FILE COPY

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

Case No. LS-9103071-MED

ALONZO R. GIMENEZ, M.D.,

Respondent

MODIFIED FINAL DECISION AND ORDER

The parties to this matter for purposes of review under sec. 227.53, Wis. Stats. are:

Alonzo R. Gimenez, M.D.
144 N. Pearl Street
Berlin, WI 54923

Medical Examining Board
1400 East Washington Ave.
Madison, WI 53708

Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708

A hearing was conducted in the above-captioned matter on February 10, 1992. The Administrative Law Judge submitted his Proposed Decision on August 14, 1992. The board considered the matter at its meeting of October 21, 1992, and issued its Final Decision and Order on November 10, 1992.

Thereafter, on November 19, 1992, Dr. Gimenez appealed the board's decision to circuit court. In July, 1995, the court ruled that the board's decision was "arbitrary," "not sustained by the record," and lacked "any findings to the ultimate material facts," The circuit court's decision was appealed to the Court of Appeals for District II, which issued its decision on July 2, 1996. The court of appeals found that the Wisconsin Supreme Court, in *Gilbert v. Medical Examining Board*, 119 Wis.2d 168, established that a finding by the board of unprofessional conduct by a physician in violation of sec. Med 10.02(2)(h), Code, requires findings which include five separate factual elements. Those elements were said to be:

(1) what course of treatment the physician provided;

(2) what the minimum standards of treatment required;

(3) how the physician's treatment deviated from the standards;

(4) how the treatment created an unacceptable level of risk; and

(5) what course of treatment a minimally competent physician would have taken.

The court concluded that the board "must provide a plain and thorough written decision that summarizes its findings. This decision must separately identify the five Gilbert elements and discuss the evidence that relates to each element. The decision must also provide details of why the evidence supports the Board's findings." The court disagreed, however, with the circuit court's conclusion that the board's failure to fully document its reasoning warranted dismissal of the matter, and instead remanded the case back to the board with direction to reconsider its charges against Gimenez in light of the court of appeals' decision. The court directed that, in modifying its findings, the board must rely on evidence from a qualified medical expert who is able to credibly testify on the factor at issue to "a reasonable degree of medical certainty."

On March 20, 1997, the board reconsidered the matter in light of the decision of the court of appeals. Based upon that decision and upon the entire record in this matter, the board modifies its Final Decision and Order in this matter, and makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Alonzo R. Gimenez, M.D. is and was at all times relevant to the facts set forth herein licensed to practice medicine and surgery in the state of Wisconsin, under license number 12171, originally granted on August 3, 1955.

2. At all times relevant to the facts set forth herein, Dr. Gimenez's medical practice consisted of general surgery and general practice, his office was in Berlin, Wisconsin, and he had hospital privileges at Berlin Memorial Hospital.

3. Prior to all the events in this complaint, Dr. Gimenez practiced in Berlin, Wisconsin in a partnership with Dr. David Sievers, a general practitioner, from 1965 until Dr. Sievers' retirement in 1986 or 1987. During the time period covered by this complaint, March of 1987 to September of 1988, Dr. Gimenez was seeing more patients than normally, due to Dr. Sievers' retirement.

With regard to Count I of the Complaint:

4. Patient I, d.o.b. 8/29/34, was admitted to Berlin Memorial Hospital via the emergency room on April 16, 1988, complaining of severe pain in the right upper quadrant of her abdomen since the previous day. She had chills, but no nausea or vomiting, and a temperature of 98.8. Her white blood count was 18,100, her hemoglobin was 18, her hematocrit was 50, and her potassium level was 2.3.

5. The admitting physician wrote a diagnosis of "Cholecystitis, rule out gallstone ileus". Dr. Gimenez's diagnosis on his History & Physical Examination notes was "(1) Acute cholecystitis with cholangitis, (2) Rule out active peptic ulcer, (3) Hypertensive vascular disease".

6. A biliary ultrasound was performed at the time of admission on April 16th, which indicated no gallbladder problems; the ultrasound also covered the abdomen, and the clinical impression was "Essentially unremarkable views of the abdomen".

7. On April 16th, Dr. Gimenez ordered that the potassium supplement and the IV antibiotics ordered by the ER physician (cefoxitin and gentamicin) be continued. He also ordered lab studies (complete blood count and electrolytes with serum amylase) the next morning, and an oral cholecystogram and a fiber-optic gastroduodenoscopy the following day. Later on the 16th, Patient I had a temperature of 101.4 with minimal abdominal tenderness.

8. On the 17th, Patient I's white blood count fell to 14,600, her hemoglobin to 13.8 and her hematocrit to 40. Her amylase level was normal. The cholecystogram failed to produce an image of the gallbladder, and the gastroduodenoscopy showed no abnormalities other than a slight inflammation of the prepyloric area. On the afternoon of April 17th, she had a temperature of 100.4.

9. On April 18th, her temperature was normal, her potassium level was 2.8 and her white blood count was 12,000, with continued tenderness and slight abdominal distension.

10. On the 19th she registered a temperature of 100.4 and reported sharp pains in the right upper quadrant of her abdomen. Dr. Gimenez ordered a CT scan of the abdomen to rule out a pancreatic mass. The report of the scan stated "There is an oval-shaped fluid collection seen above the right lobe of the liver in between the right abdominal wall, which contains several air bubbles. I cannot be sure if this represents an abscess or a fluid-filled bowel loop, which would be unusual in location. ... There is another fluid collection in the area of the sigmoid colon which again could be free fluid in the peritoneal cavity." The radiologist's impression was "Findings are suggestive of a fluid collection/abscess located between the abdominal wall and right lobe of the liver as described above and most likely another fluid collection in the pelvis, area of the sigmoid. Both findings may be suggestive of a walled off perforation from the bowel." The scan also showed "The fat planes surrounding the retroperitoneal structures are preserved". Dr. Gimenez wrote "CT scan of abdomen negative ..." and he ordered a barium enema.

11. The barium enema was performed on April 20th, and Dr. Gimenez received the following report: "Diverticula are not visualized and there is no obstructing lesion in the sigmoid or descending colon. ... Cecum is of abnormal configuration with a small stanchion in the middle. Findings are suggestive of a tumor. Extravasation of contrast is not seen." On April 20th Dr. Gimenez wrote "Review of CT scan shows questionable fluid collection superior and anterior to liver in right upper quadrant and one in right lower quadrant of abdomen. Colon x-rays today show possible caecal lesion with irregular contour of the medial wall of caecum. Because of low serum potassium question of villous adenoma with earlier walled off perforation and fluid collection in right upper quadrant and right lower quadrant" and he ordered a colonoscopy for the next day.

12. On April 21st, Dr. Gimenez performed the colonoscopic exam and later wrote "Scope passed with ease to 160 cm and into terminal ileum. Findings: bulging gray lesion on medial wall of caecum with smooth surface ... another punctuate 1 cm flat ulcer-like lesion about 120 cm from anus." He took biopsies of both lesions, which were examined on April 22nd and found to be benign.

13. The Clinical Record for Patient I shows the following temperatures:

April 16: 98.4, 101.6, 100.2, 101.2
April 17: 100.4, 101.0, 97.4, 98.8
April 18: 100.4, 98.6, 98.8, 99.8
April 19: 100.2, 99.4, 98.2
April 20: 98.6, 97.4, 100.2
April 21: 100.4, 97.0, 100.8
April 22: 99.2, 98.2, 101.4
April 23: 98.0, 98.8, 99.0
April 24: 99.2, 96.8, 102.6
April 25: 101.6, 100.4, 101.8

14. The medication administration record for Patient I shows that narcotic analgesics, either Tylenol #3 or Demerol & Vistaril, were administered at the following times:

April 16: 0645, 1010, 1510, 1515
April 17: 0130, 0925, 1030, 1715
April 18: 0145, 1430
April 19: 0015, 0500, 1430
April 20: 1240, 2030
April 21: 2130
April 22: 1000, 1400, 1815, 2315
April 23: 0320, 0900, 1315, 1725
April 24: 0345, 1100, 2040
April 25: 0600, 1200, 2000

15. The Laboratory Reports for Patient I show the following white blood counts:

April 16	18,100
April 17	14,600
April 18	12,000
April 20	9,000
April 23	10,8000

16. The Laboratory Reports for Patient I show the following potassium levels:

April 16	2.3 MEQ/L
April 17	2.5
April 18	2.8
April 19	3.1
April 20	2.5
April 23	3.4
April 25	4.4

17. The Nurses Notes for April 21st state "1400 - lab reports blood cultures show gram neg. rods - called to Dr. Gimenez's office." A Lab Report dated April 23rd, for blood drawn on April 16th, states "E. coli present".

