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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

GUILLERMO VARONA, JR., M.D., LS8903202MED

Respondent

FINAL DECISION AND ORDER

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

Guillermo Varona, Jr., M.D.
N112 W14880 Mequon Road
Germantown, WI 53022

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

Department of Regulation & Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
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The rights of a party aggrieved by this decision to petition the board for rehearing and to petition for for judicial review are set forth in the attached "Notice of Appeal Information."

A hearing was held in the above-captioned matter on April 10-12, 1990. Judith Mills Ohm, Attorney at Law, appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Guillermo Varona, Jr., M.D., appeared in person and by his attorney, Peter J. Heflin, Hausmann-McNally, S.C.

Ruby Jefferson-Moore, the administrative law judge in the matter, filed her Proposed

Decision in the matter on March 19, 1991. Ms. Ohm filed Complainant's Objections to the Proposed Decision on March 29, 1991, and the parties appeared before the board on April 19, 1991, for oral arguments on the Objections. The board considered the matter on that date.

Prior to the board's issuing a final decision in the matter, Ms. Ohm filed her *Motion for Reconsideration of Proposed Decision* dated May 3, 1991. The basis for the Motion was that Dr. Michael P. Mehr, who was the board advisor to the Division of Enforcement on the case, participated in the board's deliberation of the matter on April 19, 1991. The Motion requests in part that the board "reconsider the Proposed Decision, in conjunction with with Complainant's Objections to the Proposed Decision, Complainant's Brief in Support of Objections and Respondent's Response to Complainant's Objections and Brief, with Dr. Mehr abstaining from participation in the Board's deliberations and adjudication." Ms. Ohm and Mr. Heflin appeared before the board on May 22, 1991, to speak to Ms. Mills Motion. The board thereafter granted the Motion and reconsidered the matter on that same date.

Based upon the entire record herein, the Medical Examining Board adopts as its final decision in the matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Guillermo Varona, Jr., M.D., N112 W14880 Mequon Road, Germantown, WI, is a physician duly licensed and currently registered to practice medicine and surgery in the State of Wisconsin, pursuant to license #20708, which was granted on April 7, 1977. Dr. Varona specializes in family practice.

2. At least from August, 1982 to June, 1985, respondent provided medical care and treatment to Patient A, during which time the patient presented to respondent's office for medical care usually every 10-14 days.

3. Patient A first presented at respondent's office on August 27, 1982 complaining of severe pain, low back, secondary to cancer of the prostate.

4. Patient A was diagnosed as having carcinoma of the prostate in 1975, at St. Luke's Hospital, Milwaukee, WI., and carcinoma, as well as drug addiction, in 1977, at Columbia Hospital, Milwaukee, WI. Respondent obtained Patient A's hospital records from St. Luke's and Columbia Hospital in 1989.

5. Respondent's working diagnosis of spinal metastasis was not confirmed.

6. On August 27, 1982, respondent obtained a medical history verbally from Patient A. The medical history obtained by the respondent was not an adequate medical history of Patient A.

7. On August 27, 1982, respondent conducted a physical examination of Patient A. The physical evaluation conducted by the respondent was not an adequate physical evaluation of Patient A.

8. Respondent failed to evaluate Patient A's complaints relating to urinary problems, bowel incontinence and the patient's complaints relating to weakness, falling, fatigue, loss of balance and vomiting.

9. Respondent attempted to obtain routine chest x-rays for Patient A in response to the thoracic spine films taken for the patient on April 2, 1985.

10. Respondent failed to maintain adequate medical records for Patient A.

11. Patient A was uncooperative in that he did not assist respondent in obtaining his past medical records, diagnostic tests recommended by the respondent, or treatment measures recommended by the respondent.

12. At least from September 7, 1982 to May 20, 1985, respondent prescribed for Patient A, at each office visit, Dilaudid, 4 mg. #60, every four hours for pain. Dilaudid, a narcotic analgesic, is a Schedule II controlled substance as defined in Ch. 161 Wis. Stats.

13. Respondent's conduct in prescribing Dilaudid to Patient A was not in the course of legitimate professional practice.

14. Respondent provided medical care and treatment to Patient B at least from August, 1982 to June, 1985, during which time the patient presented at respondent's office for medical care usually every 10-14 days.

15. Patient B first presented at respondent's office on August 24, 1982 complaining of severe pain, lower back area.

16. Respondent failed to obtain an adequate history and failed to conduct an adequate physical examination of Patient B on August 24, 1982.

17. Respondent failed to evaluate laboratory data obtained for Patient B, in March, 1984, relating to findings of anemia.

18. Respondent failed to evaluate laboratory data obtained for Patient B, in March, 1984, relating to findings of hypothyroidism.

19. Patient B was uncooperative in that she did not assist respondent in obtaining her past medical records, diagnostic tests recommended by the respondent, or treatment measures recommended by the respondent.

20. Respondent prescribed Dilaudid, 4 mg. #20 to Patient B on August 24, 1982, and prescribed Dilaudid, 4 mg. #60 to Patient B, at each office visit, at least from September 16, 1982 to May 20, 1985. Dilaudid, a narcotic analgesic, is a Schedule II controlled substance as defined in Ch. 161 Stats.

21. Respondent's conduct in prescribing Dilaudid to Patient B was not in the course of legitimate professional practice.

CONCLUSIONS OF LAW

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

2. Respondent's conduct in providing medical care and treatment to Patients A and B fell below the minimum standards of practice established in the medical profession and exposed the patients to risks to which a minimally competent physician would not expose a patient.

3. Respondent's conduct constituted practice and conduct which tends to constitute a danger to the health, welfare and safety of the patients and constituted unprofessional conduct within the meaning of Wis. Stats. sec. 448.02(3) and Wis. Adm. Code sec. Med 10.02(2)(h).

4. Respondent's conduct in the prescribing of controlled substances to Patients A and B was not within the course of legitimate professional practice and constituted unprofessional conduct within the meaning of Wis. Stats. sec. 448.02(3) and Wis. Adm. Code sec. Med 10.02(2)(p).

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Guillermo Varona, M.D., to practice medicine and surgery in Wisconsin be, and hereby is, suspended for an indefinite period.

IT IS FURTHER ORDERED that suspension of respondent's license shall be stayed until October 1, 1991.

IT IS FURTHER ORDERED that at any time during the period of suspension, respondent may apply for a temporary educational permit. Such application shall be granted upon a showing by respondent that he has been accepted into an approved family practice residency program.

IT IS FURTHER ORDERED that following successful completion of one year of the approved family practice residency program, respondent may petition for termination of the suspension, and such petition shall be granted upon compliance with the following additional requirements:

(a) Respondent shall sit for and successfully complete the Special Purpose Examination of the Federation of State Medical Boards (SPEX Examination).

(b) Respondent shall sit for and successfully complete an oral examination administered by the full board.

(c) Respondent's license shall be restored with whatever conditions and limitations on respondent's practice that the board deems appropriate.

EXPLANATION OF VARIANCE

The Medical Examining Board has not accepted the Proposed Decision of the administrative law judge recommending dismissal of the charges against Dr. Varona, and instead finds that respondent's treatment of patients A and B fell below minimum standards of practice established in the medical profession, and that his conduct tended to constitute a danger to the health welfare and safety of those patients. The board also finds that Dr. Varona's conduct in his prescribing of controlled substances to these two patients was not within the course of legitimate professional practice.

The board has reached its decision based upon a careful evaluation of the testimony of the four expert witnesses called in the matter, as well as on the testimony of Dr. Varona. In making that evaluation, the board conferred with the administrative law judge to determine the nature of her conclusions relating to the credibility of the witnesses, with particular emphasis on determining to what extent, if any, she relied on the demeanor of the various witnesses in reaching whatever conclusions she did as to their credibility. Asked in this regard about the expert witnesses, Ms. Jefferson-Moore cited a number factors which might bear on their credibility, including that for some period of time, Dr. Varona was a patient of Dr. Herman, that Dr. Riesch has been a defendant in a number of malpractice lawsuits, and that Dr. Varona has in the past

referred patients to Dr. Merry. The judge indicated that she did not consider these to be significant factors and that she weighed the testimony of these three experts independent of these extraneous credibility factors. The board agrees, and therefore has also not considered these factors in its evaluation of the expert testimony in this record. As to the demeanor of the expert witnesses, the judge indicated that witness demeanor was not a factor bearing on her conclusions as to credibility of the expert witnesses, and demeanor of the expert witnesses is therefore not a factor considered by the board in its evaluation of their testimony.

As to Dr. Varona, the administrative law judge indicated that respondent's recollection of specific details of events occurring remote in time raised questions whether his testimony might be considered to be self-serving, but that none of respondent's testimony was inherently incredible and was therefore accepted. The judge also indicated that Dr. Varona's demeanor was "mild mannered" and that he testified in a manner which would tend to elicit sympathy. Nonetheless, Ms. Jefferson-Moore stated that Dr. Varona's demeanor was not a "significant factor" in her conclusions regarding the respondent's credibility. Based on the judge's overall evaluation of Dr. Varona's credibility, including her apparently favorable impression of his demeanor while testifying, the board accepts Dr. Varona's testimony except in certain instances where that testimony is contradicted by other credible evidence in the record.

Inadequate Medical Histories and Physical Examinations

Respondent treated Patient A from August 1982 until at least June, 1985. Patient A initially presented with complaints of severe lower back pain, secondary to cancer of the prostate. Based on the patient's medical history as reported by the him, respondent arrived at a working diagnosis of cancer of the prostate with metastasis. A pathology report from St. Lukes Hospital, Milwaukee, Wisconsin dated January 30, 1975, diagnosed Patient A as "Prostate showing well differentiated adenocarcinoma." A pathology report and nuclear medicine report from the same hospital dated the next day concluded "There is some slight irregular increase in concentration evident in the mid and lower lumbar spine which may be consistent with metastatic disease . . . . Repeat scan at a later date for comparison is recommended." After a hospitalization at Columbia Hospital in July, 1977, the final diagnosis as set forth on the discharge summary was carcinoma of the prostate and drug addiction. The discharge summary notes "Bone scans showed no definite evidence of bony metastases," and that acid phosphatese was done twice and "was only .1 and .1." Dr. Varona never received a copy of the Columbia Hospital records during the time that he treated patient A, relying instead on his initial working diagnosis, and did not finally receive copies of

Patient A's previous medical records until May, 1989, after the Complaint in this matter was filed.

