -- it looked like it was with the stool, not -- not from an outside bleed.
Q. And in your experience in dealing with gastroenteritis, bacterial or viral, was the content of the diaper consistent or inconsistent with gastroenteritis?
A. Consistent. (RT p. 217)

Q. If when you inspected the stool that it looked more like blood from an external source, would you have changed --
A. Gone back in --
Q. -- approach?
A. -- and looked for little sores or something? Yeah. (RT pp. 227-228)

Expert testimony

Department expert, Dr. Robert Truppe

The department called as its expert, Dr. Robert Truppe. He was Board Certified in family practice in 1991 but the certification has since expired. (His CV, exhibit 4, does not indicate that the board certification has expired.)

Dr. Truppe also indicated on his CV that he is board eligible in emergency medicine, (AAPS practice track) The respondent has pointed out that the CV is misleading in the he is not "board" eligible, with the American Board of Medical Specialites, rather, upon questioning, Dr Truppe indicated that he is eligible for a certification offered by the American Association of Physician Specialists. Dr. Truppe did not take a residency in emergency medicine.

Q. -- you in fact are not eligible to become board certified by any board certified by the American Board of -- of --
A. Physician Specialists.
Q. -- of Physician Specialists in emergency medicine, are you?
A. Yes, I am.
Q. You did take a residency in emergency medicine, did you?
A. No.
Q. And don't you need to take a residency in emergency medicine today to be able to apply for board certification by the board that is certified by the American Board of Medical Specialties?
A. No. Through the -- this is the old osteopathic board, the American Association of Physician Specialists,
which -- Q. That is not a member of the American Board of
Medical Specialties, is it?
A. I believe it is.
Q. You don't know for sure --
A. I don't know for --
Q. -- do you?
A. -- sure, no. (RT pp. 166-167)

According to one of the respondent's experts, the American Association of Physician Specialists is not a board recognized by the American board of Specialities or by any state, accredited institution of higher learning, or any specialty society in the United States. (RT pp. 302-303)

During his testimony, Dr. Truppe also stated that he would have prescribed antibiotics for this patient if he had an elevated white blood cell count. (RT pp. 170-171) The respondent's expert, Dr. Bonadio, testified that this is against everything that is taught and posed a risk of harm to the patient. (RT pp. 264-266) Similarly, the respondent's expert, Dr. Olsky, also testified that prescribing antibiotics would constitute a serious violation of the standard of care given the patient's history and presenting symptoms. (RT pp. 319-320)

I find Dr. Truppe's education and experience to only minimally qualify him as an expert in this case, and the Board may further draw its own conclusions on his expert's qualifications given the testimony related to his position on the prescribing of antibiotics in this case.

Dr. Truppe currently works for Emergency Room Specialists, (ERS). ERS provides full-time ER coverage to the Heart Hospital in Milwaukee's emergency department in Glendale. ERS also staffs an urgent care facility called Care On Demand, located in Brookfield. Dr. Truppe has been with ERS since finishing his residency in 1991.

Prior to that, Dr. Truppe was a senior resident at St. Luke's Medical Center in Milwaukee between 1990 and 1991. From 1991 till July 2003 he worked for EMS in the emergency department at Aurora Sinai Medical Center. He also worked for EMS staffing Sheboygan Memorial Hospital's emergency department in 1996.

The Aurora Sinai Medical Center saw between 50,000 and 65,000 patients per year during his tenure, approximately twenty percent were pediatric cases. At his current position, he also estimated that fifteen to twenty percent of his patients were pediatric cases.

Based upon Dr. Truppe's review of the patient's medical condition and the potential diagnoses for the patient, he opined that a minimally competent evaluation would focus on the gastrointestinal system, including an abdominal examination and checking the rectal area of the patient (RT. p. 136) The abdominal examination would include visualizing the abdomen, looking for distention. (RT p. 144) The abdomen should also be palpated for masses. The presence and quality of bowel sounds should would also need to be checked in all four quadrants by use of a stethoscope.

Q. Okay. And when you're talking about the quality of the bowel sounds, what are you talking about?
A. Again, that's just something after doing it for years you -- you know what normal ones sound like. In – in obstructions there are -- there's the classic -- which is true -- there's high-pitched tinkling, almost like water dripping into a pipe. That's something you look for in obstruction. But again, it's presence and absence. (RT p. 147)

According to Dr. Truppe, a minimally competent procedure for conducting an abdominal examination, would include the patient being placed supine on the examination table, a firm surface.