18. On April 23rd, Dr. Gimenez ordered the administration of the oral antibiotic Bactrim (Septra), and on the 24th, he discontinued the IV antibiotics which she had been receiving since she was admitted.

19. On April 26th, Dr. Gimenez performed an exploratory laparotomy, with a preoperative diagnosis of "Possible perforated bowel with abdominal abscesses, multiple", and found a ruptured retrocecal appendix with abscesses in the right upper, right lower, and left lower quadrants of the peritoneal cavity. He also found a partial small bowel obstruction, an infarcted omentum, a diverticulum of the ascending colon, and partial sigmoid colon obstruction due to adhesions. He removed the appendix and drained the abscesses. He detached the adhesions, reduced the small bowel obstruction, and removed part of the omentum. He removed the diverticulum.

20. The pathologist's report for the tissue removed during the exploratory laparotomy states "Gross Specimen is labeled omentum and abscess consists of five irregular hemorrhagic tissue fragments total weighing 180 grams and measures 3.5, 5.6, 7.0, 6.0, and 14.0 cm in maximum measurement respectively. The tissue fragments appear to be mesenteric fat all of which contains area of fibrosis and hemorrhage. One of this fatty tissue covered with blood and fibrous tissue contains appendix which measures approximately 6 cm. in length and appears to be perforated. Multiple representative sections submitted for microscopic examination. Microscopic: Microscopic sections demonstrate ruptured acute gangrenous appendicitis with extensive inflammatory reaction on the mesenteric fat forming abscesses. There is evidence of hemorrhage

and acute inflammation on the mesenteric omentum. No malignancy is noted. Diagnosis: Appendix, fragments of omentum: Ruptured acute gangrenous appendicitis with extensive inflammatory reaction in the omentum and abscess formation."

21. Dr. Gimenez' delay in performing the exploratory laparotomy until 4/26/88 in the presence of diagnosable abdominal abscesses fell below the minimum standards of competence established in the profession.

22. Dr. Gimenez' delay in performing the exploratory laparotomy to drain the abscesses created the unacceptable risks that further complications would develop including abscess formation, adhesions and wide spread infection throughout the patient's body.

23. The standards of minimal competence required that Dr. Gimenez intervene surgically by 4/20/88 or 4/21/88 to drain the abscesses and address the underlying medical problem.

With regard to Count II of the Complaint:

24. Patient II, d.o.b. 5/19/09, appeared for an office visit with Dr. Gimenez on June 23, 1988 complaining of urinary pain, urinary frequency, and pains in her left flank. A urinalysis disclosed bacteria and white blood cells, but no red blood cells, in her urine. Dr. Gimenez diagnosed an acute urinary tract infection and prescribed Septra DS.

25. On July 26, 1988 Patient II returned for another office visit with Dr. Gimenez, complaining of continued urinary frequency and a tired feeling. A urinalysis was negative. Her hematocrit was 36, which is below normal, and Dr. Gimenez ordered iron sulfate.

26. On August 9, 1988 Patient II returned to have Dr. Gimenez remove a mole on her cheek. At that time she reported continuing urinary frequency, and a urinalysis showed bacteria, white blood cells and white blood cell casts, but no red blood cells. Dr. Gimenez again diagnosed a urinary tract infection and prescribed Septra DS.

27. On August 19, 1988 Patient II appeared for an office visit related to the mole excision, and a urinalysis performed on that day showed no bacteria and only a few white blood cells.

28. On September 1, 1988, Patient II returned and reported a loss of seven pounds in three weeks. She also "felt cold", had pain in her lower back and right hip, and passed mucus in her urine. A urinalysis again showed bacteria and white blood cells, as well as a trace of albumin. Her hematocrit was 38, which is in the normal range. Dr. Gimenez noted that Patient II had had a left ovarian cyst removed in 1953, and a hysterectomy in 1967. Dr. Gimenez prescribed Macrodantin and ordered a Pap smear, an ultrasound of the pelvis, and an intravenous pyelogram (IVP).

29. The Pap smear was collected on September 1, 1988, and the report dated 9-12-88 showed a cancer reading of Class I (essentially negative) with mixed bacteria.

30. The ultrasound was performed on September 6, 1988, and the report stated "... The right ovary is moderately enlarged, measuring up to approximately 4.5 x 4 x 2.5 cm. in size. There is no evidence of any other mass lesion, cystic lesion, or free fluid within the pelvis. IMPRESSION: Moderate enlargement of the right ovary of uncertain etiology. An ovarian neoplasm cannot be totally excluded. ...".

31. The IVP was performed on September 7, 1988, and the report stated "IMPRESSION: An approximately 2x4 cm. diameter filling defect involving the right lateral bladder. This may represent either a bladder neoplasm or an indentation secondary to an extrinsic mass. There is moderate right hydronephrosis and hydroureter secondary to this. If clinically indicated, a CT scan of the abdomen and pelvis may be of additional help."

32. Patient II returned on September 15, 1988 to receive the results of the tests from Dr. Gimenez. At that time she complained of fullness and discomfort in her right lower abdomen. A urinalysis showed a trace of bacteria, a few white blood cells, and no red blood cells.

33. Based upon the enlargement of the right ovary imaged in the ultrasound, the right lateral filling defect in the bladder shown by the IVP, the patient's sudden weight loss, the absence of hematuria, and his review of medical literature, Dr. Gimenez formed the opinion that Patient II most likely had ovarian cancer. Dr. Gimenez's opinion was and is that ovarian cancer "goes like wildfire". He informed Patient II of this as the most likely diagnosis to convey a sense of urgency regarding her situation.

34. Dr. Gimenez discussed the possibility of a CT scan with Patient II, but he recommended that it be performed at another facility with a more modern CT scanner than available at Berlin Memorial Hospital. Patient II expressed a preference for exploratory surgery, and Dr. Gimenez scheduled an exploratory laparotomy and right ovariectomy for September 20, 1988.

35. Dr. Gimenez did not perform a cystoscopic examination on Patient II, nor did he insist on Patient II obtaining a urology consult or a cystoscopy from an urologist. In September 1988 a cystoscopy at Berlin Memorial Hospital would have been performed by Dr. Mary Leikness, the resident urologist.

36. On September 19, 1988, Patient II provided a urine sample for analysis at Berlin Memorial Hospital. The analysis was completed the same day, and showed that the color of the urine was "reddish" and that the urine contained "3+" occult blood and "packed" red blood cells, with the comment "blood clot present".

37. Patient II was admitted to Berlin Memorial Hospital at 6:10 A.M. on September 20, 1988. The Nurses Notes from 6:10 A.M. state "urine has been blood tinged since 9/19". Patient II was taken to the operating room at 7:10 A.M.

38. After the patient was anesthetized and prior to surgery, a catheter was inserted to drain the bladder, which returned grossly bloody urine. The catheterizing nurse brought this to Dr. Gimenez's attention as he was scrubbing for surgery.

39. Dr. Gimenez was late getting to the operating room and he did not review the laboratory report of the 9/19/88 urinalysis or the Nurses Notes from 6:10 A.M. until after he observed the patient's bloody urine.

40. Dr. Gimenez interpreted the blood in the patient's urine as evidence that a malignancy outside the bladder had invaded the bladder or the right ureter, and he proceeded with the exploratory laparotomy.

41. The surgery disclosed the right ureter dilated to approximately one inch in diameter with marked hydronephrosis, an ovarian mass on the patient's right side which was inflamed and fixed against the side of the bladder, and enlarged lymph nodes around the iliac vessels and the aorta.