Dr. Varona testified that he had sought without success to secure releases from Patient A during the period of treatment to obtain his prior medical records. But such lack of success does not excuse respondent's continued reliance on his working diagnosis, for he failed to adequately perform any of the other appropriate diagnostic procedures, including obtaining an adequate history, conducting an adequate physical examination, and accomplishing appropriate ancillary testing, such as a bone scan, bony x-rays or acid phosphatase, which would have permitted him to have confirmed or amended the working diagnosis.

Dr. George Pagels, complainant's expert, credibly testified that a minimally competent history would have included eliciting detailed information about the patient's chief complaint, and development of information regarding the patient's previous TURP's, medications the patient was on, allergies the patient had, patient's use of substances, including tobacco, alcohol and other drugs, a review of the patient's physical systems, and detailed information relating to the patient's previous diagnosis of prostate cancer. Dr. Varona's notes of the patient's history record only the patient's chief complaint and the patient's oral report of his past medical history, and Dr. Pagels concluded that respondent's failure to obtain a minimally competent medical history created unacceptable risks for Patient A. (T., pp. 212-14).

Two of respondent's experts addressed the adequateness of the medical history obtained. Dr. Steven Merry concurred with Dr. Pagels' evaluation of what would comprise a minimally competent medical history, and admitted that Dr. Varona's records for Patient A do not reflect anything other than the chief complaint and previous medical history. In testifying that it is "acceptable not to record everything told by a patient," it may be inferred that Dr. Merry simply assumed that Dr. Varona had done a minimally competent history (T., pp. 393-94, 412, 439). Similarly, Dr. John Riesch also conceded that Dr. Varona's notes do not reflect a minimally competent history, but that he suspected that it was done "because it's just a matter of course and policy." (T., pp. 633, 638, 669).

Dr. Varona testified that he would usually sit down with a new elderly patient and spend 30 minutes to an hour getting the patient's history, including eliciting the chief complaint, other present illnesses, previous illnesses and operations, present medications, allergies, habits and use of chemicals. As it applies to this patient, that testimony is discounted for a number of reasons. First, the testimony was essentially respondent's attorney's rather than his own:

Q. When you talk to [new patients] about their history, do you elicit from them their chief complaint?

A. Yeah, that's the first thing I ask: what are you here for? That's a chief complaint.

Q. Do you talk to them about any present illnesses they may have?

A. Yeah, then you discuss how long have you had this and what are the attending -- what brings on the pain, how -- is the pain constant, does it get better, and what have you been taking medication for this and this, to relieve the pain.

Q. Do you talk about their past medical history at all?

A. Yes sir.

Q. And what would that --

A. And then you go down, have you had any operations, have you ever been treated for any other illness.

Q. You talk about their -- the medications they're on you indicated.

A. That's part of the history-taking, yes, sir.

Q. Do you talk about any allergies they may have?

A. Yes, sir, you have to find out if they have any allergies to foods or to med -- to any kind of medication like penicillin.

Q. Do you talk about habits, use of narcotics?

A. Yes, sir. Do you smoke cigarettes; do you drink liquor; you -- have you ever been on drugs before, and how long have you been on these drugs. (T., pp. 116-17).

Second, respondent's testimony at hearing was considerably different from his deposition testimony on this subject:

Q. Do you recall being asked this question and giving that -- this answer at that time, on [deposition] page 6?

Question: "Do you know how extensive of a medical history you obtained from Patient A on August 27, 1982?"

Answer: "Yes, when I remember [Patient A], we had a long talk about his condition. I don't know how much time but we had -- being the first time I saw him, I'd really have to go back to my other -- my chart I bring with me."

Reporter: "I'm sorry, back to the chart?"

Answer: "I should really go back to my own chart but I don't have it now, but it's my practice that I spend about 15 to 20 minutes at a time with the patient talking about their problems, but my habit of writing is very cursory, it's very poor. I admit that."

Finally, compare Dr. Varona's hearing testimony as to the scope of the history taken with his August 27, 1982, office notes for patient A:

Wt. 158# B/P 160/180
Severe pain, low back, secondary to Ca of the Prostate. Had 4 TURP's in the past. EENT: neg. Heart and Lungs: clear. Abdomen: negative. Lost 110#.

The board accepts the expert testimony in the record as to what constitutes a minimally competent history, and concludes that respondent's notes of the initial visit by patient A, along with other evidence in the record, clearly establish that such a minimally competent history was not elicited.

Similarly, this record clearly establishes that respondent failed to obtain an adequate history from patient B (Patient A's wife) on August 24, 1982. It is undisputed that he failed to obtain Patient B's medical records during the period of treatment from August, 1982, through June, 1985, and the evidence is clear and convincing that he failed to otherwise elicit a minimally competent medical history, depending instead on her oral statement that she had undergone two laminectomies for spinal traumatic injuries and had a left artificial hip. The notes of patient B's first office visit are as follows:

(Wgt. 109) B/P 140/80 Severe pain, lower back area - 2 laminectomies for spinal traumatic injuries. Ambulatory with difficulty. Using a walker. Has left artificial hip also due to injury. Pale - EENT - okay. Heart and lungs clear. Abdomen - negative. Dilaudid 4 mg #20 Sig: One tablet every six hours.

Dr. Pagels testified that there is no evidence in any of respondent's notes indicating that he ever elicited a minimally competent history, and respondent's experts conceded that those records would not support a conclusion that he did. Dr. Varona testified that in addition to what was recorded in his notes, he got additional information from Patient B to the effect that "she had been on medication for a long time since the operation, and that she's always had severe pain. And she feels weak. And had poor balance." (T., pp. 78-9). But even assuming that this additional information was received, minimum requirements for an adequate history were far from satisfied.

Dr. Pagels testified that given Patient A's chief complaint, a minimally competent examination would have included an examination of the patient's back and prostate, including examination of the lower extremities to assess strength, reflexes, sensory loss, aggravation of the pain, and extension and flexion of the lower extremities. Dr. Pagels' testimony was that respondent failed to perform such a minimally competent examination:

> Q. Your second criticism is that Dr. Varona failed to do an adequate physical examination. If we focus just on the first office visit, do you have an opinion on whether his physical examination of [Patient A] was adequate under minimum standards of care?
>
> A. It was under minimum standards of care.
>
> Q. What's the basis for that opinion?
>
> A. Because the examination does not address the patient's back or his prostate. It looks at a variety of areas but it does not address the specific areas of complaint. (T., pp. 211-12)

Both Drs. Merry and Herman testified in effect that while respondent's records do not reflect that he performed an examination of the back or prostate, it was assumed that such an examination was performed. Based on Dr. Varona's testimony, their assumption is misplaced, for that testimony fails to reflect that such an examination was undertaken.

> Q. Your office record indicates that you examined his eyes, ears, nose and throat, heart and lungs and abdomen, is that right?
>
> A. Yes, ma'am.

Q. Was that the extent of your physical examination of [Patient A] at the first office visit?

A. According to the record, yes. But my vivid recollection when I talked to [Patient A] after doing a -- eliciting a history and physical from him, besides doing all that, I also noticed he had -- his pants were wet in front of him. And I did a rectal examination on this patient also. I didn't put it down here. (T., pp. 20-21)

Based on the expert testimony, and upon failure of respondent's records to reflect an examination related to Patient A's principal complaint while at the same time reflecting the results of respondent's routine examination of EENT, heart and lungs, and abdomen, the board finds clear and convincing evidence that respondent failed to perform a minimally competent examination of Patient A at the initial office visit or at any visit thereafter.

The board also finds clear and convincing evidence that Dr. Varona failed to do a minimally competent physical examination of Patient B. Dr. Pagels testified that in response to this patient's principal complaint of severe pain in the lower back, a minimally competent examination would include a visual examination of the patient's back, determination of the range of motion in the back, palpation of the back for muscle spasm, straight leg raising testing, and a neurologic examination of the lower extremities and back, testing reflexes, strengths and weaknesses, and sensory perception. The board accepts Dr. Pagels' testimony and notes that neither Dr. Varona's records nor his testimony reflect that such a minimally competent examination was ever performed. Rather, respondent's testimony as to the examination performed of Patient B's back at the first and subsequent office visits is typified by the following:

Q. How did you know that [Patient B] had undergone two laminectomies?

A. Again, her history, the information given to me by their friend, the pharmacist. Then I'd look at her back. There were scars, and there was scar tissue from -- there were scars from operations usually indicative of laminectomy or spinal operation, and there were -- she was -- markedly tender on the back. Could hardly touch the back. (T., p. 77).

Again, respondent's experts testified that though the respondent's records fail to indicate an appropriate examination of Patient B's back, it was their assumption that a proper examination was conducted. Those assumptions are not borne out by the other evidence in this record.

Failure to Evaluate Subsequent Signs and Complaints

Respondent's records on Patient A reflect that at the first office visit, it was observed that the patient had a problem controlling his urination. On August 9, 1983, respondent documented that Patient A was "becoming more incontinent of urine with foul smelling urine." On August 25, 1983, respondent documented that the patient was "becoming incontinent of urine and bowel functions." Patient A continued to complain of incontinence and bloody urine through June, 1985, including a complaint on November 19, 1984, that he was "urinating constantly." The board accepts the testimony of Dr. Pagels as to what the minimally acceptable medical response to these complaints would have been:

> . . . [W]e have a patient that's complaining of foul-smelling urine, incontinence of urine, who is shaking. And all of these symptoms could in fact point to urosepsis, meaning infection of the [urinary tract] with blood poisoning . . . . A minimally competent physician would have done a temperature. He should have included a pulse rate. He should have included an examination of the flanks to see whether the patient had pyelonephritis, and he should have done a urinalysis and also a urine culture. The urine culture, one might make an argument, was superfluous, but at least the urinalysis would be necessary. . . . The – my major conclusion is that those should have been evaluated to look for correctable causes for those complaints and symptoms. And they were not. So that I feel that this was below minimal acceptable standard of care."

The testimony of respondent's experts is unpersuasive on this issue. Dr. Merry's testimony on the subject is typical:

> Q. Is there anything in Dr. Varona's office record to indicate that he addressed [Patient A's] complaints of urinary incontinence?
>
> A. No.
>
> Q. Is there any evidence in Dr. Varona's office record that he did a urinalysis on [Patient A]?
>
> A. No.
>
> Q. Is there any evidence in Dr. Varona's office record that he did a dipstick test on [Patient A]?
>
> A. Not in the office record, no.

Q. Wouldn't you agree that with a patient who presents with the problems that [Patient A] had with urinary incontinence and associated problems such as painful urination and bloody urination, that, as a minimum, a doctor would have to do a urinalysis?

A. Yes.

Q. Did Dr. Varona do that?

A. He stated in his deposition that he did a dipstick examination of the urine.

Q. Is a dipstick test accurate for determining whether the patient has a urinary infection

A. The hospital routinely does dipsticks. If they are negative, they do not do further evaluations of the urine. So the answer is yes.