The patient would also be wearing a gown perhaps, but at least the diaper would be removed to provide an opportunity to view the entire abdomen. The abdomen needed to be exposed to allow the opportunity to listen for bowel sounds, for inspection and palpation. The patient also would need to be on a hard surface, ie. the examination table because the practitioner is then pressing down against a more firm surface that's supporting the patient's back. Therefore, Dr. Truppe was of the opinion that if the patient were held in this case in the manner as described by the mother a minimally competent examination of the abdomen could not be conducted:

Q. Well, if the baby is held in the mother's arm, cradled in the mother's arms, with his head up by her left arm up by her shoulder, with the body then arching down on her left arm, and the feet of the infant being down by the mother's waist. Can a -- can a minimally competent examination of the abdomen -- of the abdomen be conducted with that configuration?
A. In this patient?
Q. Yes.
A. In my opinion, no.
Q. And why not?

A. Again, it's not -- you don't have the firm surface to palpate against. You know, imagine an infant curled up like that. It's -- it's gonna be hard to localize where you're palpating and what you're palpating. It's much easier and much more appropriate lying flat on a firm surface. (RT pp. 148-150)

Dr. Truppe also was of the opinion that if the patient were positioned even as the respondent asserted, the examination would still fall below the minimal standard of a competent examination because what was still lacking was the ability to palpate the abdomen against a firm surface. (RT pp. 159)

Dr. Truppe also testified that a minimally competent examination would have included an examination of the patient's rectal area. Because there was blood in the stool a rectal examination could indicate lesions, a mass, a fissure, or another condition that could be causing the bleeding. (RT p. 158)

On cross examination, Dr. Truppe stated that he thought there was no literature that supported performing an examination of a child while the child was positioned in the mother's or parent's lap. He consulted Bates Guide to Physical Examination as an authority to support his position. (Exh. 5) (RT p. 172)

When challenged on his standard of practice opinion, he did not adequately address how his opinion reconciled with Bates:

Q. -- to the page that is Page 630. If you look at the bottom of that page and the approach --
A. Mm-hmm.
Q. -- to older infants --
A. Mm-hmm.
Q. -- doesn't it state that you can perform much of the examination with the infant lying or sitting in the parent's lap or held in an upright position against the parent's chest?
A. Yes. You can do some of the exam there, yes.
Q. And isn't it also true that Bates' also indicates that it's wise to leave the diaper in place throughout the examination, removing it only to examine the genitalia, rectum, lower spines and hips, without mention of the abdomen?
A. That's --
Q. I'm look --
A. -- possible. I didn't see that, but that's possible.
Q. It's the paragraph immediately – the second-to-last paragraph of the page.
A. Mm-hmm.
Q. And that would be authoritative, wouldn't it?
A. Yes.
Q. So that would be within the standard of practice of a minimally competent physician, would it not?
A. Well, I -- I would say that to genitalia. You need to remove it, 'cause that's an inguinal area where you're looking for hernias. That's the lower part of the abdomen.
Q. Only if you cannot visualize them with the diaper on?
A. With the diaper on. (RT pp. 173-175)

In the context of Bates, which appears to provide for an examination such as performed by the respondent, Dr. Truppe stated that his opinion to the contrary, was based on his experience:

Q. And so it's your opinion that it's not sufficiently firm for a minimally competent physician to perform an abdominal examination?

A. Correct.

Q. And the basis that you have to make that statement, what is the foundation for that?

A. Just experience. And I -- I'd prefer to take the child away to get their response to the -- to the separation from the parent and to get their response on palpation without being comforted in the mother's lap or the father's lap. (RT p. 176)

Dr. Truppe's expert opinion appears less credible in this regard, in that he bases his concept of a minimally competent examination upon what he would do, or stated another way, his optimal personal preference. He states that he "prefers" to take the child away from its mother, the reason being to get the child's "response".

Therefore, I do not accept this portion of his opinion, especially in light of the contrary opinion provided by one of the respondent's experts which is based upon what appears to be more professionally thought out reasoning. Contrary to Dr. Truppe's rationale, taking a child from its mother may have the adverse effect of causing distress in the child which might increase guarding, and mask or create symptoms, as testified to by one of the respondent's experts, Dr. William Bonadio:

Q. And what is that effect of -- why do you need to have the abdominal examination or the -- the important parts done when the infant is not crying or straining?