42. After observing the enlarged ureter, Dr. Gimenez requested a consultation with the staff urologist, Dr. Mary Leikness, to obtain her assistance in deflating the ureter to prevent damage to the kidney.

43. When Dr. Leikness entered the operating room and was informed of the patient's condition, she disagreed with Dr. Gimenez's decision to operate. It was her opinion that further diagnostic testing should be done to determine whether bladder cancer was present and if so, whether it could be removed without abdominal surgery. Dr. Leikness, who was also chief of surgical staff at Berlin Memorial Hospital, directed Dr. Gimenez to close the patient's abdomen without further surgery, which he did after taking biopsies of the lymph nodes and an area of the ovary away from the bladder wall.

44. Dr. Leikness then spoke to the patient's daughter, who was in the waiting room, obtained permission to perform a cystoscopy on the patient, and proceeded to examine the patient's bladder.

45. The cystoscopic exam showed an ulcerating tumor inside the bladder which Dr. Leikness biopsied.

46. Analysis of the biopsied tissues showed (1) metastatic cells in the lymph nodes consistent with stage IV transitional cell carcinoma, (2) an infiltrating transitional cell carcinoma,

either stage III or stage IV, inside the bladder, and (3) a simple cyst without evidence of malignancy in the right ovary.

47. Dr. Gimenez' conduct in providing medical care and treatment for patient II fell below the minimum standards of competence established in the profession in that he failed to adequately evaluate the patient's urinary tract before proceeding with the exploratory laparotomy, he failed to order a CAT scan prior to surgery to help establish the organ systems that were involved, and he failed to obtain a urology consult prior to proceeding with the exploratory laparotomy.

48. Dr. Gimenez' conduct created the unacceptable risks for patient II that Dr. Gimenez would not be fully informed and, therefore, could not make a good decision on the best surgical procedure to recommend to the patient, that she may be subjected to the risks of unnecessary surgery including the general risks of anesthesia, and that the surgical procedure itself would result in cutting across tumor lines spreading the tumor cells to other areas in the abdominal cavity.

49. The standards of minimal competence required that Dr. Gimenez perform a full evaluation of the patient's urinary tract, including cystoscopy and a CAT scan to evaluate the organ systems involved, and obtain a urology consult before intervening surgically.

With regard to Count III of the Complaint:

50. Dr. Gimenez first treated Patient III, d.o.b. 5/4/04, on June 30, 1986, when he reported "shortness of breath and 'gas' problems". Prior to that, Patient III had been treated by Dr. Gimenez's recently-retired partner, Dr. Sievers. Patient III visited Dr. Gimenez on 7/14/86, and he wrote "feeling much better ... less dyspnea by far. Stomach still bothers with 'gas'". On 8/12/86: "numbness with soreness in calves of legs ... Also pains and stiffness in neck and shoulderblades. Donnatal caps help for 'gas' pains - but still present". On 10/28/86: "numbness still bothers ... 'gas' problem with constipation ... x-rays of g-b, colon, and ugi 2 years ago normal". On this last date, Dr. Gimenez ordered a barium enema.

51. Patient III did not have the barium enema performed, and subsequent visits to Dr. Gimenez were as follows: 12/11/86, "feeling pretty good now and did not get the barium enema"; 1/5/87, "itched all over yesterday and felt rotten"; 2/10/87, "circulation problems in legs"; 2/26/87, "weakness and dizzy spells ... gassy feeling in abdomen at times but bowels working well"; 3/5/87 "awoke 5 days ago with severe abdominal pains". On this last date, Dr. Gimenez ordered serum electrolytes, complete blood counts and a chemical profile.

52. On March 10, 1987 Dr. Gimenez reviewed the lab tests with Patient III, who reported "feeling a little better ... soreness in calves". Patient III's hematocrit was 33, whereas a normal hematocrit for an 82-year-old man would be no lower than 42. On this date, Dr. Gimenez prescribed iron sulfate for Patient III to address his low iron level. Dr. Gimenez chose this treatment based on several facts:

- his former partner, Dr. Sievers, had prescribed iron sulfate for the patient on previous occasions; specifically, after Patient III was hospitalized under Dr. Sievers' care in September 1985, and when his hematocrit was 36, Dr. Sievers diagnosed microcytic anemia and prescribed iron sulfate;
- x-rays of the gastrointestinal tract taken on August 6, 1984 were normal;
- a nurse who took care of Patient III had reported to Dr. Gimenez that Patient III was a very poor eater; and
- Patient III had been treated for cancer of the bladder and was being seen on an annual basis by a urologist.

53. Patient III returned on March 20, 1987 reporting "numbness - beginning from legs upward to shoulders and neck with shaking and tightening pains". Another lab test showed an hematocrit of 32.

54. On March 24, 1987 Patient III visited Dr. Gimenez and reported that he "felt the best today for a long time". Patient III visited Dr. Gimenez on 4/7/87 for faintness and itching, on 4/23/87 for severe indigestion and itching, on 6/1/87 for numbness in lower extremities, on 6/26/87 for itching and numbness in lower extremities, and on 7/10/87 when he reported "feeling a little better. Gassiness at times with passage of flatus. Nervous tension at times."

55. Other than ordering the barium enema which Patient III did not have performed, Dr. Gimenez did not investigate possible explanations for Patient III's anemia other than dietary deficiency. Specifically, he did not have Patient III's stool analyzed for occult blood, and he did not establish the iron, B_{12} and folic acid levels in the patient's blood.

56. Patient III was admitted to the emergency room at Berlin Memorial Hospital on August 16, 1987 complaining of dizziness. A blood test showed an hematocrit of 27, and blood was detected in his stool. On August 25, 1987 Dr. Gimenez operated and removed a 4 x 5 cm. grade III adenocarcinoma from the ascending colon near the cecum.

57. Dr. Gimenez' conduct in providing medical care and treatment for patient III fell below the minimum standards of competence established in the profession in that he failed to promptly investigate the cause for the patient's anemia.

58. Dr. Gimenez' conduct created the unacceptable risk that the anemia may have been due to a cancer in the gastrointestinal tract, the delayed diagnosis of which would permit the cancer to progress to a more advanced stage and, thereby, decrease the probability of a cure.

59. The standards of minimal competence required that Dr. Gimenez evaluate the cause for the anemia in March, 1987, by conducting blood studies including a serum iron level, serum B12 and folic acid levels, by checking the patient's stool for blood and by performing a rectal examination to determine if the patient had a rectal tumor.

With regard to Count IV of the Complaint:

60. Patient IV, d.o.b. 11/17/22, was hospitalized on September 5, 1988, and on September 7, 1988 Dr. Gimenez performed abdominal surgery on her, draining an abscess and removing two areas of obstruction in her bowel. He then created two anastomoses to close the bowel and inserted a Jackson-Pratt (JP) drain.

61. At the time of the surgery, Patient IV suffered from severe diabetes and chronic pulmonary obstructive disease. Prior to that time, she had had gallbladder surgery, ulcer surgery, a hysterectomy, surgery for carotid problems in her neck, and cardiac bypass surgery.

62. Following the surgery, Patient IV had no immediate complications, but she began to have difficulty breathing. On September 8th, Dr. Gimenez obtained a medical consult from Dr. Shattuck, who opined that Patient IV was in mild cardiac failure and prescribed digoxin. On September 9th, Dr. Shattuck saw Patient IV again and his impression was "congestive heart failure, much improved, but question of new infarction."

63. On September 10th, Patient IV had no shortness of breath, though she continued to have rales in the bases of her lungs, indicating that she was still in heart failure. She also had increased levels of LDH, ALT and AST, indicating that she had suffered a myocardial infarction.

64 On September 11th, Dr. Carroll interpreted an ECG of Patient IV as showing "clear, posterior wall myocardial infarction."

65. On September 12th, Dr. Gimenez saw Patient IV and noted that she had passed BMs and was afebrile, although she had some purulent drainage from the JP drain. Later on September 12th, Patient IV began to have abdominal distress with pain in her lower right abdomen and increased purulent-appearing drainage. At 1730 on the same day she developed a fever of 101.3 degrees, her abdomen became distended, and the JP drain showed "stool-like drainage, brownish/tan". Dr. Gimenez ordered a CT scan, "looking for abscess from anastomosis leak".