Q. Are they as accurate as a urinalysis test?

A. Well, the hospital accepts them as being accurate, so I would have to answer yes.

Q. Would you agree that it's not possible to determine from the office record whether [Patient A] had a urinary tract infection?

A. Yes. (T., pp. 484-86).

Dr. Riesch's testimony was essentially that respondent acted appropriately in responding to the incontinence problem in doing a dipstick test, and that the fact that respondent's records do not indicate that such a test was performed may be attributed to the fact that the results were negative and that negative results are often not recorded. (T., pp. 640-42) While Dr. Riesch's testimony may be somewhat speculative, Dr. Herman's was not. It was also not favorable to respondent's position. In response to questions regarding Patient A's painful urination, Dr. Herman, at his deposition, first testified that an individual who had several prostatic resections might be expected to be incontinent under any circumstances. When asked as to the significance of painful urination, Dr. Herman stated that the symptom would indicate a possible bladder infection. His further testimony was that there is no indication in the office records that Dr. Varona did anything in response to the symptom, and that it would be appropriate for a minimally competent physician to have done a urinalysis. (T., pp. 374-76)

Dr. Varona's testimony was that he had attempted to refer Patient A to a urologist for the problem, and his records do reflect that such a suggestion was made. But whether it was or not, respondent continued to treat this patient without regard to these ongoing symptoms and without performing or providing for the performance of the minimally competent examination set forth above; and Dr. Varona's conduct in this aspect of his practice clearly fell below minimum standards of the profession.

On May 13, 1983, Patient A complained of loss of balance, weakness and fatigue. On June 16, 1983, Patient A reported to Dr. Varona that he had fallen on the previous day. He also reported episodes of falling at office visits on January 17, 1984, March 6, 1984, and May 15, 1984. On November 8, 1983, respondent documented that Patient A was vomiting several times a day. The board finds that there is clear and convincing evidence that respondent failed to evaluate Patient A's complaints relating to these symptoms in having failed to conduct a minimally competent physical examination or to initiate any diagnostic testing to determine what was causing the patient's problems with falling, weakness, fatigue and vomiting.

Dr. Pagels testified that a minimally competent physician, in response to Patient A's complaints of falling, weakness, fatigue and vomiting, would have evaluated the nervous system, would have looked for vascular instability by checking the patient's blood pressure and pulse in the lying, sitting and standing positions, would have evaluated the patient for diabetes, anemia and endocrine problems, and would have checked for rectal bleeding. Dr. Pagels testified that there is no evidence that Dr. Varona did any of these things. (T., pp. 242-43).

The board accepts Dr. Pagels' testimony as to what constitutes a minimally competent response to Patient A's problems with falling, weakness, fatigue and vomiting and agrees that this record contains clear evidence that such a response was not made.

Dr. Varona testified that he wanted to initiate testing to determine the cause of the complaints, including blood testing to determine electrolyte patterns and hemoglobin, hematocrit status, but that he met with resistance from the patient. (T., pp. 59-65, 153-54). He further testified as follows:

> Q. (by Ms. Mills) Do you recall -- well, first, does your office record indicate whether you did anything on March 6, 1984 to assess the cause of his falling?
>
> A. I don't recall specifically what I did.
>
> Q. And your record doesn't indicate whether you did anything?

A. It does not indicate.

Q. Does your office record for March 15, 1984, also indicate that (Patient A) fell?

A. Yeah, he "fell about five days ago."

Q. Is that something your secretary noted in your record?

A. Yes, ma'am.

Q. And what did you notate in your record?

A. I said, "In pain. Demanding more pain medications."

Q. And then did you prescribe Dilaudid and Doriden to him?

A. Yes, Ma'am.

Q. Do you recall whether you did anything to assess the cause of his falling?

A. I must -- I must have done -- on all those falling spells that he had, I always ask, but I don't recall specifics.

Q. Did you ever consider whether the Dilaudid that you were prescribing to (Patient A) could be contributing to his problems with weakness, fatigue and falling?

A. Yes, ma'am, I considered that. That's why I would tell him to please space out the medication, try to space them farther away, because you might be taking too much of it. (T., pp. 62-63).

The testimony of neither Dr. Merry nor Dr. Riesch directly addresses the question of whether respondent properly evaluated Patient A's problems with weakness and falling. Dr. Merry testified that the use of Dilaudid may have contributed to the problems; Dr. Riesch testified that those problems could be caused by reasons other than Dilaudid related to metastatic illness. Dr. Herman testified that he did not consider Dr. Varona's response to these problems to fall below minimum standards of care in that he attempted to address the problems by suggesting that Patient B be hospitalized for evaluation, and by continuing to see him on a regular basis to continue to observe him. Dr. Herman's more compelling testimony in this area was contained in his deposition testimony introduced at hearing.

Q. Can you tell from the record what Dr. Varona did to address the problems the patient was having with falling?

A. I don't see that he addressed them by any change in treatment.

Q. In other words, he didn't vary the amount of Dilaudid he was giving him?

A. I don't see any indication that he did, no.

Q. Is that what a minimally competent physician should have done?

A. He should have.

Q. Is there some other treatment that would be appropriate for complaints of falling?

A. If the cause of his falling was entirely to the use of medications, a reduction in the amount of medication is appropriate. If it was due to some other intercurrent problem, then reduction in the medication is not likely to give you any improvement and the search for that cause is appropriate.

Q. How do you find out what is causing the patient to fall?

A. If you think the individual is truly ataxic or can't control himself, then examination of his ears and his balance mechanisms in the office is appropriate.

Q. Is there any evidence that Dr. Varona did that?

A. I don't see any. (T., pp. 372-74).

The testimony of both Dr. Varona and of his expert witnesses thus either supports the conclusion that Dr. Varona's conduct in this area fell below the minimum standards of the profession, or does not address that issue.

Dr. Varona documented that Patient B appeared pale at her first office visit on August 24, 1982, and continued to document that she was pale and weak throughout his treatment of this patient. Notwithstanding these ongoing symptoms, respondent failed

as late as March, 1984, to order laboratory tests which would have confirmed an anemic condition. On March 24, 1984, Patient B was seen by Dr. John Kraft at Dr. Varona's office. Dr. Kraft's note regarding his treatment of Patient B appears in respondent's office record, where it is noted: "i.) Chronic myalgia; ii.) Chronic low back syndrome; iii.) Pallor - cause?" Dr. Kraft ordered a complete blood count, chem screen, folic acid level and B-12 level. On March 28, 1984, Patient B underwent the laboratory tests ordered by Dr. Kraft. The laboratory report, dated March 31, 1984, was sent to Dr. Varona's clinic and was at some point placed in his office record for Patient B. The values established by the laboratory testing indicate that Patient B suffered from anemia and hypothyroidism. In response to the indication of anemia, respondent on April 6, 1984, prescribed Feosol, an iron supplement, notwithstanding the fact that the laboratory report established that Patient B's iron level was within normal limits, and that the underlying cause of her anemia was unknown.

Dr. Pagels testified that because the laboratory tests indicated that thyroid function was clearly abnormal and clearly low, the anemia could in fact be related to hypothyroidism, but that there was insufficient data to confirm that. Dr. Pagels was asked what a minimally competent physician would be required to do given that data. He responded "I believe a minimally competent physician in this case would have two choices. One, he could elect to further evaluate this anemia himself or he might ask a hematologist to look at this patient, because this is really sort of an unusual anemia." Dr. Pagels testified that respondent's failure to undertake either of these two alternatives constituted conduct falling below the minimum standards of the profession; and that this would be true regardless of whether or not respondent was aware of the laboratory report in light of the patient's ongoing symptomatology. (T., pp. 267, 269-70, 279, 344-45)

Dr. Merry testified that a minimally competent physician would have reviewed the March 28, 1984, office note prepared by Dr. Kraft and that if Dr. Varona had seen the lab test results indicating that the patient had hypothyroidism, it would have been below minimum standards of care not to have taken responsive action. (T., pp.507-515). Dr. Riesch's testimony was in effect that if Dr. Varona had seen the report, it would have been below minimum standards for him to have failed to treat Patient B for hypothyroidism; but that respondent could not have seen the report, because Dr. Riesch was sure that if he had, respondent would have treated the patient for hypothyroidism. (T., pp. 621-22).

The board finds clear and convincing evidence that respondent failed to obtain necessary laboratory data to properly diagnose and treat Patient B's hypothyroidism,

and failed to evaluate available laboratory data indicating hypothyroidism. Those failures constitute conduct falling below the minimum standards of the profession.

Inadequate Records

Every expert witness who testified on the subject indicated that respondent's medical records for both patients were difficult to interpret because they were both very brief and practically illegible. Dr. Pagels testified that those records in his opinion fell below minimum standards of competence because he failed to record pertinent positive and negative findings (T., p. 251). Dr. Merry testified to his hope that Dr. Varona's records did not record the entire content of the office visits, and conceded that it is customary for doctors to document positive findings from a physical examination, though not unusual to fail to record negative findings. Dr. Riesch opined that respondent's record keeping was competent for a "family practitioner in a solo practice in a solo office without the availability of dictating machines, etcetera." (T., pp. 438-39). Dr. Varona conceded the problem with his record keeping. Asked why he had failed to document that he had done a rectal examination on Patient A, Dr. Varona responded,

> I have no reason, I'm just so remiss in my record keeping. It's one of my problems in my practice. Especially if you see about three or 40 -- 30 or 40 patients a day. You plan to go back and write more things, and sometimes you don't have time, and then your secretary puts your records away before you can complete them and then you forget to complete them later on. It's always been a problem that I've been facing in my practice. (T., pp. 24-25)

Dr. Varona puts his finger on the very problem described by Dr. Pagels when he testified,

> . . . [T]he record in fact becomes an integral part of care of the patient. And without the pertinent positives and negatives recorded, I don't believe that a physician has a good enough memory, given many physicians seeing 20 or 30 patients a day, to remember all the pertinent positives/negatives on an individual patient without recording those in the records. (T., pp. 250-51)

The board concludes that there is clear and convincing evidence that Dr. Varona's records of his treatment of these two patients are not minimally competent.

Prescribing of Controlled Substances

Beginning with Patient A's second office visit on September 7, 1982, Dr. Varona prescribed 60 units of Dilaudid for pain, and he renewed that prescription on an average of approximately every 10 days until May 16, 1985, when he refused further prescriptions in response to the investigation leading to these proceedings. Beginning with patient B's first office visit on August 24, 1982, Dr. Varona prescribed 20 units of Dilaudid 4 mg. for pain. By September 16, 1982, Dr. Varona had increased the prescription to 60 units, and that prescription was renewed every 10 to 14 days until May 20, 1985, when further prescriptions were denied, also in response to these proceedings. It is undisputed that Dilaudid, a brand of hydromorphone hydrochloride, is a strong narcotic drug with high potential for abuse, classified under Wis. Stats. ch. 161 as a Schedule II controlled substance.