A. I'm sorry?

Q. Why is it important to -- to do --

A. Well, in -- a crying, straining infant is going to tense up their abdominal muscles. And what you want to do is have them as relaxed and non-agitated as possible so you can assess whether or not there's any reaction to palpation. So you want to have a soft abdomen, you want to have a relaxed patient, who as a -- you know, is not tensing up, so that you can accurately determine whether or not there is any tenderness or guarding, or abdominal rigidity. If the baby's crying, then you can't tell for sure if it's because of the anxiety or if there's truly an abdominal process going on. (RT p. 257)

Dr. Truppe has essentially testified that his experience creates his minimum standard. As to the "why", that this standard exists, he asserts that laying a pediatric patient on a firm surface allows for a proper and thorough palpation abdomen. The problem with this assertion is that he can't back it up with specifics that Dr. Langemo's method is improper. He presents no evidence that a small child cannot be palpated with deep palpation in four quadrants when positioned on a mother's lap. He provides no support as to why the fat, muscle, and physical makeup of a pediatric patient precludes the type examination done by the respondent.

The department correctly points out, that textbooks may not be authoritative or all inclusive in all circumstances, this is true. However, I do not find that Dr. Truppe has presented a viable basis to support his purported standard of examination that for a pediatric patient, presenting with the history and potential diagnoses in this case, an abdominal examination must be performed on a firm surface which does not include the mother's lap.

Visual inspection of rectal area

When cross examined regarding the minimum standard requirement for inspecting the patient's rectal area, Dr. Truppe stated:

Q. -- tell me where a rectal fissure comes into play in appendicitis.
A. Doesn't.
Q. Where does a rectal fissure come into play in Meckel's diverticulum?
A. Doesn't.
Q. Where does it come into play in pyloric stenosis?
A. It doesn't.
Q. Where does it come into play in any of the diagnoses -- the differential diagnoses that -- that you've been discussing this afternoon?
A. It may not. It comes in with blood in the stool. It is -- you want to look to see if there's a fissure that may be bleeding.
Q. Okay. But if you visualized the actual stool --
A. Mm-hmm.
Q. -- isn't it true that you can tell that it's not from a rectal fissure by the appearance of the blood in the stool that you're inspecting?
A. You could.
Q. And what would you gain by inspecting the rectum?
A. Again, to look for any source of blood. It – any -- any possible source of blood or any active bleeding. (RT pp. 176-177)

Given the differential diagnoses (or a rectal fissure which has not been asserted by the department as one of the differential diagnoses) in this case, the examination of the rectal area would have not been a useful diagnostic technique. The respondent only noted reddish brown stool in the patient's diaper, but no frank blood. Dr. Truppe agreed that from the description of the stool in the record, (Exh. 5) there was no red frank blood, and thus would not have come from rectal bleeding. (RT pp. 189-190)

Therefore, this type of examination may have been Dr. Truppe's practice to check for "active bleeding", yet for purposes of the *Gilbert* standard, his testimony does not provide support for a violation in this case. This is because he admits that by looking at the stool in this case a practitioner could achieve the same diagnostic effect to determine that no rectal bleeding was occurring. Checking the rectal area would not have assisted in making a differential diagnosis and therefore was not below the minimum standard of care, and would not pose an unacceptable risk to the patient.

Checking for bowel sounds

Dr. Truppe testified on cross-examination that it would be possible to assess bowel activity through palpation but the presence of bowel activity would not rule out pyloric stenosis, even if there were no tenderness in any of the four quadrants of the abdomen. However it would make it less likely (RT p. 180-181) For intussusception as one of the differential diagnoses, being that it is intermittent, there isn't anything that could be done to diagnose it. (RT pp. 183-184)

Dr. Truppe testified in a way that appeared contradictory, that listening for bowel sounds does not, yet does, assist in making a differential diagnosis between the potential diagnoses in this case:

BY MR. LUBCKE:

Q. And Doctor, in terms of evaluating the various differential diagnoses that you listed as being the differential diagnoses every minimally competent practitioner should consider in this case, in terms of valuing those differential diagnoses, does the list – does the information obtained from listening for bowel sounds, presence and absence, and quality, assist you in differentiating between the various differential diagnoses in this case?