66. Patient IV continued to register elevated temperatures of 100.9 at 2215 on September 12th and 100.7 at 0010 on September 13th, but by 0400 on the 13th it had lowered to 99, and otherwise from September 8th through September 16th it fluctuated between 96.4 and 99.8. The CT scan was performed on September 13th, disclosing a 7 by 4 cm fluid collection containing air bubbles in the lower right abdomen. On September 13th, 14th and 15th, Patient IV began experiencing pain in her abdomen, as reflected in the numerous nurses' notes regarding Patient IV's use of a patient-controlled analgesic (PCA).

67. Dr. Gimenez did not intervene surgically, but on September 13th he ordered a change in the antibiotics Patient IV was receiving from Mefoxin to gentamycin, Flagyl, and Zinacef. Patient IV's white blood count on 9/7/88 was 11,400, on 9/8 it was 16,400, on 9/10 it was 17,000,

on 9/13 it was 13,000, on 9/14 it was 22,200, on 9/15 it was 23,100 and later 23,000, and on 9/16 it was 17,000.

68. On September 16th Dr. Gimenez was called out of town. He turned the care of Patient IV over to Dr. Barry Rogers. Patient IV was afebrile but later that day she developed increased abdominal pain. Dr. Rogers discussed an operation with Patient IV's daughter, estimating that a 20 percent cardiac risk existed. He then operated on Patient IV and found that one of the anastomoses had been disrupted and that about 10 ccs of stool had entered the abdominal cavity but that it had been completely walled off by the omentum. He also found the fluid collection shown on the CT scan to be cloudy serosanguinous fluid and aspirated it. He created a colostomy to replace the disrupted anastomosis.

With regard to Count VI of the Complaint:

69. Patient VI, 10/26/01, was a patient of Dr. Gimenez for approximately 25 years, with a history of diverticulosis.

70. In November 1987, Patient VI was hospitalized complaining of slurred speech, facial weakness and difficulty chewing. She was treated by Dr. Richard Gubitz and diagnosed as having suffered a transient ischemic attack. During this hospitalization several ECGs were done, and the ECG strip dated November 23, 1987 at 0038 hours contained the notation "atrial fib". Dr. Gubitz also wrote a physician's note on 11/23/87 as follows (with technical abbreviations expanded): "11/23/87 ... did have episode of rapid atrial fibrillation which resolved spontaneously ... Dr. Scanlan to consult regarding treatment for occasional atrial fibrillation with digitalis, coumadin". A telemetry note at 0400 on 11/23/87 mentions "probable uncontrolled atrial fib?" and the 11/23/87 entry on the physician order sheet includes "Dr. Scanlan to consult regarding intermittent atrial fib". The final diagnosis on the Record of Admission says "1. Transient Ischemic Attack, ... 7. Wandering Atrial Pacemaker, 8. Left Atrial Hypertrophy, 9. Premature Ventricular Contractions, 10. Mitral Prolapse, 11. Mitral regurgitation ...."

71. On December 31, 1987, Dr. Gimenez conducted a colonoscopic examination on Patient VI and detected a "practically complete" obstruction of the sigmoid colon. During the course of the colonoscopy he performed five or six biopsies. Dr. Gimenez recommended surgery and Patient VI refused it.

72. On January 1, 1988, Patient VI called Dr. Gimenez and complained of rectal bleeding and Dr. Gimenez explained that it could have come from the biopsies. He prescribed oral ferrous sulfate to offset any loss of blood.

73. On January 8, 1988, Patient VI was admitted to the emergency room of Berlin Memorial Hospital complaining of nausea, vomiting and abdominal pain. Her stool was black.

74. A nasogastric tube was placed in Patient VI on January 9, 1988, which returned black or dark brown liquid from her stomach on 1/9, 1/10, 1/11, and 1/12. Her stool continued to be black until 2300 hours on 1/11, when it was reported as brown and on 1/12 as dark brown.

75. Dr. Gimenez did not test the return from the nasogastric tube for blood.

76. On 12/30/87, Patient VI's hematocrit was 41, on 1/8 it was 42, on 1/9 it was 37, on 1/10 it was 32, on 1/11 30. During a 24-hour period on January 11th Patient VI was given four units of blood. On 1/12 her hematocrit was recorded twice, as 50 and 52.

77. Upon her admission to the hospital Dr. Gimenez conducted a stethoscopic examination of Patient VI's heart and noted "irregular sinus rhythm with grade II/VI aortic systolic murmur heard with slight megaly to the left." After her admission he reviewed her previous history of heart problems, including her hospitalization in November of 1987. On January 9, 1988, he conducted another stethoscopic examination and noted "auricular fibrillation with ventricular rate around 84". On January 12th he noted "heart irregular, sinus rhythm with auricular fibrillation". Dr. Gimenez ordered electrocardiograms of Patient VI, which did not show atrial (also called auricular) fibrillation. Atrial fibrillation is intermittent and may or may not be present at any given time.

78. On January 12, 1988 Patient VI suffered a cerebrovascular accident (CVA). Dr. Gimenez sought a consultation with Dr. Kenneth Viste, a neurologist, who diagnosed "stroke-- embolic-- probably from underlying atrial fibrillation" and recommended heparinization to prevent future CVAs of embolic origin. Heparin inhibits the formation of blood clots. Dr. Gimenez ordered heparin on January 14th and discontinued it on January 17th when dark red blood appeared in Patient VI's stool.

79. Dr. Gimenez' conduct in providing medical care and treatment for patient VI fell below the minimum standards of competence established in the profession in that he failed to adequately evaluate the patient for an upper gastrointestinal bleed to determine if pharmacological treatment may have been available without the necessity for surgical intervention.

80. Dr. Gimenez' conduct in providing medical care and treatment for patient VI fell below the minimum standards of competence established in the profession in that he administered heparin to patient VI in the presence of active gastrointestinal bleeding.

81. Dr. Gimenez' conduct in failing to adequately evaluate patient VI for an upper gastrointestinal bleed subjected the patient to the unacceptable risk that the patient would continue to bleed as a result of a condition which may have been treatable by pharmacological means.

82. Dr. Gimenez' conduct in administering heparin to patient VI in the presence of active gastrointestinal bleeding created the unacceptable risk of exacerbating the gastrointestinal bleeding.

83. Continued bleeding in patient VI created the unacceptable risk of decreased blood pressure which leads to decreased oxygen delivery to vital structures and ultimately death if left unchecked.

84. The standards of minimal competence required that Dr. Gimenez not administer heparin in the presence of active gastrointestinal bleeding and that he analyze the material returned through the nasogastric tube to determine if it contained blood indicating an upper gastrointestinal source for the bleeding which may have been treated by pharmacological means.

With regard to Count VII of the Complaint:

85. Patient VII, d.o.b. 1/25/1899, was diagnosed by Dr. Carroll in July of 1987 as having rather significant congestive heart failure with edema. Dr. Carroll prescribed a diuretic, Bumex, 1 mg/day. This prescription was continued and increased by Dr. Gimenez when he saw Patient VII in April of 1988; specifically, he ordered Bumex 2mg/day when he had edema, and 1mg/day otherwise.

86. On May 4, 1988 Patient VII saw Dr. Gimenez, complaining of pain in his chest from where he had struck a chair the day before.

87. On June 5, 1988, Patient VII was admitted to the emergency room of Berlin Memorial Hospital, complaining of shortness of breath, especially upon exertion, and occasional sharp chest pains from where he had injured his right chest. Dr. Gimenez examined him and noted rapid shallow breathing with bluish lips, a contusion on the right side of his chest, and marked edema of the legs, scrotum and penis. An electrocardiogram was run which showed atrial fibrillation. Dr. Gimenez diagnosed congestive heart failure and ordered digoxin and a different diuretic, Lasix, 40 mg/day.