In defense of his prescribing Dilaudid on a regular basis to Patient A, respondent cited his working diagnosis of prostate cancer with metastasis to the spine, and his opinion that there was no available treatment for patient A. In 1982, respondent felt that Patient A was terminally ill with from six months to a year to live, and that his purpose in prescribing Dilaudid was to make him more comfortable in the time he had left. (T., pp. 45-46). He testified that at the time he initially saw Patient A, he knew the patient was addicted, but cited the difficulty and danger in the withdrawal process.

Dr. Merry testified in part as follows:

> Q. (by Mr. Heflin) Do you feel that Dr. Varona's prescribing of Dilaudid to [Patient A] was during the -- or comported to the minimum standards of care, given the history and physical examination done on [Patient A]?
>
> A. Yes. There's evidence that [Patient A] did have metastatic -- did have cancer of the prostate. There is evidence that he was previously on Dilaudid, and Dr. Varona compassionately continued the Dilaudid. Unfortunately, the patient was resistant to further evaluation and possible alternative treatment.
>
> * * * *
>
> Q. Do you think the fact that Dr. Varona prescribed this Dilaudid for almost three years -- strike that. Let me ask this. Would it have been dangerous for Dr. Varona to simply stop prescribing Dilaudid for these individuals?

A. It may have been dangerous. It may have resulted in severe withdrawal symptoms, which might have included seizures, which might have included myocardial arrhythmias, which might have included death. (T. pp. 409-11).

De. Riesch's defense of respondent's actions in prescribing Dilaudid for Patient A was similar.

Q. (by Mr. Heflin) Do you think prescribing Dilaudid for this patient was above the minimum standards of care?

A. I think the patience in caring for this patient was superlative, his patience in caring for him, and the frustration he must have experienced. I think the usage of drugs in this man was appropriate with the belief that he apparently believed. I think it's unfortunate that, in all likelihood, from what I've heard today, this man was probably already addicted to the drug, and Dr. Varona was caught between the two of them in a compassionate situation and was caught up into the web and the whirlpool that just sucked him under and brought him to this setting today.

Q. If a person's addicted on a drug, is it necessarily required of a doctor to take measures to cause him not to be addicted or to wean him off that drug?

A. Not if it's being prescribed for a terminal situation or a situation that is intractable. (T., pp. 647-48).

Dr. Herman testified merely that he felt it appropriate for Dr. Varona to prescribe Dilaudid for Patient A so long as he believed that the patient was having pain. (T., p. 573).

Much more compelling than the somewhat apologetic testimony of respondent's experts was the analysis provided by Dr. Pagels. That testimony is well summarized in the administrative law judge's Proposed Decision as follows:

Dr. Pagels testified that Dr. Varona's prescribing of controlled substances to Patient A was below minimal standards because Dr. Varona gave the narcotics before adequately evaluating the patient to determine that the patient needed that narcotic.

Dr. Pagels testified that beginning with Patient A's second office visit on September 7, 1982, Dr. Varona initiated the use of Dilaudid, 4

milligrams every four hours, for pain. Dr. Pagels stated that given how Dr. Varona reached the diagnosis that he reached in this case it was inappropriate for Dr. Varona to initiate treatment with Dilaudid. Dr. Pagels further stated that a minimally competent physician may be justified in prescribing narcotics to a patient who is in severe pain before confirming the underlying diagnosis of prostate cancer with metastatic disease until he had been able to make a diagnosis. Dr. Pagels stated that a minimally competent physician should be able to confirm the diagnosis within the "next one to two visits". (Tran. p. 212-213, 218-219, 301).

Dr. Pagels testified, in reference to unacceptable risks, that by prescribing the drug Dr. Varona may have "masked other symptoms that would have helped to make the proper diagnosis. Second of all, by prescribing the drug, he may have been treating inappropriately. Third of all, the patient clearly was at risk for injury from side effects. And fourth, the patient seemed to be addicted to the drug". (Tran. pp. 252-254).

The testimony of Dr. Varona's experts to the effect that his prescribing of Dilaudid for Patient B was essentially the same as their testimony relating to patient A, and Dr. Pagels' testimony as to the problems in that prescribing practice was also essentially the same as his testimony relating to Patient A. The board agrees that Dr. Varona's conduct in prescribing this highly addicting substance to these two patients over a period of almost three years constitutes unprofessional conduct in that such conduct created an unacceptable risk that the Dilaudid would mask other significant symptoms of diseases or conditions which could be treated if diagnosed, created the unacceptable risk that these patients would not be treated appropriately, created the unacceptable risk that these patients would suffer injuries secondary to the use of Dilaudid, and created the unacceptable risk that these patients' addiction to Dilaudid would be perpetuated.

Discipline

Having found that Dr. Varona's practice fell below the minimum standards of practice established in the medical profession by exposing Patients A and B to risks to which a minimally competent physician would not have exposed them, that his practice and conduct constituted a danger to the health, welfare and safety of these patients, and that his prescribing practice in these instances constituted unprofessional conduct, the question becomes what discipline, if any, is appropriate.

It is well settled that the purposes of discipline include protection of the public, rehabilitation of the licensee, and deterrence of other licensees from engaging in similar

conduct. *State v. Aldrich,* 71 Wis. 2d 207. Punishment of the licensee is not an appropriate consideration. *State v. McIntyre,* 41 Wis. 2d 481.

The violations found here do not involve momentary lapses in judgment, conduct involving a single isolated incident, or incompetent practice involving but a single area of practice. Dr. Varona's treatment of the two patients involved in this case demonstrates repeated, long-term practice error and incompetency pervading practically every aspect of his practice. He failed to elicit a competent medical history from either patient and failed to supplement those histories with the patients' previous medical records. He failed to do a competent physical examination of either patient, but instead continued to treat each of them for almost three years based on a working diagnosis which in one case was demonstrably wrong. As each of the patients exhibited additional symptoms during the course of respondent's treatment of them, he in each instance failed to properly diagnose or treat those symptoms.

In the last analysis, Dr. Varona did little more in the course of treating these patients than treat their reported pain. Dr. Varona's witnesses continually stressed that in so doing, Dr. Varona was demonstrating his compassion in attempting to assist two elderly people to live out without pain what little time he thought they had left. The board does not question Dr. Varona's intentions, and does not assume that his actions were motivated by other than compassion. The problem is that his patients' problems were exacerbated rather than alleviated by his course of treatment. To say that Dr. Varona's inadequate and inappropriate medical treatment of these patients was motivated by his sympathy and compassion thus does nothing to address the responsibility and duty which the board has to protect the public health, safety and welfare from incompetent medical practice.

The board has struggled at length with the question of discipline at both the initial consideration of this matter and at the time of its reconsideration. While the board deems Dr. Varona's conduct to be of the most serious nature, in the end the board has decided that while revocation of the license in this case may be argued to be justified, such discipline does nothing to promote Dr. Varona's rehabilitation. Accordingly, the board has attempted to fashion discipline which will afford the necessary protection to the public and will deter others from similar conduct, while at the same time permitting Dr. Varona to maintain some form of licensure while undergoing professional remediation. Under the order, Dr. Varona's license is indefinitely suspended, but the suspension is stayed for a short period to permit Dr. Varona to arrange to be accepted into a family practice residency program. Upon such acceptance, the board will grant Dr. Varona's application for a temporary educational

permit and, upon completion of the program, the board will lift the suspension upon demonstration by Dr. Varona of his competency through successful completion of both the SPEX examination and of an oral examination before the board. If it thereafter appears that there remains some need to place limitations on Dr. Varona's practice, the board's order reserves its right to do so. While these limitations are extensive, they are reformative rather than penal and, in the opinion of the board, satisfactorily subserve the accepted disciplinary objectives.

Dated this 4 day of June, 1991.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by Michael P. Mehr MD
Michael P. Mehr, M.D.,
Secretary

WRA:BDLS2:300

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)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decision. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Medical Examining Board.

A petition for rehearing is not a prerequisite for appeal directly to circuit court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of Wisconsin Medical Examining Board

within 30 days of service of this decision if there has been no petition for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Medical Examining Board.

The date of mailing of this decision is June 13, 1991.

227.49 Petitions for rehearing in contested cases. (1) A petition for rehearing shall not be a prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025 (3) (e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

(2) The filing of a petition for rehearing shall not suspend or delay the effective date of the order, and the order shall take effect on the date fixed by the agency and shall continue in effect unless the petition is granted or until the order is superseded, modified, or set aside as provided by law.

(3) Rehearing will be granted only on the basis of:

(a) Some material error of law.

(b) Some material error of fact.

(c) The discovery of new evidence sufficiently strong to reverse or modify the order, and which could not have been previously discovered by due diligence.

(4) Copies of petitions for rehearing shall be served on all parties of record. Parties may file replies to the petition.

(5) The agency may order a rehearing or enter an order with reference to the petition without a hearing, and shall dispose of the petition within 30 days after it is filed. If the agency does not enter an order disposing of the petition within the 30-day period, the petition shall be deemed to have been denied as of the expiration of the 30-day period.

(6) Upon granting a rehearing, the agency shall set the matter for further proceedings as soon as practicable. Proceedings upon rehearing shall conform as nearly may be to the proceedings in an original hearing except as the agency may otherwise direct. If in the agency's judgment, after such rehearing it appears that the original decision, order or determination is in any respect unlawful or unreasonable, the agency may reverse, change, modify or suspend the same accordingly. Any decision, order or determination made after such rehearing reversing, changing, modifying or suspending the original determination shall have the same force and effect as an original decision, order or determination.

227.52 Judicial review; decisions reviewable. Administrative decisions which adversely affect the substantial interests of any person, whether by action or inaction, whether affirmative or negative in form, are subject to review as provided in this chapter, except for the decisions of the department of revenue other than decisions relating to alcohol beverage permits issued under ch. 125, decisions of the department of employe trust funds, the commissioner of banking, the commissioner of credit unions, the commissioner of savings and loan, the board of state canvassers and those decisions of the department of industry, labor and human relations which are subject to review, prior to any judicial review, by the labor and industry review commission, and except as otherwise provided by law.

