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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
EILEEN M. REARDON, M.D., RESPONDENT.	:	ORDER 0001968

Division of Enforcement Case No. 09MED431

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

Eileen M. Reardon, M.D.
P.O. Box 28233
Oakdale, MN 55128

Division of Enforcement
Department of Safety and Professional Services
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Medical Examining Board
Department of Safety and Professional Services
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Medical Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Eileen M. Reardon, M.D., Respondent (DOB: August 12, 1964) holds a license to practice medicine and surgery in the State of Wisconsin (#39295-20) which was first granted on August 22, 1997. Respondent's registration to practice under that license expired on October 31, 2011 and Respondent holds the right to renew this registration. Respondent is board certified

in obstetrics and gynecology. While practicing in Wisconsin, Dr. Reardon was employed by St. Croix Women's Center.

2. At the time of the expiration of her license, Respondent's address of record with the Department of Safety and Professional Services was P.O. Box 28233, Oakdale, Minnesota 55128.

ALLEGATIONS RELATING TO PATIENT A

4. On September 7, 2006, Patient A, a 25 year-old obese female, with a history of gestational diabetes with her last two pregnancies, presented to Respondent at 12 weeks gestation for her first obstetrics and lab exam. Patient A also had a history of large babies resulting in difficult deliveries with severe shoulder dystocia. Respondent noted on this date that the plan was to perform a cesarian section at term to avoid shoulder dystocia complications.

5. On January 30, 2007, Patient A presented to Respondent at which time she reported no contractions. Respondent noted that the fetal non-stress test ("NST") was reactive. Respondent ordered an ultrasound and noted that a c-section would be scheduled depending on results of the ultrasound. The ultrasound was completed on that date and showed the following:

> *FINDINGS: A single live fetus lies in the breech position. There is appropriate movement and documented cardiac activity. Fetal survey was normal and a three-vessel umbilical cord present.*
>
> *Biparietal diameter: 8.3 (33 weeks, 5 days)*
> *Head circumference: 31.9 cm (36 weeks)*
> *Abdominal circumference: 33.2 (37 weeks, 1 day)*
> *Femur length: 6.7 cm (37 weeks, 5 days)*
>
> *Average sonogestational age: 35 weeks, 3 days. By previous ultrasound of 10/24/2006, interval growth would be consistent with 33 weeks, 4 days and clinical menstrual age would be 34 weeks based on Patient A's LMP of 6/6/2006. Estimated fetal weight was 2,820 grams.*
>
> *Volume of amniotic fluid normal. Placenta is fundal, posterior and lateral and is well away from the internal cervical os. The previously noted marginal placenta previa is no longer visible. No abruption or uterine wall abnormality.*
>
> *IMPRESSION: Normal obstetrical ultrasound with appropriate interval growth. Current measurements are slightly greater than expected from the previous ultrasound. Placenta is now normal.*

6. On February 7, 2007, Patient A presented to Respondent's office at which time she was seen by a certified nurse midwife and Respondent completed the office note. She noted that the NST was reactive and that patient had occasional contractions. Respondent also noted that the ultrasound of January 30th revealed an estimated fetal weight of 2,820 grams and that there was no previa. Respondent did not note any plans to perform a cesarian section based on the results of the ultrasound from January 30th.

7. On the morning of February 14, 2007, Patient A presented at Hudson Hospital for an elective cesarian section. Respondent noted in the following in the History & Physical on that date:

> *ASSESSMENT: Fetal heart tones were obtained and are reactive. The baby remains in the breech presentation. Gestation diabetic, EDC of 03/09/2007.*
>
> *PLAN: Cesarean delivery today and add a note that the patient did have antenatal testing as recommended with gestation diabetics and had serial growth ultrasounds and reactive NSTs with 8 out [sic] 8 bio-physical's weekly from 32 weeks on. Our last estimated fetal weight on 02/07 was 2800 grams."*

The notation from the patient's office visit on February 7, 2007 made reference to the estimated fetal weight on January 30, 2007 which was 2,820 grams (not 2,800 grams as indicated by Respondent in her note).

8. The perioperative record indicated a preoperative diagnosis of macrosomia (condition in which a newborn is abnormally large) and 36 weeks gestation. Respondent performed the cesarian section and Patient A's baby was born at 2:12 p.m. The baby's birth weight was 3062 grams. The baby was transferred to Children's Hospital and Clinics of Minnesota in St. Paul with respiratory distress (transient tachypnea newborn) which the pediatrician felt could not be handled at Hudson Hospital. The baby was admitted to Children's Hospital with a diagnosis of prematurity and respiratory distress. The admitted physician estimated the baby's gestational age to be 34 2/7 weeks.

9. At no time prior to Respondent performing the cesarian section on February 14, 2007, did the Respondent perform an amniocentesis or document that she attempted to perform an amniocentesis.

10. Respondent's conduct in providing care and treatment to Patient A fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to either perform an amniocentesis on Patient A at anytime during the pregnancy or failed to document that an amniocentesis had been attempted and failed.

b. Respondent performed an elective cesarian section prior to term of 37 weeks in a patient with a history of diabetes.