88. Patient VII remained in the hospital for twelve days with slow progress and reduction of edema. Chest x-rays taken during this time showed pleural effusions on both sides of his chest. On June 15th, Patient VII was continuing to have shortness of breath with low oxygen pressure in the blood, below 50, and oxygen saturation "about 88", so Dr. Gimenez aspirated 900 ccs of fluid from Patient VII's right chest, which alleviated the shortness of breath. An x-ray taken immediately after the aspiration showed less pleural fluid, but the cardiac silhouette was enlarged with widened upper mediastinum.

89. Dr. Gimenez then ordered a CT scan, which was done on June 16th, disclosing a "huge" pericardial effusion. Dr. Gimenez examined Patient VII for signs of tamponade and found

none. His investigation covered whether the veins in the neck were distended and whether the blood pressure lowered upon taking a deep breath.

90. Dr. Gimenez requested a consult with Dr. Carroll, who wrote "Agree pericardiocentesis may be indicated. However I do not do elective pericardiocentesis. Believe cardiologist under fluoroscopy do this procedure on an elective basis. Would get echocardiogram and Dr. Scanlan's opinion." Dr. Gimenez interpreted this note to mean that Dr. Carroll did not consider the patient to be in tamponade and did not consider the situation to be an emergency.

91. An echocardiogram was available at Berlin Memorial Hospital only one day per week, when Dr. Scanlan was there. Medicare would pay for Patient VII to be transported to Dr. Scanlan's office only if it was an emergency. Patient VII had never been hospitalized before, had spent twelve days in the hospital, and requested to go home. His weight had dropped from 188 1/2 to 164. Dr. Gimenez arranged an appointment for Patient VII to return and see Dr. Scanlan for an echocardiogram after he was discharged.

92. Dr. Gimenez discharged Patient VII from the hospital on June 18th after having arranged home health care for him including oxygen. At the time of his discharge, Dr. Gimenez noted "no scrotal edema. Extremities - trace of edema", and continued Patient VII on Lasix, 40 mg/day.

CONCLUSIONS OF LAW

1. The Medical Examining Board has personal jurisdiction over the Respondent based on fact #1.

2. The Medical Examining Board has jurisdiction over the subject-matter of this complaint, under sec. 15.08(5)(c), Wis. Stats, sec. 448.02(3), Wis. Stats. and sec. MED 10.02(2)(h), Wis. Admin. Code.

3. With regard to his treatment of Patient I, Respondent violated sec. MED 10.02(2)(h), Wis. Admin. Code and sec. 448.02(3), Wis. Stats. by delaying an exploratory laparotomy beyond April 21, 1988 in the presence of one or more diagnosable abdominal abscesses. Respondent did not violate any rule or statute by performing a diverticulectomy during the exploratory laparotomy.

4. With regard to his treatment of Patient II, Respondent violated sec. MED 10.02(2)(h), Wis. Admin. Code and sec. 448.02(3), Wis. Stats. by performing an exploratory laparotomy on September 20, 1988 without having performed tests which might have determined whether the primary site of a suspected cancer was the bladder or an ovary, specifically without having obtained a urology consult prior to surgery.

5. With regard to his treatment of Patient III, Respondent violated sec. MED 10.02(2)(h), Wis. Admin. Code and sec. 448.02(3), Wis. Stats. by failing to promptly investigate the cause of the patient's anemia as indicated by the low hematocrits on March 10, 1987 and March 20, 1987.

6. With regard to his treatment of Patient IV, Respondent did not violate sec. MED 10.02(2)(h), Wis. Admin. Code.

7. With regard to his treatment of Patient VI, Respondent violated sec. MED 10.02(2)(h), Wis. Admin. Code and sec. 448.02(3), Wis. Stats. by failing to test the return from the nasogastric tube for the presence of blood and to consider the ramifications of such bleeding, and by administering heparin to the patient without having thoroughly investigated the nature and extent of bleeding in her gastrointestinal tract.

8. With regard to his treatment of Patient VII, Respondent did not violate sec. MED 10.02(2)(h), Wis. Admin. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that license number 12171 to practice medicine and surgery in Wisconsin, granted to Dr. Alonzo R. Gimenez, is suspended for a period of six months, effective ten days following the date hereof.

IT IS FURTHER ORDERED that Dr. Gimenez shall, prior to termination of the period of suspension, submit to an assessment by Dr. Thomas Meyer, M.D., Director of the Continuing Medical Education Department of the University of Wisconsin, Madison, to determine Dr. Gimenez' current ability to competently practice medicine and surgery in Wisconsin. Should the assessment establish a need for a remedial educational program, Dr. Gimenez shall promptly arrange to participate in such program. The assessment prepared by Dr. Meyer shall include recommendations as to limitations, if any, to be imposed on Dr. Gimenez' license pending completion of any recommended remedial educational program. The board may in its discretion impose limitations on Dr. Gimenez' license at the time of restoration of the license.

IT IS FURTHER ORDERED that three-quarters (75%) of the costs of this proceeding shall be assessed against Dr. Gimenez.

EXPLANATION OF MODIFICATIONS

With regard to Count I of the Complaint:

The board has modified its findings relating to patient I to add the following:

21. Dr. Gimenez' delay in performing the exploratory laparotomy until 4/26/88 in the presence of diagnosable abdominal abscesses fell below the minimum standards of competence established in the profession.

22. Dr. Gimenez' delay in performing the exploratory laparotomy to drain the abscesses created the unacceptable risks that further complications would develop including abscess formation, adhesions and wide spread infection throughout the patient's body.

23. The standards of minimal competence required that Dr. Gimenez intervene surgically by 4/20/88 or 4/21/88 to drain the abscesses and address the underlying medical problem.

These additional findings of fact are supported in the record by the expert testimony of Dr. Neal A. Melby:

Q. Doctor, do you have an opinion to a reasonable degree of professional certainty whether Dr. Gimenez' conduct in managing this patient during the course of her hospitalization fell below the minimum standards of competence established in the profession in any respects?

A. I do.

Q. And what is that opinion?

A. It is my opinion that, in light of this patient's serious ruptured appendix, with her, I think, abscess formations and CT evidence of CAT -- with CT scan of her abdominal region, that she had abscess formation present and that earlier surgical intervention should have been carried out.

Q. Now, you indicated that one of the respects in which you believe Dr. Gimenez' conduct fell below the minimum standards of competence was related to the delay in performing the exploratory surgery upon receipt of the results of the CT scan. Do you have an opinion to a reasonable degree of professional certainty regarding the latest possible date upon which such surgery should have been performed to still fall within the standards of minimal competence?

A. I have an opinion.

Q. And what is your opinion?

A. My opinion is that within four or five days of the initial hospitalization that the patient should have had her surgical procedure.

Q. And so that would place the surgery on what date?

A. Either the 20th or the 21st.

Q. To some extent you have already discussed this, but let me ask you. Utilizing your knowledge of the patient's presenting complaints, the patient's clinical course, the x-ray and laboratory findings and studies and the basic principals of medicine which apply to this case, could you explain your basis for reaching the conclusion or the opinion that this patient should have had surgical intervention by April 21st, or April 20th of 1988?

A. It is my opinion that Dr. Gimenez had enough information by that time to be able to make a surgical opinion that this patient did have an abscess in her abdominal cavity, that because of the nature of the presentation with fever, the fact that she had an elevated white count, the fact that the blood cultures were eventually positive--now, it's true they did not initially show anything, but, however, on the 21st there is a lab report indicating that there was E coli found on a blood culture. This information was called to Doctor's office, as I understand it from the report. It is my opinion, that, with delay in draining abscesses or taking care of the problem as they present, that further complications can develop; those potential complications include abscess formation, adhesions, wide spread infection throughout her body. These are potential problems, obviously.

Q. Do you have an opinion to a reasonable degree of medical certainty whether these problems that you mentioned represent unacceptable risks to this patient under the facts and circumstances of this case; that is, unacceptable risks because they may arise out of the failure to intervene surgically on the dates you have indicated?

A. Yes.

Q. What is your opinion?

A. My opinion that delay in this patient who, in reference to previous records of the patient indicating that she was already compromised medically, that this would lead to an undue risk to this patient." (Transcript, 2/12/92, pp. 403-405)

The Medical Examining Board finds Dr. Melba's testimony to be credible and accepts it in support of the added Findings of Fact.