227.53 Parties and proceedings for review. (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

(a) 1. Proceedings for review shall be instituted by serving a petition therefor personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. If the agency whose decision is sought to be reviewed is the tax appeals commission, the banking review board or the consumer credit review board, the credit union review board or the savings and loan review board, the petition shall be served upon both the agency whose decision is sought to be reviewed and the corresponding named respondent, as specified under par. (b) 1 to 4.

2. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency.

3. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59 (6) (b), 182.70 (6) and 182.71 (5) (g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified. The petition may be amended, by leave of court, though the time for serving the same has expired. The petition shall be entitled in the name of the person serving it as petitioner and the name of the agency whose decision is sought to be reviewed as respondent, except that in petitions for review of decisions of the following agencies, the latter agency specified shall be the named respondent:

1. The tax appeals commission, the department of revenue.

2. The banking review board or the consumer credit review board, the commissioner of banking.

3. The credit union review board, the commissioner of credit unions.

4. The savings and loan review board, the commissioner of savings and loan, except if the petitioner is the commissioner of savings and loan, the prevailing parties before the savings and loan review board shall be the named respondents.

(c) A copy of the petition shall be served personally or by certified mail or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon each party who appeared before the agency in the proceeding in which the decision sought to be reviewed was made or upon the party's attorney of record. A court may not dismiss the proceeding for review solely because of a failure to serve a copy of the petition upon a party or the party's attorney of record unless the petitioner fails to serve a person listed as a party for purposes of review in the agency's decision under s. 227.47 or the person's attorney of record.

(d) The agency (except in the case of the tax appeals commission and the banking review board, the consumer credit review board, the credit union review board, and the savings and loan review board) and all parties to the proceeding before it, shall have the right to participate in the proceedings for review. The court may permit other interested persons to intervene. Any person petitioning the court to intervene shall serve a copy of the petition on each party who appeared before the agency and any additional parties to the judicial review at least 5 days prior to the date set for hearing on the petition.

(2) Every person served with the petition for review as provided in this section and who desires to participate in the proceedings for review thereby instituted shall serve upon the petitioner, within 20 days after service of the petition upon such person, a notice of appearance clearly stating the person's position with reference to each material allegation in the petition and to the affirmance, vacation or modification of the order or decision under review. Such notice, other than by the named respondent, shall also be served on the named respondent and the attorney general, and shall be filed, together with proof of required service thereof, with the clerk of the reviewing court within 10 days after such service. Service of all subsequent papers or notices in such proceeding need be made only upon the petitioner and such other persons as have served and filed the notice as provided in this subsection or have been permitted to intervene in said proceeding, as parties thereto, by order of the reviewing court.

BEFORE THE STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	NOTICE OF FILING PROPOSED DECISION LS8903202MED
GUILLERMO VARONA, JR., M.D., RESPONDENT.	:	

TO: Peter J. Heflin
Attorney at Law
Hausmann-McNally, S.C.
633 West Wisconsin Ave.
Suite 2000
Milwaukee, WI 53203
Certified P 438 251 440

Judith Mills Ohm
Attorney at Law
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Medical Examining Board by the Administrative Law Judge, Ruby Jefferson-Moore. A copy of the Proposed Decision is attached hereto.

If you have objections to the Proposed Decision, you may file your objections in writing, briefly stating the reasons, authorities, and supporting arguments for each objection. Your objections and argument must be received at the office of the Medical Examining Board, Room 176, Department of Regulation and Licensing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before March 29, 1991. You must also provide a copy of your objections and argument to all other parties by the same date.

You may also file a written response to any objections to the Proposed Decision. Your response must be received at the office of the Medical Examining Board no later than seven (7) days after receipt of the objections. You must also provide a copy of your response to all other parties by the same date.

The attached Proposed Decision is the Administrative Law Judge's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision together, with any objections and arguments filed, the Medical Examining Board will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 19th day of March, 1991.

Ruby Jefferson-Moore
Ruby Jefferson-Moore
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
GUILLERMO VARONA, JR., M.D., RESPONDENT.	:	

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

Guillermo Varona, Jr., M.D.
N112 W14880 Mequon Road
Germantown, WI 53022

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

A hearing was held in the above-captioned matter on April 10-12, 1990. Judith Mills Ohm, Attorney at Law, appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Guillermo Varona, Jr., M.D., appeared in person and by his attorney, Peter J. Heflin, Hausmann-McNally, S.C.

Based upon the record herein, the 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. Guillermo Varona, Jr., M.D., N112 W14880 Mequon Road, Germantown, WI, is a physician duly licensed and currently registered to practice medicine and surgery in the State of Wisconsin, pursuant to license #20708, which was granted on April 7, 1977. Dr. Varona specializes in family practice.

2. At least from August, 1982 to June, 1985, respondent provided medical care and treatment to Patient A, during which time the patient presented to respondent's office for medical care usually every 10-14 days.

3. Patient A first presented at respondent's office on August 27, 1982 complaining of severe pain, low back, secondary to cancer of the prostate.

4. Patient A was diagnosed as having carcinoma of the prostate in 1975, at St. Luke's Hospital, Milwaukee, WI., and carcinoma, as well as drug addiction, in 1977, at Columbia Hospital, Milwaukee, WI. Respondent obtained Patient A's hospital records from St. Luke's and Columbia Hospital in 1989.

5. Respondent's working diagnosis of spinal metastasis was not confirmed.

6. On August 27, 1982, respondent obtained a medical history verbally from Patient A. The medical history obtained by the respondent was an adequate medical history of Patient A.

7. On August 27, 1982, respondent conducted a physical examination of Patient A. The physical evaluation conducted by the respondent was an adequate physical evaluation of Patient A.

8. Respondent did not fail to evaluate Patient A's complaints relating to urinary problems, bowel incontinence or the patient's complaints relating to weakness, falling, fatigue, loss or balance and vomiting.

9. Respondent attempted to obtain routine chest x-rays for Patient A in response to the thoracic spine films taken for the patient on April 2, 1985.

10. Respondent did not fail to maintain adequate medical records for Patient A.

11. Patient A was uncooperative in that he did not assist respondent in obtaining his past medical records, diagnostic tests recommended by the respondent, or treatment measures recommended by the respondent.

12. At least from September 7, 1982 to May 20, 1985, respondent prescribed, for Patient A at each office visit, Dilaudid, 4 mg. #60, every four hours for pain. Dilaudid, a narcotic analgesic, is a Schedule II controlled substance as defined in Ch. 161 Wis. Stats.

13. Respondent's conduct in prescribing Dilaudid to Patient A was in the course of legitimate professional practice.

14. Respondent provided medical care and treatment to Patient B at least from August, 1982 to June, 1985, during which time the patient presented at respondent's office for medical care usually every 10-14 days.

15. Patient B first presented at respondent's office on August 24, 1982 complaining of severe pain, lower back area.

16. Respondent obtained an adequate history and conducted an adequate physical examination of Patient B on August 24, 1982.

17. Respondent did not fail to evaluate laboratory data obtained for Patient B, in March, 1984, relating to findings of anemia.

18. Respondent did not fail to evaluate laboratory data obtained for Patient B, in March, 1984, relating to findings of hypothyroidism.

19. Patient B was uncooperative in that she did not assist respondent in obtaining her past medical records, diagnostic tests recommended by the respondent, or treatment measures recommended by the respondent.

20. Respondent prescribed Dilaudid, 4 mg. #20 to Patient B on August 24, 1982, and prescribed Dilaudid, 4 mg. #60 to Patient B, at each office visit, at least from September 16, 1982 to May 20, 1985. Dilaudid, a narcotic analgesic, is a Schedule II controlled substance as defined in Ch. 161 Stats.

21. Respondent's conduct in prescribing Dilaudid to Patient B was in the course of legitimate professional practice.

CONCLUSIONS OF LAW

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

2. Respondent's conduct in providing medical care and treatment to Patients A and B did not fall below the minimum standards of practice established in the medical profession or expose the patients to risks to which a minimally competent physician would not expose a patient.

3. Respondent's conduct was not practice and conduct which tends to constitute a danger to the health, welfare and safety of the patients and did not constitute unprofessional conduct within the meaning of s. 448.02 (3) Stats., or s. MED 10.02 (2)(p) Wis. Adm. Code.

4. Respondent's conduct in the prescribing of controlled substances to Patients A and B was within the course of legitimate professional practice and did not constitute unprofessional conduct within the meaning of s. 448.02 (3) Wis. Stats., or s. MED 10.02 (2)(p) Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that Counts I and II of the Complaint filed in this matter, be and hereby are, Dismissed.

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OPINION

I. GENERAL OVERVIEW

The evidence presented at the hearing consisted of numerous exhibits, the deposition testimony of Dr. LaVern H. Herman (offered by the complainant), and the testimony of five witnesses. Dr. Varona (adversely) and Dr. George A. Pagels testified at the request of the complainant. Drs. Steven L. Merry, LaVern H. Herman and John Riesch testified at the request of the respondent. Dr. Varona's original office notes for Patients A and B are contained in Exhibits #1 and #2. The typewritten versions of respondent's original office notes for Patients A and B are set forth in Exhibits #1A and #2A.

II. LEGAL ANALYSIS

The Complaint filed in this matter alleges the following in reference to Dr. Varona's treatment of Patient A and Patient B:

1. Respondent's conduct in providing medical care and treatment to Patient A and Patient B fell below the minimum standards of practice established in the profession and exposed Patient A and Patient B to risks to which a minimally competent physician would not expose a patient.

2. Respondent's conduct was practice and conduct which tends to constitute a danger to the health, welfare and safety of the patients and therefore constitutes unprofessional conduct within the meaning of s. 448.02 (3) Stats., and s. MED 10.02 (2)(h) Wis. Adm. Code.

3. Respondent's conduct in the prescribing of controlled substances to Patient A and Patient B, otherwise than in the course of legitimate professional practice, constituted unprofessional conduct within the meaning of s. 448.02 (3) Wis. Stats., and s. MED 10.02 (2)(p) Wis. Adm. Code.

PATIENT A

Dr. George Pagels testified that in his opinion, Dr. Varona's conduct in providing medical care to Patient A failed to meet minimum standards of care in the following respect:

1. failure to obtain a complete history, including outside records;

2. failure to do an adequate physical evaluation of the patient;

3. failure to evaluate subsequent signs and complaints;

4. failure to follow up on laboratory and other ancillary test results that were available;

5. failure to maintain adequate medical records, and

6. prescribing controlled substances otherwise than in the course of legitimate professional practice.

1) Failure To Obtain A Complete History

A. Determination

The evidence presented does not establish that Dr. Varona failed to obtain an adequate medical history of Patient A.

B. Analysis

Dr. Pagels' first criticism of the medical care which Dr. Varona provided to Patient A is that Dr. Varona failed to obtain an adequate medical history, including outside records (Tran. p. 205).