A. No. It's just an assist. It's another tool that you have. (RT p. 190)

Upon further questioning, he clarified that if the sounds were abnormal, it would point in the direction of something that needed to be checked more thoroughly. (RT p. 192)

The respondent also addressed Dr. Truppe's testimony regarding bowel sounds, as her emergency room experience is similar to his. She provided a more succinct professional explanation in contradicting Dr. Truppe:

Q. Okay. And Dr. Truppe also addressed bowel sounds. And in your experience, and you have about the same experience as --

A. Yeah, almost the same.

Q. -- Dr. Truppe --

A. Mm-hmm.

Q. -- how valuable have bowel sounds been in making differential diagnoses?

A. I don't think they help you sort out the differential very well, particularly not in a soft abdomen. I mean this is a soft, benign abdomen. I would have expected bowel sound in him because he's vomiting and diarrhea, but it wouldn't help you with the differential. And I -- I just can't say that I could have. I don't -- it's not dictated. (RT pp. 213-214)

While listening for bowel sounds may be optimum practice, it was not required in this case given the patient's history, presenting symptoms and the respondent's differential diagnosis.

Respondent's experts

Testimony of Dr. William Bonadio

Dr. Bonadio is a board-certified pediatrician practicing pediatric emergency medicine for close to twenty years. He is currently employed at Children's Health Care,St. Paul in St. Paul, Minnesota, as a pediatric emergency medicine physician. The ER patient volume at that facility is 36,000 to 37,000 visits per year. He is not board certified in emergency medicine.

Dr. Bonadio has also published close to a hundred medical journal articles on various topics and written textbook chapters and review articles. He has given presentations at national meetings on his research, specifically; he has done research on intussusception in infants, published in Clinical Pediatrics, a basic pediatric medical journal. (Peer reviewed.)

Dr. Bonadio testified that the respondent met the standard of care for a minimally competent examination in this case. (RT pp. 252-253)

Palpation of the abdomen

Regarding palpating the abdomen:

Q. Okay. Now, she -- Dr. Truppe, who is the state's witness, identified that in his opinion it would be below the standard of care of a minimally competent physician to perform a palpation on the infant in the mother's lap. Dr. Langemo testified that she had the mother form a table and palpated the abdomen with the baby on the mother's lap in a table. The parents testified differently, but I'm -- I will get to that later. So with the assumption that the baby's abdomen was palpated with the mother forming a table with her legs and the baby stretched out in a supine position, can you identify whether there is -- whether it is within the standards of practice to perform that examination on the mother's lap in a baby -- a four-month-old baby with gastrointestinal complaints?

A. It absolutely is.

Q. And what is the foundation for your opinion on that?

A. My training. This is widely taught during the course of my residency. My teaching presently, my practice. And just so we take it out of the subjective realm, I've got five -- I've got six textbook ab -- abstracts in front of me, all of which recommend that the child be placed in the most comfortable, relaxed, non-anxious position and that that frequently is within the -- on the mother's lap, to perform the most accurate abdominal exam as possible.

Q. And what are --

A. Six textbooks. (RT pp. 254-255)

Q. And in your opinion, to a reasonable degree of medical certainty, is it -- are -- is a physician capable of performing an adequate abdominal examination on a mother's lap?

A. Absolutely. (RT p. 257)

As support for his opinions, Dr. Bonadio stated that he generally doesn't characterize textbooks as authoritative, but he has found nothing in them to support Dr. Truppe's opinion:

Q. All right. Dr. Bonadio, you -- you did review a number of textbooks. Do you consider any of them to be authoritative?

A. I generally don't use that term in characterizing textbooks.

Q. And why --

A. The Nelson Textbook of Pediatrics is a standard textbook that is widely used in the pediatric field. I know the Barkin's Emergency Medicine is also a very standard textbook for adult ER. The Fleischer Textbook is the standard textbook for pediatric emergency medicine. So I've selected a range of textbooks. And it certainly wasn't like I had to look through 100 textbooks to get six to support my case. You know, I looked through maybe ten textbooks, and the other four that I have not included just didn't make reference to it one way or another. I found no instance in which a resource recommended that an infant should not be examined on the mother's lap, it should always be put on a table. I -- I have never found that in my reading. I don't teach it. I've never been taught that. And whereas the opposite is -- is true. It's been widely recommended. It's

widely taught. And I've got some objective, you know, resources here that also support the case. (RT pp. 267-268)

Deep palpation can also be performed on an infant with only one hand, as the respondent did, if the infant is relaxed, even more deeply than on a teenager or adult, because there's less muscle to get in the way. (RT pp. 291-292)

Dr. Bonadio testified that palpating the abdomen while the patient is clothed is also within the minimum standard, to eliminate false positive responses based upon a cold temperature irritant. He in fact will palpate with the shirt pulled down over the patient for this reason. (RT p. 258-259) The same reasoning applies for leaving the diaper on. (RT p. 259)

The Board is reminded that respondent testified that she actually did palpate directly against the skin of the patient. The patient's parents have asserted that she did not. Dr. Bonadio's testimony therefore supports the appropriateness of the palpation even were the parents' version to be adopted.