With regard to Count II of the Complaint:

The board has modified its findings as to Patient II to add the following Findings of Fact:

47. Dr. Gimenez' conduct in providing medical care and treatment for patient II fell below the minimum standards of competence established in the profession in that he failed to adequately evaluate the patient's urinary tract before proceeding with the exploratory laparotomy, he failed to order a CAT scan prior to surgery to help

establish the organ systems that were involved, and he failed to obtain a urology consult prior to proceeding with the exploratory laparotomy.

48. Dr. Gimenez' conduct created the unacceptable risks for patient II that Dr. Gimenez would not be fully informed and, therefore, could not make a good decision on the best surgical procedure to recommend to the patient, that she may be subjected to the risks of unnecessary surgery including the general risks of anesthesia, and that the surgical procedure itself would result in cutting across tumor lines spreading the tumor cells to other areas in the abdominal cavity.

49. The standards of minimal competence required that Dr. Gimenez perform a full evaluation of the patient's urinary tract, including cystoscopy and a CAT scan to evaluate the organ systems involved, and obtain a urology consult before intervening surgically

These findings of fact are supported in the record by the expert testimony of Dr. Melby:

"Q. Based upon your review of Ms. Mathia's medical records, do you have an opinion to a reasonable degree of medical certainty whether Dr. Gimenez' conduct in managing this patient's care fell below the minimum standards of competence established in the profession?

A. I do.

Q. And what is your opinion?

A. It is my opinion that this patient, prior to her having her surgery, had an incomplete evaluation. It is my opinion that before one does any exploratory surgery, that one needs to have as much information as possible at the time to be able to make a sound surgical judgment. It is my opinion that this patient needed to have an evaluation of her urinary tract prior to the exploratory laparotomy.

Q. And did your have information that that evaluation was done or not?

A. The record indicates that it was not done prior to the actual exploratory surgery. It was done during the time of the actual anesthetic setting and surgical setting in the hospital on the 20th of September, 1988.

Q. What unacceptable risks, if any, were created by Dr. Gimenez' conduct in failing to do an adequate evaluation of the patient and the patient's urinary tract? What unacceptable risks were created by that conduct for this particular patient?

A. Well, it is my opinion that in order to give the patient the best information and to help her make the best decision, that she needs to have as much information about what her clinical situation is, that is, in this situation, the extend of the tumor, the type of tumor, the extent of the tumor and what her potential cure rate or treatment

could very well be. It is my opinion the cystoscopy, which is a procedure performed by ones trained in that particular diagnostic procedure, would be able to be done as an outpatient without anesthesia to be able to look inside the urinary bladder, at least to be able to make a diagnosis of the type of tumor and its involvement in the area that was described.

It is my opinion that, without an adequate workup, one cannot be fully informed as to make a good surgical decision as to the procedure that could be best done for this patient without having all of the information.

Q. And what unacceptable risk, if any, does this pose for the patient?

A. Well, I think that in order to--again, to be able to help the patient, at least to be able to access all of the factors involved, you have to have, again, all the information that you can get. Potentially it could subject her to unnecessary risks with other surgical procedures which may not have been necessary.

Q. Now, specifically, what unacceptable risks, if any, arise by intervening surgically, as Dr. Gimenez did, before working up the potential problems in the urinary tract?

A. Well, one can look at the general forms of risk with general anesthesia. That would involve all of the potentials for problems with lung problems and reaction to medication, etc. The actual procedures itself, as far as removing tumors or not having a full, adequate evaluation, one can spread tumor cells around inside of the abdominal cavity. One can potentially, at least, do some harm to the patient.

Q. When you're talking about spreading cancer cells by doing surgery without full evaluation, can you give us a little bit more detailed explanation of what is actually involved there?

A. Basically, if one cuts across tumor lines, one of the principals of surgery is that one likes to incorporate the entire mass within your operative specimen to try to keep the tumor within its own confines, and by cutting across tumor lines or by cutting across different spread of tumors, one can potentiate the spread.

Q. And how would a full urological workup assist you in making the determination of what surgery or how much surgery should be done to avoid this type of contamination?

A. It was my belief that the recommendations made by the radiologist, including a CAT scan prior to this time, perhaps by having the cystoscopy and the full evaluations prior to this, that the patient may have been a candidate for a potentially curable problem involving doing regional dissections or her bladder and diversion and all those types of things, which are really quite complicated, which I am not qualified to discuss, really.

Q. Now, you've also-- already indicated that cystoscopy is a procedure for evaluating the--this particular patient's urinary tract problems; is that correct?

A. Correct.

Q. To what extent, if any, would cystoscopy, in your opinion, be a minimally competent response to this patient's presenting complaints prior to the surgical intervention?

A. It's my opinion that it would have led to the evaluation and the diagnosis of why she had hematuria, perhaps why she had recurrent urinary tract infections, and making an earlier diagnosis of invasive bladder cancer.

Q. Would it be your opinion to a reasonable degree of professional certainty that cystoscopy would have been a minimally competent response to this situation.

A. That's my opinion.

Q. And that would have been when with respect to the time of surgery?

A. Basically, I think that, in general principles, that if one has a recurrent urinary tract infection, there is some reason for that, and again, these are all judgment calls. However, with recurrent urinary tract infections on a monthly basis, that one should, in my surgical opinion, work up the patient, and that includes the procedures that were initially performed followed by cystoscopy. I think this would have tipped one's--this would have led to the diagnosis of this cancer earlier.

Q. In your opinion, then, would the cystoscopy constitute a minimally competent response?

A. Correct.

Q. Now, you've also mentioned a CT scan, that's the same thing as a CAT scan?

A. That's a CAT scan, correct.

Q. To what extent, if any, would a CT scan, as you have mentioned it, represent a minimally competent response to this patient's presenting complaints and developing symptoms?

A. Basically, the CT scan helps evaluate involvement of structures. Early it is not real helpful; however, along in the course of the disease, it will help establish the

organ system that's involved. I think that that is helpful for our screening procedure.

Q. To what extent in this case do you believe that that would have been a minimally competent response to this patient's condition?

A. I think it would have tipped off the--again, the concern about the urinary bladder itself being involved with some type of tumor process, either from within the bladder or external to it, but with invasion. As far as its helping for lymph node enlargement, I don't think that would have been helpful at all for this patient.

Q. To what extent, then, would it be your opinion that the CT scan performed prior to surgery would be a minimally competent response?

A. It is my belief that this would have set the clinical setting where the urinary bladder would have been evaluated prior to the exploratory surgery.

Q. I guess what I am trying to find out is whether or not in your opinion, then, the CT scan should or should not have been done prior to surgery to meet the standards of minimal competence in addressing this patient's condition.

A. That's my opinion. A CT scan should have been done before the surgery.

Q. To what extent, if any, would a urological consultation constitute a minimally competent response to this patient's situation?

A. It's my opinion that if this had been done earlier, that the diagnosis could have been made earlier without the unnecessary risk of general--the general exploration." (Transcript, 2/12/92, pp. 422-428)

"Q. What effect, if any, would it have in your opinion that the urological evaluation, including the cystoscopic examination with urology consult--what effect, it any, would it have on your opinion that the presence of the blood in the urinary tract was not discovered until after the patient was under anesthesia but before an incision was made?

A. Well, it would appear to me that that would be an undiagnosed situation, and I'd feel very uncomfortable about approaching that patient without having, again, all the information that I'd--that I can have at my--available to me.

Q. An in terms of a minimally competent response, what would that dictate with respect to whether or not the pat--whether or not the doctor would proceed with the surgery at that point without having first done a cystoscopy with a urological consult?

A. Well, I believe that a minimally competent physician would want to have all of that information available.

Q. And what does that mean in the context of performing the cystoscopic examination and obtain the urological consult given that the patient is under anesthesia at that time?

A. Well, I think it would be mandatory that that should be done.

Q. After he's under anesthesia but before the surgical intervention?

A. Before the surgical exploratory incision was made."
(Transcript, 2/12/92, pp. 431-432)

The Medical Examining Board finds Dr. Melby's testimony as to Patient II to be credible, and accepts it in support of the added Findings of Fact.