1. Medical Histories - In General

Dr. Pagels testified in reference to the patient's first visit of August 27, 1982, that Dr. Varona did not document a "reasonable, a complete history"; that "there is not an adequate review of systems; that if you look at the "only history there is, its severe low back pain without further development of the symptoms ...", and that "he gives only what I refer to as a chief complaint". Dr. Pagels further stated that the chief complaint which Dr. Varona documented was "Severe pain, low back", "secondary to cancer of the prostate", and that Dr. Varona also documented that the patient had "four TURP's in the past" (Tran. p. 206).

Dr. Pagels stated that a minimally competent physician would have obtained additional medical history which would have included the following (Tran. p. 206-207; 211, 298):

- chief complaint - development of information with respect to the back: those things that would have made the pain worse; those things that would have made it better; the quality of the pain; the specific areas involved with the pain; the severity of the pain; and the time he'd had the pain, whether "it came and went", and how long the duration from the beginning of his problem had been;
- development of information regarding four TURP's to determine whether he'd actually had those, and other past medical and surgical history the patient had;
- medications the patient was on;
- allergies the patient had;
- the patient's habits, that would include the use of cigarettes, tobacco, alcohol, other illicit drugs, possibly coffee;
- a review of systems: whether the patient had been gaining weight; losing weight; whether the patient had been eating well; whether the patient had been having difficulties with fever, chills or sweats; a review of specific areas of the body including the head, ears, eyes, nose, mouth, neck and throat; the cardiorespiratory system; the gastrointestinal system, the genitourinary system; the endocrine system; the hematopoietic system; musculoskeletal system; integument; and the neuropsychiatric system, and
- prostate cancer: how the diagnosis was made, who made the diagnosis and whether or not the patient had any symptoms relative to it.

Dr. Pagels further testified that in looking at subsequent office visits, he did not see evidence in the record that Dr. Varona ever obtained any more extensive medical history of Patient A, and as "new symptoms came up, that any sort of history was taken with respect to those either" (Tran. p.207-208).

Finally, Dr. Pagels stated, in reference to the unacceptable risks created by Dr. Varona's failure to adequately assess Patient A's problems by medical history and physical examination, that the first unacceptable risk was "in failing to identify the specific etiology of the patient's pain, he would then fail to treat the patient appropriately. Second of all, by failing to do an adequate evaluation, including history and physical exam and getting the appropriate ancillary information, he had the possibility of missing other correctable diseases. Thirdly, he risked injury to the patient secondary to side effects of what was potentially an inappropriate treatment. (Tran. p. 233, 318).

Dr. Merry testified that a physician is required under minimum standards of care to take an adequate history during a patient's first office visit. Dr. Merry stated that an adequate history includes eliciting from the individual a chief complaint; the patient's present illness; the patient's past medical history; any medication he or she is on; the patient's allergies, some of his or her habits, including narcotics, and a review of systems (Tran. p.392-393).

Dr. Herman testified that he did not feel qualified as an expert to judge Dr. Varona's standard of care because he had not practiced family practice. Dr. Herman stated that he felt that he could give an opinion as an expert in reference to whether Dr. Varona's treatment was either appropriate or inappropriate. Dr. Herman stated that on the first consultation with the physician, a general review of the history and a general physical examination is entirely appropriate. (Tran. p. 542, 544; 559;563-64, 567, 577).

2. <u>Documentation of Medical History</u>

Dr. Pagels testified that his criticism of Dr. Varona's failure to obtain an adequate medical history for Patient A is based upon his review of Dr. Varona's office records (Ex. #1; Tran. p.205,206,290).

Dr. Varona's office note for August 27, 1982, reads as follows:

> WT. 158# B/P 160/100 Severe pain, low back, secondary to Ca of the prostate. Had 4 TURP's in the past. EENT neg. Heart and lungs: clear. Abdomen: negative. Lost 110#.

Dr. Varona's office note for September 7, 1982 reads as follows:

> Not feeling well. Back pain, severe, off and on. Heart and lungs: clear. Dilaudid 4 mg. #60 every 4 hours for pain.

Dr. Pagels stated that in his opinion, Dr. Varona did not adequately document the medical history of the patient because he did not document the "pertinent positive and negative aspects of the history". (Tran. p.209; 210, lines 3-6, 20-25; p. 211, lines 1-20; p. 314, lines 5-13; 315).

In reference to the "review of systems", Dr. Pagels stated that a minimally competent physician would record the pertinent positives and negatives. Dr. Pagels stated "if the patient had no complaints going through the entire review of systems, the physician would be correct in writing down the review of systems was entirely negative and noncontributory. However, if there were positives in the review of systems, the physician might state, 'The review of systems was negative with the exception of the following positive findings' and then list the appropriate positive findings. Likewise, in a patient who complained of joint pain, the physician might also list the negatives relative to that, that is, that the joint was not swollen, red or hot but merely painful, so that we have an adequate description of what the physician was trying to describe." (Tran. p.209-210).

In reference to the pertinent positive and negative aspects of the patient's history that a minimally competent physician would record, given the patient's "complaint", Dr. Pagels stated that "If the patient came in and talked to me about severe low back pain, then I would go through what I initially suggested would be a reasonable history ... the things that cause or make the pain less, the quality of the pain, regions affected by the pain, severity of the pain, temporal relationships of the pain. Those would be the things that I would want to know about that patient's pain. Then I would like to know about his cancer of the prostate: how the diagnosis was made, who made the diagnosis, and whether or not the patient had any symptoms relative to it which in fact I might have found out from doing the first part of the history." (Tran. p.211).

Dr. Merry stated, in reference to the medical history recorded by Dr. Varona at the first office visit, that the "patient apparently had complained of severe low back pain. Stated that it was secondary to cancer of the prostate. That he had four TURP's" (Tran. p.449, lines 22-25; p.450, lines 1-6).

Dr. Merry further stated that Dr. Varona's notes of Patient A's first office visit contained pertinent findings such as the patient's chief complaint, past medical history and recording of the physical exam, but all the details of the history and physical are not recorded (Tran. p. 393-394; 442).

According to Dr. Merry, complete records of histories and physicals are found mainly in hospital admission records and are rarely found in physician office records.

Dr. Merry testified that it is not customary for a physician taking a history of a patient to record everything told to him by the patient; that it is acceptable not to record everything told by the patient, and that Dr. Varona's note for the first office visit is "less than ideal, but it is acceptable" (Tran. p. 393-394). Dr. Merry stated that "you will find complete records of histories and physicals in hospital admissions. Rarely will you find complete recordings of histories and physicals in a physician's office, particularly a family practice physician." (Tran. p. 412, 439).

Dr. Riesch testified that in his opinion, based upon his review of Dr. Varona's initial office note, the history taken by Dr. Varona was sufficient and above mimimum standards (Tran. p.633, 638, 669).

3. Verbal History

Dr. Pagels testified that an adequate medical history can be elicited from a patient verbally; that the verbal history taken from the patient in this case was not an adequate data base, and that, if available, outside records should be included in the data base (Tran. p.295-297).

According to Dr. Varona's testimony, with the exception of the review of systems, he elicited verbally from the patient information regarding all of the items which Dr. Pagels stated that a minimally competent physician is required to include in an adequate medical history. In reference to review of systems, although Dr. Varona did not state whether he elicited such information from the patient, the evidence does not establish that he did not elicit the information from the patient. Patient A did not testify at the hearing of this matter.

Dr. Varona testified that during Patient A's first office visit he had a lengthy conversation with Patient A during which time he elicited history about the patient's condition. Dr. Varona stated that the patient told him that he had lost 110 pounds; that he had four TURP's in the past and that he had had cancer of the prostate (Tran. p.18-19,25). Dr. Varona testified that he elicited the patient's chief complaint; talked about present illnesses, past medical history, medications, allergies and habits (Tran. p.25; 116, lines 4-25; p.117, lines 1-18).

Dr. Varona further stated that he took a more extensive medical history of the patient on September 7, 1982, than he had done on the first office visit, which included more than he had written in his notes (Tran. p.31, lines 18-25; p.32, line 1).

4. Past Medical Records

Dr. Pagels testified, in reference to past medical records, that Dr. Varona failed to obtain a complete history, including outside records (Tran. p.205; 296-299).

Dr. Pagels testified that the verbal history taken from the patient in this case was not an adequate data base. Dr. Pagels stated that "outside information about those patients should be included there as well", and that "if there's past history and there's records available, he should attempt to get those". Dr. Pagels testified that the "obtaining of the information itself does not make a -- or lack thereof does not make him incompetent." ... It is not the effort. The competence has to do with getting an adequate amount of information to evaluate that patient appropriately. If the patient refuses to let him get that information he still needs to get enough information somehow by doing his own testing then, repeating things, or whatever, to get enough information to evaluate the patient appropriately (Tran. p.296-298; 299, lines 1-8).

Dr. Pagels stated that there are two ways to obtain a data base, "you can create your own or you can save some effort and get somebody else's." Dr. Pagels further stated that if a physician "attempts" to obtain outside information, he would be acting as a competent physician, but that if the patient refuses to assist the physician in obtaining outside records or if the patient won't allow a physician to create his own data base, it would be below the minimum level of competence for the physician to continue to treat the patient without adequate information. (Tran. p.297, lines 11-19; p.298, lines 9-22, 23-25; p.299, lines 1-4, 5-7, 13-19, 20-25; p.300; p.301, lines 1-5).

The evidence presented indicates that Dr. Varona did "attempt" to obtain outside records relating to the patient's past medical history and to have the patient evaluated with diagnostic measures.

Dr. Varona testified that he tried to get Patient A's medical records. Dr. Varona stated that during the first office visit Patient A talked about Dr. Borowski, a doctor in Indiana and that he told Patient A that he needed "those records from all those doctors". Dr. Varona stated that he elicited a telephone number in Indiana from Patient A, and that when he called the number nobody answered. Dr. Varona stated that Patient A kept promising that he was going to produce his records; that he had Patient A sign an authorization form for release of medical information when he first started seeing the patient; that he gave the papers to Patient A for him to take to Indiana for purposes of obtaining the records, and that Patient A did not provide him with the records. (Tran. p.25-26; 36-40; p.140-141).

Dr. Varona also testified that when he was treating Patient A from 1982 to 1985, he was not aware that Patient A was being treated at Columbia Hospital or any of the hospitals in the Milwaukee area because Patient A never told him about the treatments. Dr. Varona stated that he did eventually receive some medical records for Patient A and that he obtained medical records from St. Luke's in 1989 (Tran. p.38-39; 49-50; 140-141).