Listening for bowel sounds

Dr. Bonadio also testified that not listening for bowel sounds in this case also did not fall below the minimum standard of care:

Q. Okay. Dr. Truppe when he testified also indicated that -- that a failure to auscultate the abdomen, to listen for bowel sounds, was below the standard of care that a minimally competent position would perform. And Dr. Langemo has testified that she did not record any findings of bowel sounds and at this point in time cannot recall whether or not she listened for bowel sounds. Can you give us your opinion as to whether a failure to listen for bowel sounds was below the standard of care for a minimally competent physician in the case of Andrew Meier?

A. Well, that exam is part of -- that -- that portion of the exam is -- is standard and important. I -- specifically in this case, I know that the nurse listened, and documented that there were bowel sounds in all four quadrants, and that was right before Dr. Langemo's exam. If we're talking about intussusception specifically, I think if you were going to bring it down to the most important basic part of the exam to determine whether or not that was present, the single most important factor would be whether or not there was tenderness to palpation. So I would not expect somebody to have intussusception that would only be detectable, the risk for that to be detectable, strictly because bowel sound frequency or character was abnormal. So in other words, this baby was documented to be alert, smiling, interactive, normal vital signs, and a non-tender abdomen, and didn't vomit at all during the course of the stay in the emergency room, yeah, for good form, they should have documented, should have listened with the stethoscope and documented what the bowel sounds pattern was like. But having stacked up all those other factors that I just mentioned, an isolated finding of diminished bowel sounds or absent bowel sounds, in the wake of everything being as I said, would not make me then consider that the baby had an acute abdomen or surgical problem.

Q. So is it your opinion that a failure to listen to bowel sounds was not below the standard of care -- in this case, was not below the standard of care of a minimally competent physician?

A. Correct. (RT pp. 260-261)

On cross examination, Dr. Bonadio did state that it would fall below the minimum standard of care to fail to listen for bowel sounds for a patient that presented with diarrhea, vomiting, blood in the stool, crying and fussiness. However, he stated in this instance the patient was documented as presenting being awake, alert, smiling and active. (RT pp. 285-287) Dr. Langemo testified that the patient was asleep when she entered the examination room, and was not fussy, and was interactive with his mother during the remainder of the time. (RT p. 56) (Exh 1. pp. 89-90)

According to Dr. Bonadio, not listening for bowel sounds also posed no unacceptable risk of harm to the patient in this case. (RT p. 269-270)

Visualization of rectal area

Visually examining the patient's rectal area also while part of the examination could only reveal a rectal fissure. The fissure, if it existed, could be internal which would not be seen in any event. Therefore, given this patient's history there was no risk of harm not to visualize the rectal area:

Q. Okay. Now, Dr. Langemo has also indicated that she did not visually examine the -- Andrew Meier's rectum as part of examination and her differential diagnosis judgment. Can you -- do you have an opinion as to whether the failure to visually examine the infant's rectum was below the standard of care for a minimally competent physician?

A. Well, I think that's part of the exam – a standard part of the exam, if you have an infant who's got a question of blood in the stool, but it's important only from the standpoint of diagnosing a rectal fissure, which would be a small tear down at the -- at the rectum, which is probably the most common cause for an infant to have blood in the stool. And if you -- sometimes the fissures can be internal, so you may not see it. If you see it and you diagnose a rectal fissure, or you don't look and miss it, it doesn't make any difference in the long run. That's something that heals spontaneously. It doesn't cause blood loss to the point where the baby becomes anemic. So it's a -- it's a benign outcome kind of diagnosis, and whether you actually document that the fissure's present or not, is of little consequence.

Q. So there would be no risk of -- of harm to the public, or really to this infant, for the failure to visualize the -- the rectum in performing the examination given that patient's symptoms and history, and other find -- physical findings?