With regard to Count III of the Complaint:

The board modifies its Final Decision and Order in this matter to add the following Findings of Fact:

57. Dr. Gimenez' conduct in providing medical care and treatment for patient III fell below the minimum standards of competence established in the profession in that he failed to promptly investigate the cause for the patient's anemia.

58. Dr. Gimenez' conduct created the unacceptable risk that the anemia may have been due to a cancer in the gastrointestinal tract, the delayed diagnosis of which would permit the cancer to progress to a more advanced stage and, thereby, decrease the probability of a cure.

59. The standards of minimal competence required that Dr. Gimenez evaluate the cause for the anemia in March, 1987, by conducting blood studies including a serum iron level, serum B12 and folic acid levels, by checking the patient's stool for blood and by performing a rectal examination to determine if the patient had a rectal tumor.

These findings of fact are supported in the record by the expert testimony of Dr. Lynn D. Koob:

Q. Based upon your review of Mr. Betry's medical records, have you formulated a professional opinion to a reasonable degree of professional certainty whether Dr. Gimenez' conduct in managing this patient's care fell below the minimum standards of competence in any respects?

A. Yes.

Q. And what is that opinion?

When he was seen in March, he had a significant anemia with a hematocrit of 19--or of 33, and this anemia was not worked up. It was not investigated, but the patient was just treated with iron medication.

Q. By what date should a workup of that anemia have been commenced?

A. It should have been done--started then.

Q. That would be in March of 1987?

A. In March of 1987."\
(Transcript, 2/12/92, p. 494)

Q. Why in this particular case involving Mr. Betry was it important to work up this patient's symptom of anemia given the patient's other symptoms prior to that time?

A. One cause of anemia is blood loss, and a person can have occult blood loss or unrecognized blood loss from the bowel due to an ulcer or tumor or other problems, but whatever it is, it's important to find out what that is and treat that, treat the underlying cause rather than just treat the anemia itself."
(Transcript, 2/12/92, p.495)

Q. What, in your professional opinion, would have been a minimally competent workup of this patient's anemia in March of 1987?

A. Start off with draw of various blood studies to determine the type of anemia, which would involve drawing a serum iron level, serum B12 and folic acid levels, and then determining if he is loosing blood from his gastrointestinal tract by checking his stool for blood. There is a chemical test called a guaiac test that detects very small amounts of blood in the stool.

Q. Was there any type of a physical examination that would be done at that point as a minimally competent response to the anemia in March of 1987?

A. Well, the most direct way to check the stool is to do a rectal exam and then check the stool that comes on the gloved finger from a rectal exam. Also, doing a rectal exam helps determine if it could possible be a rectal tumor that's causing the problem.

Q. In your professional opinion, would the performance of a rectal exam be a minimally competent response--one of the elements of a minimally competent response to the anemia in March of 1987?

A. Yes."
(Transcript, 2/12/92, pp. 496-497)

"Q. Now, the record does reflect that the patient returned to the emergency room on, I believe, August--on August 16 of 1987. Do you recall that?

A. Yes.

Q. And that was about five months after the low hematocrits upon which you have expressed your opinion that the patient was anemic. At that time, the record reflects that Dr. Willett, who was the emergency room physician did order a number of tests, and I--if we looked at the record, we would see that included in those tests would be the three you have mentioned.

A. Yes.

Q. In your professional opinion, would the ordering of those tests in August of 1987 constitute a timely and minimally competent response to the anemia that appeared back in March of 1987?

A. No. I feel those tests should have been ordered back in March."
(Transcript, 2/12/92, p. 498)

"Q. In your professional opinion, what unacceptable risks, if any, were created for this patient by Dr. Gimenez' failure to perform a minimally competent workup of the anemia in March of 1987?

A. The risk was that there was a tumor of the large bowel, and over that six month period of time, that was allowed to grow and possibly spread to the regional lymph nodes. When a tumor of the large bowel spreads beyond the large bowel into the regional lymph nodes, the chance of a cure decreases significantly, and so the risk to the patient was a decreased chance of cure of his large bowel cancer.

Q. Under the facts and circumstances of this case, would that be an unacceptable risk, in your professional opinion?

A. Yes."
(Transcript, 2/12/92, p. 501)

The board finds Dr. Koob's testimony as to Patient III to be credible, and accepts it in support of the added Findings of Fact.

With regard to Count VI of the Complaint.

The board has modified its findings to add Findings of Fact 75, 79, 80, 81, 82, 83 and 84, as follows:

75. Dr. Gimenez did not test the return from the nasogastric tube for blood.

79. Dr. Gimenez' conduct in providing medical care and treatment for patient VI fell below the minimum standards of competence established in the profession in that he failed to adequately evaluate the patient for an upper gastrointestinal bleed to determine if pharmacological treatment may have been available without the necessity for surgical intervention.

80. Dr. Gimenez' conduct in providing medical care and treatment for patient VI fell below the minimum standards of competence established in the profession in that he administered heparin to patient VI in the presence of active gastrointestinal bleeding.

81. Dr. Gimenez' conduct in failing to adequately evaluate patient VI for an upper gastrointestinal bleed subjected the patient to the unacceptable risk that the patient would continue to bleed as a result of a condition which may have been treatable by pharmacological means.

82. Dr. Gimenez' conduct in administering heparin to patient VI in the presence of active gastrointestinal bleeding created the unacceptable risk of exacerbating the gastrointestinal bleeding.

83. Continued bleeding in patient VI created the unacceptable risk of decreased blood pressure which leads to decreased oxygen delivery to vital structures and ultimately death if left unchecked.

84. The standards of minimal competence required that Dr. Gimenez not administer heparin in the presence of active gastrointestinal bleeding and that he analyze the material returned through the nasogastric tube to determine if it contained blood indicating an upper gastrointestinal source for the bleeding which may have been treated by pharmacological means.

Finding of Fact 75 is supported by the testimony of Dr. Gimenez:

Q. All of these indications of dark brown to black drainage from the nasogastric tube would raise the potential for the drainage of blood from the stomach, isn't that correct?

A. That is correct, yes.

Q. And if there was blood in the stomach, that would also account for the black stools at the other end, wouldn't it?

A. If there was blood, yes, it could account for black liquid stools.

Q. Did you ever have that return from the nasogastric tube tested for blood?

A. No, I did not.
(Transcript, 2/11/92, . p. 277)

Findings of Fact 79 through 84 are supported in the record by the testimony of Dr. Koob and Dr. Robert M. Green. Dr. Koob testified as follows:

"Q. Now, you're aware that Loretta Fralish had rejected surgical intervention both at the time that the partial obstruction was initially diagnosed back in December of 1987 and then again when she was hospitalized during this hospitalization on January 8, 1988. Having the fact--this fact in mind that the patient had rejected surgical intervention, do you have a professional opinion whether Dr. Gimenez' conduct in managing this patient's care fell below the minimum standards of competence established in the profession in any respects?

A. Yes, I feel that I did.

Q. And what is your opinion?

A. I feel that the cause of the bleeding should have been evaluated by checking the N.G. aspirate for blood to see if it was indeed blood, and if it was, this could have been treated with pharmacological means short of surgery.

Q. Is it your opinion that this conduct in failing to analyze the nasogastric tube return material fell below the minimum standards of competence established in the profession?

A. Yes.

Q. Now, the--it also indicates in the record, and I believe you've indicated, that Dr. Gimenez administered heparin to this patient. Do you have an opinion to a reasonable degree of professional certainty whether or not that conduct fell below the minimal standard of competence accepted in the profession?

A. Yes. I feel that it did fall below the minimum standards because giving a blood-thinning or anticoagulant medicine to somebody who is actively bleeding poses an undue risk of continued bleeding."
(Transcript, 2/12/92, pp. 524-525)

"Q. Can you explain for me what the unacceptable risks were that arose from Dr. Gimenez' failure to analyze the nasogastric tube return for blood?

A. The risk was continued bleeding, which, presumably, could have been treated with pharmacologic means.

Q. What's the consequence of continued bleeding?

A. Continued bleeding leads to decreased blood pressure, which leads to decreased oxygen delivery to vital structures, such as the kidneys, brain and liver, and can ultimately lead to death if unchecked.