In reference to whether Dr. Varona conducted independent tests when he first starting treating Patient A to confirm whether Patient A had prostate cancer, Dr. Varona testified that "I always tried. I tried very hard. Say, 'Mr. A .., let's do this test. Let's do this blood test, let's do this bone scan. Let's do this x-ray'. He said 'I can't afford that, Doctor, I have no money. I can hardly feed my wife. I can hardly do this. You know I've got cancer of the prostate." Dr. Varona stated that the tests were "never done. I tried to send him to a urologist to reevaluate him. He said -- he promised he would go to Froedtert, even want to go to Mayo Clinic. I said, 'I will call Mayo Clinic for you'. 'Well, let's wait until I can get some help from the state'. He said he was going to call his congressman, he's going to call his alderman to help him get the -- some financial support. He couldn't -- he could never get it". (Tran. p.41-42).

In reference to tests performed on Patient A either at Dr. Varona's office or on an outpatient basis to confirm whether the patient had prostate cancer, Dr. Varona stated that he could not have performed any test in his office but he could have had tests done on an outpatient basis in a hospital, like bone scan or serum acid phosphatase. Dr. Varona testified that he suggested several times to Patient A that he undergo an acid phosphatase test, and that he "always say that he should go for more tests, more tests". Dr. Varona stated that Patient A said 'What do I need those tests for?' He would ask me 'What is the test for?' I said, 'Well, to find out how high.' You see, the serum acid phosphatase after an operation on a prostate ... it rises." In reference to the purpose of the test, Dr. Varona stated that he told Patient A that "it will help us know how far you're doing with your cancer, with your metastasis too'. And he said, 'What for? .. I'm dying. I'm an old man. I,m going to die from this cancer.' He had a fatalistic attitude towards his condition. All he wanted was to assuage his pain." (Tran. p.44-45; 46, lines 9-11).

Dr. Merry testified that Dr. Varona was required under mimimum standards of care to make some further inquiry into Patient A's chief complaint of back pain and that such further inquiry included obtaining "old records showing that he did have cancer of the prostate and any other studies that had been done with regard to metastatic disease" (Tran. p.394,398-401; 450). Dr. Merry further stated that it was imperative to obtain Patient A's previous medical record since Patient A complained of a pain syndrome and since he stated that he had had prostate cancer and Dr. Varona suspected metastatic disease.

Dr. Merry further stated that how quickly a minimally competent physician would be required to obtain previous medical records in this case would depend on patient cooperation; that the patient has to be cooperative in order to obtain the records, and that it would not be appropriate to set an exact time frame. Dr. Merry further stated that "old records are much more helpful in reference to what has changed with more recent studies (Tran. p.399,453-455; 460-461; 475, 527-529).

In reference to diagnostic test, Dr. Merry stated that Dr. Varona advised the patient to go to Froedtert Hospital for evaluation in February, 1983 and that three attempts were made in the first six months to have the patient be hospitalized for a more thorough evaluation of his complaints. Dr. Merry stated that his impression of Patient A is that he was "a drug-seeking individual. I have had experience with these individuals and they are extremely resistant to alternative methods of treatments. And Mr. A ... followed this pattern that I've observed very frequently in these types of individuals." (Tran. p.401-403;461-466).

Finally, Dr. Merry stated, in reference to the conduct of a physician when confronted with a patient who is non-cooperative and refuses to allow the doctor to conduct an adequate evaluation, that "It may be acceptable for the doctor to refuse to see the patient, in that the patient is not cooperative for further evaluation. It may be also acceptable for the doctor to continue to treat the patient based on less than a hundred percent documency of exactly what the problem is if the patient has a reasonable history, such as this patient presented with metastatic cancer to the spine." Dr. Merry stated that if a patient is thought to have metastatic cancer, it would be considered inappropriate not to treat them or offer them some form of analgesia while they are being evaluated. Dr. Merry stated, in reference to how long you can keep treating a patient with analgesia without doing an evaluation of the patient's problems, that "This depends on patient cooperation. Patients have the right to refuse treatment. Patients have the expectation to be given appropriate analgesics. And so the answer is that treatment can go on for a long period of time." (Tran. p.466-470).

Dr. Riesch testified that Dr. Varona's attempts to get the patient's previous medical record for the patient comports with mimimum standards of care, and that the history taken by Dr. Varona was above minimum standards of care. In reference to diagnostic tests, Dr. Riesch testified that it was obvious that Dr. Varona was attempting to evaluate the problem; that there was nothing more Dr. Varona could do in his office, and that the patient was "putting him off by stating he was going here, there and everywhere to have treatment, and it was not being accomplished". Dr. Riesch stated that Dr. Varona made multiple requests to obtain records and multiple requests to obtain additional diagnostic efforts, but that the patient was uncooperative. (Tran. p.636-638; 698-699).

2) Failure To Do An Adequate Physical Evaluation

A. Determination

The evidence presented does not establish that Dr. Varona failed to do an adequate physical evaluation of Patient A.

B. Analysis

Dr. Pagels' second criticism of the medical care which Dr. Varona provided to Patient A is that Dr. Varona failed to do an adequate physical evaluation (Tran. p. 205; 211-212).

Dr. Pagels testified, in reference to Patient A's first office visit, that Dr. Varona's physical examination of the patient was below minimum standards of care "because the examination does not address the patient's back or his prostate. It looks at a variety of areas but it does not address the specific areas of complaint". Dr. Pagels stated the examination was "very cursory and incomplete", and that Dr. Varona's office records do not reflect that he did an examination of the patient's back or lower extremities. (Tran. p.206, lines 2-11; p.211-212).

In reference to a working diagnosis, Dr. Pagels stated that he believed that Dr. Varona's felt the patient had "low back pain secondary to metastatic disease from cancer of the prostate". Dr. Pagels further stated that a minimally competent physician would go about confirming or ruling out a working diagnosis by doing an adequate history and physical examination, and that "He would get appropriate ancillary test and he would try and obtain other records to confirm the diagnosis" (Trans. p. 212-214; 233,318).

Dr. Varona testified that according to his office records, the extent of his physical examination of Patient A was an examination of the patient's eyes, ears, nose and throat, heart and lungs and abdomen (Tran. p. 20; 117-119).

Dr. Varona stated that he also did a rectal examination of the patient and that it is always his practice that whenever he sees a patient for the first time in his office that he does a complete physical examination, including pelvic or rectal examination, even in a patient who does not have any rectal or prostate problem. Dr. Varona further stated that he did not have a reason as to why he did not document in his record for August 27, 1982, the fact that he did a rectal examination, except that he was remiss in his recordkeeping (Tran. p.20-22; p.23, lines 19-25; 27, 119).

Dr. Varona further stated, in reference to the September 7, 1982 office visit, that he checked the patient's "heart and lungs and EENT"; that he looked at the patient's legs because the patient would sometimes complain of his legs "they're painful, they're swollen". (Tran. p.26-27).

Dr. Varona testified that follow-up physical examinations were more cursory than complete, and that he would take blood pressure, talk to the patient, take his pulse, ask his secretary to take a temperature, listen to the patient's heart and lungs, and look at his ears, nose and throat (Tran. p.32-34; 135, lines 24-25; p.136).

Dr. Merry testified, in reference to a patient's first office visit, that a minimally competent physician would do a survey. Dr. Merry stated that "relating to the patient's chief complaint of back pain, there would be a survey of the head, eyes, ears, nose and throat, auscultation of the lungs, examination of the heart with regard to murmurs or abnormal sounds, examination of the abdomen, examination of the back, examination of the lower extremities, with regard to weakness, with regard to aggravation of the back pain, with extension or flexion of the lower extremities (Tran. p. 395-398; 433-449; 518; 531-535).

Dr. Merry testified that based upon Dr. Varona's office note for Patient A's first office visit, Dr. Varona did an examination of the patient's head, ears, eyes, nose and throat, and that he did an evaluation of the patient's abdomen, lungs and heart. (Tran. p.395).

In reference to examination of Patient A's back and lower extremities, Dr. Merry stated that Dr. Varona's office notes do not reflect that he examined those areas. Dr. Merry further stated that "the office records do not reflect the entire physical exam carried out, similar as they do not reflect the entire conversation with the patient. Office notes are much briefer and are pertinent to abnormal or positive findings that have been found. Negative findings frequently do not get recorded" (Tran. p. 396, 434).

Dr. Merry stated that "there are frequently few positive findings in the back that one can find on a physical examination, but if there were any positive findings, that would be very helpful to have them recorded". Dr. Merry further stated that in the majority of patients who have back pain, the physical examination of the back is not very helpful. (Tran. p.437).

Finally, Dr. Merry stated that an examination of the lower extremities would be the "observation of the gait, the observation of weakness, the observation of the reflexes, the observation for sensory loss". Dr. Merry testified that a physician's observation of a patient walking comports with minimum standards of care in reference to examination of the patient's lower extremities. (Tran. p.397).

Dr. Riesch testified, in reference to a patient's first visit, that a minimally competent physician would examine the patient's "head, eyes, ears, nose, throat, heart, lungs, breasts, abdomen, musculoskeletal, neurological". Dr. Riesch further stated that his impression based upon Dr. Varona's office notes, was that Dr. Varona did a minimally competent examination of the patient (Tran. p.592-594; 633-634; 639, 695).

Dr. Herman testified that on the first consultation with the physician, a general review of the history and a general physical examination is entirely appropriate, and that in his opinion, Dr. Varona handled that first office visit and his treatment of the patient appropriately. (Tran. p.542, 544, 546-547; 580-581; see also Tran. p.370, 376).

According to Dr. Varona, with the exception of conducting an examination of the patient's back and lower extremities, he examined the patient in regard to all of the aspects which Dr. Merry testified that a minimally competent physician would do in performing an examination relating to the patient's chief complaint. Although Dr. Varona did not state whether he examined the patient's back and lower extremities, the evidence does not establish that he did not examine those areas. Patient A did not testify at the hearing of this matter.

3) Failure To Evaluate Subsequent Signs And Complaints

A. Determination

The evidence presented does not establish that the respondent failed to evaluate subsequent signs and complaints reported to respondent by Patient A.

B. Analysis

Dr. Pagels' third criticism of the medical care which Dr. Varona provided to Patient A is that Dr. Varona failed to evaluate subsequent signs and complaints that the patient had (Tran. p.205, 234).

Dr. Pagels testified that the patient "over the course of the time of the complaint, had other significant symptoms and complaints that he mentioned to Dr. Varona. And again when these were brought up to Dr. Varona's attention, there was no documented, adequate history about those symptoms or signs, and there was no adequate evaluation of those symptoms and signs by examination or by appropriate lab tests and x-rays" (Tran. p.234).