A. Correct. (RT pp. 261-262)

Aside from Dr. Bonadio's opinion that there was no risk of harm, I also find that based on the type of the blood in the stool, such an examination was not required for a minimally competent examination. Dr. Bonadio is speaking generically of "blood", without differentiating its appearance. However, Dr. Truppe previously agreed that from the description of the stool in the record, (Exh. 5) there was no red frank blood, and thus would not have come from rectal bleeding. (RT pp. 189-190) Thus, there was no reason to check for a fissure.

Dr. Bonadio's testimony actually means that by "blood" he means "frank blood" for purposes of requiring an examination of the rectal area for a fissure. This view is supported by the further clarification made by Dr. Bonadio when he testified that with no bright red blood per rectum and

with vomiting, (as this patient presented), Meckel's diverticulum could be ruled out. (RT pp. 272-273)

Testimony of Dr. Mark Olsky

Dr. Mark Olsky is the medical director of the Monroe Clinic, and a board certified diplomate of the American Board of Emergency Medicine. He is the medical director of the Monroe Clinic and the medical director of its emergency medicine department. Dr, Olsky is on the faculty of the University of Wisconsin family practice residency program and also the University of Wisconsin medical school.

In the course of his duties he reviews medical records of the physicians he supervises, including the respondent. He has no reason to believe that she uses a rote style of dictation or failed to dictate a record either during or immediately after seeing a patient. (RT pp. 299-300)

Regarding Dr. Truppe's qualifications, Dr. Olsky is not aware if the American Association of Physician Specialists is a board recognized by the American Board of Specialities or by any state, accredited institution of higher learning, or any specialty society in the United States. (RT pp. 302-303) Dr. Olsky does not think Dr. Truppe has any particular qualifications to act as an expert witness in emergency medicine or pediatrics. (RT p. 303)

Palpation of abdomen

Dr. Olsky testified that based upon his review of the record in this case, the respondent met the minimum standard of practice in her evaluation of the patient and his testimony tracked that generally of Dr. Bonadio. (RT pp. 305-323)

Visualization of rectal area

Dr. Olsky on cross examination highlighted in greater detail the reason why a rectal examination was not needed in this case.

First, assuming bright red blood in the stool, (which was not established in this case), it would be an indication of bleeding. However, the assumption that the bleeding occurred "certainly closer" to the rectal area than higher up in the intestine is not necessarily correct:

A. Not necessarily. The -- the location of bleeding or where it comes from the intestinal tract, isn't, you know, if you see some -- if you see a little blood mixed into the stool, into the -- in the diarrhea, or you see some blood in the diaper, it's simply a very common finding in children who have gastroenteritis of any cause. It's somewhat more common in bacterial enteritis. But -- and in essence in just about any of the conditions that are within the differential diagnosis of this situation, the possibility of a small amount of blood in a diaper, is – is there. (RT p. 334)

It is true for adults that the farther away from the rectum itself that bleeding occurs, it will be darker at the rectum. However, not for children. Dr. Olsky directly attacks Dr. Truppe's evaluation of this case on this point:

A. No. That's -- that's something that would be true in adults. Not so much in -- in children. In -- in a patient -- it sounds like something that someone would say who would -- **that would not be said by someone who was familiar with the circumstances that are relevant to this case**. In any event, in an adult that would definitely be true that if they had bleeding, say from an ulcer, the blood would be dark, if they had bleeding from more of a rectal area that the blood would be bright. In a child with gastroenteritis, everything passes through fast enough that the blood would be bright red no matter what. (RT pp. 334-335) [**emphasis added**]

Dr. Olsky then also discounted the theory that bright red blood in the diaper could originate from a bleeding source at the rectum:

Q. And bright red blood in the diaper could very well originate form a bleeding source at the rectum, couldn't it?
A. Not really. A bleeding source at the rectum, the -- the main things that we would be looking for in patients of any age would be rectal trauma, hemorrhoids, or cancer, and none of those really are realistic possibilities in this picture.
Q. But Doctor, bleeding that originates at the rectum at the rectal outlet in that area, that blood would be red, wouldn't it?
A. Yeah, but I don't see what that has to do with --
Q. Well, Doctor --
A. -- this case.
Q. -- I'm not asking it -- to analyze --
A. Okay, that's fine.
Q. -- has to do with. I'm just trying to get this color thing straightened out.
A. No, all right. Yes. It --
Q. Okay?
A. Yeah.
Q. It is fair to say that if you have --
A. If the child had -- if this child had cancer of the rectum, a hemorrhoid, or trauma to the rectum, the blood would be red, absolutely.
Q. Okay. And if this patient had a history of red blood in the stool, in the diaper --
A. Yes.
Q. -- it's possible that that bleeding originated at the site of the rectum?
A. Sometime in the history of this country, this may have happened once with a baby, yes.
Q. Okay. So you think it to be an extremely rare event that you'd see red blood in a diaper from a bleeding source at the outlet of the rectum?
A. Yes. (RT pp. 334-337)