Q. And what are the unacceptable risks, if any, in administered heparin in the presence of a GI bleed?

A. Again, the risk is continued or even exacerbating the bleeding, leading to the same scenario."
(Transcript, 2/12/92, pp. 525-526)

"Q. And as part of that consultation, Dr. Viste had indicated that in his opinion the CVA was of embolic origin and has suggested heparinization to prevent future CVA's. Given the factual heparinization to prevent future CVA's. Given the factual circumstances of this case and what we know about the patient's other problems in addition to the CVA, and applying the accepted standards of the profession, do you have a reasonable--do you have an opinion to a reasonable degree of professional certainty who had the responsibility of determining if there were any contraindications to the neurologist's recommendation to heparinize the patient?

A. I feel that the attending physician, Dr. Gimenez, who knows the patient's total hospital course and who is the one who actually writes the order for heparin, is responsible for determining if that should be ordered or not.

Q. Is that your opinion to a reasonable degree of professional certainty?

A. Yes.

Q. Do you have an opinion to a reasonable degree of professional certainty whether or not Dr. Gimenez, in fact, exercised this responsibility in a minimally competent fashion?

A. I feel that he did not.

Q. And why is that?

A. Because he did order heparin in the presence of a gastrointestinal bleed, and this did, in fact, cause continued bleeding.
(Transcript, 2/12/92, pp. 526-527)

"Q. Dr. Koob, irrespective of the fact that you do not--you're not able to quantitize with absolute precision the relative risk between a future CVA in the case of Ms. Fralish and the quantitized risk of heparinization, is it your opinion to a reasonable degree of professional certainty that to heparinize this patient, Fralish, in the presence of the evidence of gastrointestinal bleed in this case fell below the minimum standards of competence accepted in the profession?

A. Yes.

Q. Also, with respect to Ms. Fralish, you indicated in your testimony earlier that you didn't see any evidence that Dr. Gimenez had analyzed the return from the nasogastric tube for the presence of blood.

A. That's correct.

Q. In your professional opinion, did that failure to analyze the return from the nasogastric tube for the presence of blood in the context of this particular patient, given what we know about her refusal to have surgical intervention, fall below the minimum standards of competence accepted in the profession?

A. Yes.

Q. And can you explain for us again why it is that failure to analyze that return under the circumstances of this case fell below the minimum standards of competence accepted in the profession.

A. By analyzing and confirming that it was blood, one could treat this bleeding from the stomach by pharmacologic means rather than surgery and hopefully slow or stop the bleeding by pharmacologic means rather than--and not having to go to surgery. Just confirming that she had blood there would not lead one to recommend surgery.

Q. And that's because pharmacological means are also available?

A. That would be a first step.

Q. And I gather until you make that confirmation of bleeding from the upper gastrointestinal tract you're not in a position to decide one way or the other what treatment could be implemented in the stomach?

A. That's correct."

(Transcript, 2/12/92, pp. 544-546)

Dr. Green testified as follows:

"A. Having reviewed the records of November 20, 1987 and January 28, 1988. I have come to the conclusion that Dr. Gimenez did not know the difference at that time between atrial fibrillation and regular sinus rhythm with multiple premature atrial contractions.

Ordinarily this would not make much difference except that there are substantial data to show that patients with artrial fibrillation are much more likely to have cerebral emboli than patients with other atrial arrhythmias.

Mrs. Fralish was then subsequently placed on heparin in spite of the fact that she was not in atrial fibrillation and did not have well substantiated significant periods of time with atrial fibrillation.

When the patient began to bleed excessively after the institution of therapy with heparin, she should have been given Protamine immediately to correct the aggravation of the bleeding which was probably related to the heparin.

Although it is true that heparin might prevent a subsequent cerebral embolism, no reasonable physician who is fully aware of the facts in this case would administer heparin to a patient who already had gastrointestinal bleeding. The risk/beneficial ratio is such that the risk far outweighs any kind of possible benefits that could accrue from the use of heparin. Heparin might prevent a cerebral embolism but it certainly would aggravate gastrointestinal bleeding."
(Transcript, 2/26/92, pp. 681-682)

"Q. The question was: Doctor, why, in your professional opinion, did it fall below the minimum standards of competence established in the professional to administer heparin to this particular patient?...

A. Well, for one, I do not--a reasonable--for one, a reasonable--reasonably competent physician does not employ heparin in a patient who is having enough gastrointestinal bleeding to cause the hemoglobin to drop to this degree--that's number one--in any patient.

Number two is the data that was available to show that this patient had had an embolism was very weak. And I'll just make a side comment here, that although strokes under age 60 are most likely due to emboli from the heart, over age 70 most strokes are due to local atherosclerosis. Local atherosclerosis leading to a stroke does not benefit from the use of heparin.

Q. Now, in giving your opinion you spoke of a reasonably competent physician, and let me ask you, do you have an opinion to a reasonable degree of professional certainty whether or not the administration of heparin to this particular patient fell below the minimum standards of competence accepted in the profession?

A. Yes. Okay. I--it is my opinion, it is my professional opinion that this fell below the minimum standards of professional competence."
(Transcript, 2/26/92, pp. 683-684)

"Q. What unacceptable risks flowed form Dr. Gimenez' conduct which you have described as falling below the minimum standards of competence in this case?

A. That the patient's gastrointestinal bleeding would be aggravated by the use of heparin."
(Transcript, 2/26/92, p. 698)

"Q. And what are the absolute contraindications to anticoagulation?

A. Active bleeding.

Q. Where?

A. Gastrointestinal tract, the brain, the retroperitoneal area.

Q. Just so I'm sure what you're saying, Doctor, are they relative or absolute?

A. In my opinion, it's an absolute contraindication, in this type of situation."
(Transcript, 2/26/92, p. 709)

"Q. Is that a mistake not commonly but done by other physicians that you're aware of?

A. As a matter of fact, one of my interns recently was going to do something similar to that and I ordered them not to give the heparin. I think that's a basic premise that--its a medical school-type of thing, that they should teach you in medical school. You don't give heparin to patients who are actively bleeding."
(Transcript, 2/26/92, p. 720)

The board believes that its Findings of Fact, as modified, satisfactorily fulfill the criteria and fully incorporate the factual elements determined by the Court of Appeals in its decision in this matter

to be required by *Gilbert*, supra. The board also considers its Findings of Fact and Conclusions of Law to fully support the discipline previously ordered, and reinstates its previous disciplinary order effective on the date hereof.

Dated this 23 day of April, 1997.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by Glenn Hoberg M.
Glenn Hoberg, D.O.
Secretary

WRA 9703193.doc

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
BEFORE THE MEDICAL EXAMINING BOARD

In the Matter of the Disciplinary Proceedings Against

Alonzo R. Gimenez, M.D.,

Respondent.

AFFIDAVIT OF MAILING

STATE OF WISCONSIN)
)
COUNTY OF DANE)

I, Kate Rotenberg, having been duly sworn on oath, state the following to be true and correct based on my personal knowledge:

1. I am employed by the Wisconsin Department of Regulation and Licensing.

2. On April 25, 1997, I served the Modified Final Decision and Order dated April 23, 1997, LS9103071MED, upon the Respondent Alonzo R. Gimenez' attorney by enclosing a true and accurate copy of the above-described document in an envelope properly stamped and addressed to the above-named Respondent's attorney and placing the envelope in the State of Wisconsin mail system to be mailed by the United States Post Office by certified mail. The certified mail receipt number on the envelope is P 201 374 186.

Milton Spoehr, Attorney
118 N. Pearl Street
Berlin WI 54923-0191

Kate Rotenberg
Kate Rotenberg
Department of Regulation and Licensing
Office of Legal Counsel

Subscribed and sworn to before me
this 25th day of April, 1997.

Notary Public, State of Wisconsin
My commission is permanent.

NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review. The Times Allowed For Each. And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN MEDICAL EXAMINING BOARD
1400 East Washington Avenue
P.O. Box 8935
Madison. WI 53708.

The Date of Mailing this Decision is:

April 25, 1997

1. 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 sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

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

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision 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.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)