ALLEGATIONS RELATING TO PATIENT B

11. On January 22, 2009, Patient B, a 29 year old female, underwent a colposcopy examination by Respondent. The results indicated high grade dysplasia and a biopsy was performed as well. The biopsy results showed high grade squamous intraepithelial lesion in the cervical region.

12. On February 5, 2009, Patient B presented to Respondent for follow-up regarding the colposcopy and biopsy on January 22, 2009. Respondent's consult notes for February 5, 2009 indicated the following:

> *CIN III on colposcopy bx. Pt is pregnant (7^5). D/w pt she needs LEEP and should not wait until [after] delivery. D/w pt cervical dysplasia & progression to cervical cancer. Pt has [positive] HR HPV also.*

Respondent further discussed the loop electrosurgical excision procedure (LEEP) with Patient B as well as the risks associated with it.

13. On February 16, 2009, Patient B was referred to another OB/GYN for a second opinion regarding the LEEP during pregnancy. It was his opinion that risks of pregnancy loss outweighed the risks of advancement to invasive cancer. Following the American College of Obstetrician guidelines, it was his recommendation to wait for delivery and proceed with LEEP at approximately 6 weeks postpartum. A letter was sent to Respondent by the OB/GYN notifying her of this recommendation.

14. On March 12, 2009, Patient B presented to Respondent for her first appointment regarding her pregnancy. Respondent again spoke to Patient B about the recommended LEEP procedure and Patient B advised that she wanted to wait until after the baby was delivered.

15. On June 4, 2009, Patient B presented to Respondent at which time she reported feeling exhausted after work. Respondent recommended she go to a six hour work day and noted the examination of Patient B's cervix showed no lesions or bleeding. There is no record indicating that a colposcopy was performed on Patient B on that date.

16. On July 2, 2009, Patient B presented to Respondent for another appointment at which time Respondent discussed mode of delivery of the baby with Patient B. Respondent noted that with untreated CIN III Patient B was at higher risk for cervical laceration/bleeding and that she was a candidate for cesarian delivery which also had risks. She noted that the patient was leaning toward cesarian section.

17. On July 30, 2009, Patient B presented to Respondent, reporting no cervical bleeding or abnormal discharge. Respondent noted that the patient probably wanted a cesarian section and that she understood that would be done at 39 weeks or greater.

18. On August 25, 2009, Patient B presented to Respondent reporting no bleeding or labor. Respondent noted that patient "definitely will have csxn". The record does not indicate if this is the patient's choice or the reason for that choice of delivery.

19. On September 9, 2009, Patient B presented to Hudson Hospital at 38 weeks pregnancy and in active labor. Respondent noted that risks and benefits of cesarian section were discussed with the patient and that informed consent was obtained prior to the procedure. On that date, Respondent performed a cesarian section and delivered Patient B's baby.

20. From the initial colposcopy in January of 2009 through the cesarian delivery on September 9, 2009, Respondent failed to perform any additional colposcopy evaluations to monitor the status of the cervical lesion during her pregnancy. Respondent states that the patient refused additional colposcopy, but that is not documented in the medical record.

21. Respondent's conduct in providing care and treatment to Patient B fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to monitor Patient B's cervical lesion during pregnancy. Respondent should have evaluated it every tri-mester and performed repeat colposcopies.

b. Respondent failed to document adequate justification for doing an elective cesarian section.

22. On May 30, 2012, Respondent completed the ACOG Prolog Course, Obstetrics, Sixth Edition and achieved a score of greater than 95% in the accompanying test. The course is designed to help identify ways to optimize maternal and perinatal outcomes in normal and complicated pregnancies, diagnose and manage medical and obstetric conditions, identify risks, and prognoses of selected complications of pregnancy, and much more.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in any practice or conduct that tends to constitute a danger to the health, welfare, or safety of the patient or public, has committed unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h), and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

IT IS HEREBY ORDERED that the stipulation of the parties is approved.

IT IS FURTHER ORDERED that Respondent, Eileen Reardon, M.D., (license #39295-20) is REPRIMANDED for the above conduct.

IT IS FURTHER ORDERED that:

1. The Board recognizes the aforementioned continuing medical education course as an equivalent of the education the Board would have otherwise required. The course(s) attended may not be used in satisfaction of the statutory continuing education requirements for licensure.

2. Within ninety (90) days from the date of this Order, Respondent shall pay costs of this proceeding in the amount of ONE THOUSAND DOLLARS ($1,000.00). Payment shall be made payable to the Wisconsin Department of Safety and Professional Services and mailed to:

Department Monitor
Division of Enforcement
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

3. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Section in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely pay the costs or submit proof of successful completion of the education as set forth above, Respondent's license (#39295-20) may, in the discretion of the Section or its designee, be SUSPENDED, without further notice or hearing, until Respondent has paid costs and submitted proof of successful completion of the education.

4. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: _____ 9/15/12
A Member of the Board Date