I take this interchange by the department's attorney Dr. Olsky to also be significant in clarifying Dr. Bonadio's previous testimony. In essence, even were bright red blood to be seen in the diaper (which isn't factually in the record in any event) this wouldn't reasonably require a rectal examination. Such an examination would not help in the differential diagnoses in this case. Thus, the opinion by Dr. Truppe may be his practice, but it is not required by the standard of care in this case.

Listening for bowel sounds

Dr. Olsky was consistent with Dr. Bonadio, that given this particular patient's presenting symptoms, the standard of care did not require checking bowel sounds. Dr. Olsky described it as only being useful if the sounds were checked at the time the patient was: "in the throws of a -- of a spasm of the gastrointestinal tract, and then you see a lot of other signs simultaneous with it." (RT p. 338) He does, however, listen for bowel sounds as a matter of habit. (RT p. 339) Dr. Olsky's professional habit of listening for bowel sounds may be optimal practice, but doing to the contrary in this instance is not supported as falling below the minimum standard of care.

Testimony of Dr. Steven Werlin

Dr. Werlin is board certified in pediatric gastroenterology and is a full professor of pediatrics at the Medical College of Wisconsin. He teaches primarily pediatric gastroenterology. (RT pp. 347-348) He currently works at Childrens Hospital of Wisconsin, Milwaukee.

Abdominal examination

Dr. Werlin stated that the respondent's abdominal examination was appropriate. (RT pp. 349-350)

Dr. Werlin specifically does examine infants on their mother's lap:

Q. Mm-hmm. Another factor would be where the examination was performed. Would performing a – an examination making a lap of the mother's table (sic) with the -- the infant supine on the lap and performing the palpation of the abdomen with the baby in that position, would that below -- be below the standard of care of a minimally competent physician?

A. No. In fact, that's the method that's preferred. I did it twice myself yesterday. (RT p. 352)

Additionally, even if the patient were positioned cradled in the mother's arm, as the patient's mother asserts, that would be acceptable to have them quiet so they don't cry. (RT p. 352-353)

Visual examination of the rectum

Dr. Werlin disagreed with Dr. Truppe's opinion that the failure to visually examine the patient's rectum was below the standard of care for two reasons:

Q. Now, the state -- the Department of Regulation & Licensing has taken a contrary view to that, and has presented testimony from Dr. Truppe that Dr. Langemo's failure to visually inspect the child's rectal area was below the standard of practice of a minimally competent physician. Dan you address that?

A. I disagree.

Q. Okay. And why do you disagree?

A. Be -- for two reasons. One, the abdominal examination was normal. And secondly, there would be nothing additional that would be found on examination of the rectum that would add to the exam in this case. A rectal exam in an infant is difficult to do well on the best of circumstances, because the best of circumstances the babies start crying, and the information gained is -- is rarely of benefit.

Q. In the differential diagnoses that were in play with this patient's presenting history and -- and symptoms and affect, would visible rectal fissure or any – anything from a rectal visualization have provided information to help you differentiate the diagnoses?

A. No. (RT pp. 350-351)

Listening for bowel sounds

According to Dr. Werlin, the failure to listen for bowel sounds would not fall below the minimum standard of care:

Q. Another issue involves whether or not Dr. Langemo listened to bowel sounds in performing her examination of this infant. And there -- Doctor -- the record does not reflect Dr. Langemo's listening to bowel sounds and she does not recall one way or the other whether she actually did listen to bowel sounds. Would a failure to have listened to bowel sounds have fallen below the standard of care of a minimally competent physician in evaluating this patient?

A. It would not.

Q. And why not?

A. The baby had -- the parents -- there was a -- a -- a dirty diaper present, and I don't recall whether it was brought in by the parents or the baby had the dirty diaper while in the emergency room. Given the fact that the baby had just passed a bowel movement, we know there were bowel sounds present, because the bowel was contracting. (RT pp. 351-352)

As a part of a standard abdominal examination he does listen for bowel sounds. However, if a child, as the patient in this case had just had a bowel movement, that would indicate bowel sounds present, but listening for pitch would tell him anything:

Q. Okay. But the fact that the -- the stool had moved, thereby giving you bowel sounds, wouldn't tell you anything about the -- the second component of bowels sounds, the quality, would it?

A. No, but in a baby the pitch can be very unreliable.

Q. Okay. But my -- my question was, in seeing the fact that the patient had just had a bowel movement, that wouldn't tell you anything about the quality of the bowel sounds?

A. You mean pitch? What do you mean by quality?

Q. Pitch. That's -- that's what we had talked about before --

A. Okay.

Q. -- yeah.

A. Yes.

Q. It's true, it wouldn't tell you anything?

A. Wouldn't tell me anything, correct. (RT pp. 366-367)

On redirect he further explained why the "pitch" of bowel sounds would not be useful in a different diagnosis process:

Q. All right. You were also asked about the high-pitched bowel sounds, but -- and you indicated that in a baby, essentially determining the quality is unreliable. Is -- could you explain that?

A. Yeah. Well, it's -- it's -- it's hard to define pitch, and different people are going to hear the bowel sounds and call it differently, but in viral gastroenteritis you're going to have the same abnormal kind of sounds that you have in -- in -- in an early obstruction.

Q. So that you would feel that that would be useful in differentiating that?

A. No, not at all. (RT, p. 373)

He doesn't teach his students that they are not required to listen for bowel sounds under similar circumstances to the this. (RT p. 369)

Conclusion

My review of the expert testimony in this case leads me to conclude that the respondent's experts are more credible in their expert opinions. This conclusion is based upon their greater experience, and their greater depth of analysis and explanation for their opinions.

Dated: December 21, 2004

William Black

William Anderson Black
Administrative Law Judge

NOTICE OF RIGHTS OF APPEAL

TO: Sarah Elliott - Atty. for Christine Langemo

You have been issued an Order. For purposes of service the date of mailing of this Order is 2-17-05. Your rights to request a rehearing and/or judicial review are summarized below and set forth fully in the statutes reprinted on the reverse side.

A. REHEARING.

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in section 227.49 of the Wisconsin Statutes. The 20 day period commences on the day of personal service or the date of mailing of this decision. The date of mailing of this Order is shown above.

A petition for rehearing should name as respondent and be filed with the party identified below.

A petition for rehearing shall specify in detail the grounds for relief sought and supporting authorities. Rehearing will be granted only on the basis of some material error of law, material error of fact, or new evidence sufficiently strong to reverse or modify the Order which could not have been previously discovered by due diligence. The agency may order a rehearing or enter an order disposing of the petition without a hearing. If the agency does not enter an order disposing of the petition within 30 days of the filing of the petition, the petition shall be deemed to have been denied at the end of the 30 day period.

A petition for rehearing is not a prerequisite for judicial review.

B. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in section 227.53, Wisconsin Statutes (copy on reverse side). The petition for judicial review must be filed in circuit court where the petitioner resides, except if the petitioner is a non-resident of the state, the proceedings shall be in the circuit court for Dane County. The petition should name as the respondent the Department, Board, Examining Board, or Affiliated Credentialing Board which issued the Order. A copy of the petition for judicial review must also be served upon the respondent at the address listed below.

A petition for judicial review must be served personally or by certified mail on the respondent and filed with the court within 30 days after service of the Order if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing. Courts have held that the right to judicial review of administrative agency decisions is dependent upon strict compliance with the requirements of sec. 227.53 (1) (a), Stats. This statute requires, among other things, that a petition for review be served upon the agency and be filed with the clerk of the circuit court within the applicable thirty day period.

The 30 day period for serving and filing a petition for judicial review commences on the day after personal service or mailing of the Order by the agency, or, if a petition for rehearing has been timely filed, the day after personal service or mailing of a final decision or disposition by the agency of the petition for rehearing, or the day after the final disposition by operation of the law of a petition for rehearing. The date of mailing of this Order is shown above.

The petition shall state the nature of the petitioner's interest, the facts showing that the petitioner is a person aggrieved by the decision, and the grounds specified in section 227.57, Wisconsin Statutes, upon which the petitioner contends that the decision should be reversed or modified. The petition shall be entitled in the name of the person serving it as Petitioner and the Respondent as described below.

SERVE PETITION FOR REHEARING OR JUDICIAL REVIEW ON:

Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison WI 53708-8935