First, in reference to the patient's complaints in August, 1983, of urinary problems, Dr. Pagels stated that "if we take the three encounters there, we have a patient that's complaining of foul-smelling urine, incontinence of urine, who has shaking. And all of those symptoms could in fact point to urosepsis, meaning infection of the urine with blood poisoning". Dr. Pagels testified that given the complaints that the patient had, a minimally competent physician would have "done a temperature. He should have included a pulse rate. He should have included an examination of the flanks to see whether the patient had pyelonephritis, and he should have done a urinalysis and also a urine culture. The urine culture, one might make an argument, was superfluous, but at least the urinalysis would be necessary". (Tran. p. 234-236).

Dr. Pagels also testified that the patient "frequently complained about urinary incontinence. Again there was no effort to identify the etiology of that. He also complained of sometimes bloody urine. And again we have no evidence that there was any evaluation done of that problem". Dr. Pagels stated, in reference to the patient's frequent complaints of urinary problems, that the "major conclusion is that those should have been evaluated to look for correctable causes for those complaints and symptoms. And they were not. So that I would feel that this was below minimal, acceptable standard of care". (Tran. p. 236-237).

Dr. Pagels stated, in reference to unacceptable risks created by Dr. Varona's failure to assess Patient A's problems with urinary incontinence and associated problems, that urinary tract symptoms of incontinence could point to what is referred to as overflow incontinence which can cause renal failure in some cases and can also cause infection which can cause sepsis and death. Dr. Pagels stated that with respect to the blood in the urine, the patient could have had a bladder tumor.

In reference to urinating constantly, Dr. Pagels stated that the symptom complex, in fact, could have been related to diabetes, " but it wasn't assessed so we really don't know. If it had been diabetes, it was easily treatable. Untreated it could have cause severe complications or even death". (Tran. p.238-240).

Dr. Varona testified that he agreed that Patient A had persistent problems with urinary incontinence and that he wanted to have Patient A reevaluated by a urologist but the patient never went to a urologist. Dr. Varona stated that there were times when he would do a urinalysis with a dipstick to see if there was a urinary tract infection, and that a dipstick test was the only test he could do in his office. Dr. Varona further stated that he wanted to order a urinalysis for Patient A; that he did not have the facility in his office to do a urinalysis, and that he did not treat Patient A for his urinary incontinence. (Tran. p.65-66).

In reference to the patient's complaint of "painful urination" and "bloody urine", Dr. Varona testified that there is no documentation that he did anything on August 28, 1984, to determine what was causing Patient A to have painful urination, but that he must have done a urine dipstick again. Dr. Varona stated that "This is one of the common complaints of Mr. A ... whenever he comes to the office: back pain and painful urination. It was back and forth between the two of them. And he might -- and sometimes he would tell me 'I have blood in the urine.' And then you examine, there is none. When a TURP is performed on a patient, once in a while he may have bloody urine from the site of the TURP." (Tran. p. 66-68; 128-129; 144, 146-147; 155-156).

Dr. Merry stated that Dr. Varona did reach minimal competence in treating the patient for urinary incontinence. Dr. Merry testified that "I believe that Dr. Varona did reach minimal competence. The care of the patient or the outcome of the patient is not ideal. The outcome is dependent on the physician and the patient. The patient resisted advice, and that is simply the reason, I believe, that the outcome is not ideal" (Tran. p. 407-408).

Dr. Merry testified that patients who are coming to the office with other complaints, such as severe pain, have to be prioritized; that the severe pain normally would command the initial evaluation and treatment; that evaluation of urinary incontinence, as far as a primary care physician, is basically that of ruling out urinary tract infection; that a more detailed evaluation and treatment usually belongs to the realm of a urologist; that a dipstick test can be used to evaluate urinary incontinence; that hospitals routinely does dipsticks, and if they are negative, the hospitals do microanalysis, and that if the dipsticks are positive, that would require further analysis of the cause of the urinary incontinence (Tran. p. 405-406; 484-486).

Dr. Merry further stated that an appropriate treatment or an appropriate response by a minimally competent physician to a patient's complaint of urinary incontinence, burning sensations when urinating, bloody or painful urination, in instances in which a dipstick test is negative, is to refer the patient to a urologist. Dr. Merry testified that "the primary care physician does not have the training to evaluate or treat bloody urine or painful urination in the absence of infection. That would imply that there is more complicated features that are causing the symptoms, and that's in the realm of a urologist". (Tran. p. 407, 486,488, 524-525).

Dr. Riesch testified that if Dr. Varona had done a dipstick test on Patient A he would have acted appropriately in response to the patient's complaints of incontinence; that if the dipstick tests were negative the results may not be recorded because negative tests often are not recorded, and that it would not be below minimum standards of care not to put negative tests results in the patient record. (Tran. p. 639-643).

Dr. Herman testified that in his opinion, Dr. Varona's treatment of the patient's urinary incontinence problem was appropriate (Tran. p.374-375; 553).

Second, in reference to bowel incontinent, Dr. Pagels stated that the symptom complex of being incontinent of urine and incontinent of stool could in fact indicate a spinal cord lesion, which eventually the patient could have become paraplegic as a result of the legion, and that Dr. Varona did not assess or evaluate the patient for the symptoms (Tran. p.240).

Dr. Varona testified, in reference to Patient A's complaint of bowel incontinence, that his office notes document that the patient complained of incontinence on August 25, 1983, and of diarrhea on September 6, 1984, but that his notes do not indicated whether he instituted any treatment. Dr. Varona stated that whenever a patient of his has loose stools, the first thing that he does is tell the patient to avoid any diary products in their diet, because diary products aggravate loose stools, and that he would tell the patient to call him if the diarrhea does not stop, then maybe he would prescribe something. Dr. Varona further stated that he did not ask Patient A to have tests done relating to bowel incontinence because it only occurred occasionally, and that he did not know what he could have done if the patient's incontinence became more of a regular problem. Dr. Varona stated that obtaining hospital tests would have been a way to determine why the patient was having the problem. (Tran. p.70-71; 156-157).

Dr. Merry stated, in reference to a patient's complaint of bowel incontinence, that a minimally competent family practitioner would do a rectal exam to determine whether there is sphincter tone - whether its adequate or inadequate - and to see if there is anything that is palpable as far as pathology, and then refer the patient to a surgeon or gastroenterologist. Dr. Merry stated that bowel incontinence most commonly is evaluated by surgeons or gastroenterologists, and that normally family practitioners will not be able to come to a conclusion as to a cause for bowel incontinence (Tran. p. 486-488).

Third, Dr. Pagels testified, in reference to the problems the patient was having with weakness, falling, fatigue, loss of balance and vomiting, that a minimally competent physician would have reviewed the medications the patient was on. Dr. Pagels also stated that "a minimally competent physician would have evaluated the nervous system by doing an office examination of the nervous system, which would include motor examination, that is, walking, gait, strength, reflexes; sensory perception; strength; looking for posterior column damage, which we would do something called a Romberg sign, look for a Romberg sign, and on the basis of that, make some determination of whether or not the patient had a central nervous system problem". (Tran. p.242; 252-254).

In reference to risks relating to loss of balance, weakness, fatigue and vomiting, Dr. Pagels stated that the most obvious risk is that the patient was injuring himself, and of equal importance is the fact that by not evaluating the patient a physician does not look for correctable causes of the problem. (Tran. p.240-243).

Dr. Varona testified, in reference to the patient's complaints of loss of balance, weakness, fatigue and falling spells, that he considered whether the Dilaudid that he was prescribing was contributing to the patient's problems. Dr. Varona testified that he told the patient to space out the medication and to interspace it with some other medication like extra-strength Tylenol, but that the patient never did. Dr. Varona stated, in reference to tests or examinations to determine the cause of the patient's falling, that he "would do reflexes, check his balance by doing Romberg's test and check ... the pulses in the legs, and then do a neurological exam, and listen to his heart and lungs". (Tran. p.63-64).

Dr. Varona further stated that he wanted to do something to determine the cause of the problem, but that he got "his old answers", 'I cannot afford it. I don't have any money to do that'. Dr. Varona stated that he wanted to do some blood tests to find out what the patient's electrolyte patterns were in the blood because the patient was taking Aldactazide for blood pressure, and to find out the patient's hemoglobin, hematocrit status. Dr. Varona also stated that he wanted to do "some vascular study, circulatory study of the lower extremities". (Tran. p.59-65; 153-154).

Dr. Merry testified that Dilaudid may cause constipation, unsteadiness, which may lead to falling, and may cause confusion. Dr. Merry stated that Patient's A falling may have been attributable to the narcotic that the patient was taking. Dr. Merry further stated that the side effects of Dilaudid may be an acceptable risk when a person has severe pain. (Tran. p.404-405; 411).

Dr. Riesch testified that if a doctor is prescribing Dilaudid and the patient subsequently develops symptoms such as falling, anemia or urinary incontinence, the doctor is required under minimum standards of care to address those problems. Dr. Riesch stated that "you have to take the whole context when the patient has had four TUR's. There's a reason there for incontinence. As far as falling, this could happen for any generalized weakness, malaise or bone metastasis. And as far as weakness, etcetera, the same holds true. If this man indeed has metastatic cancer to the bones, all those things can be explained for reasons other than from the use of Dilaudid. (Tran. p.701-702).

Dr. Herman stated, in reference to the patient's complaints of weakness, loss of balance and falling, that Dr. Varona's failure to assess and treat the patient for those problems was not below minimum standards of care (Tran. p. 372-374; 566- 569).

4) Failure To Follow Up On Tests

A. Determination

The evidence presented does not establish that Dr. Varona failed to obtain routine chest x-rays for the patient in response to the thoracic spine films taken for the patient on April 2, 1985.

B. Analysis

Dr. Pagels' fourth criticism of the medical care which Dr. Varona provided to Patient A is that Dr. Varona failed to follow up on laboratory and other ancillary test results that were available.

Dr. Pagels testified that his opinion is based on the thoracic spine films taken for the patient on April 2, 1985. Dr. Pagels stated that it was noted on the thoracic spine films that "On the AP view of the thoracic spine there is a suggestion of a round density beneath the sternal end of the right clavicle. This may merely be superimposition of structures but a possibility of a lesion on the right apex cannot be excluded. And if a chest x-ray has not been recently taken, would recommend that routine studies of the chest be done". Dr. Pagels stated that the "abnormality could have been infectious process; it could have been a malignant process; it could have been a benign process. And there was no appropriate follow-up done so again the patient was not afforded an opportunity to be treated if there was something there to treat". (Tran. p. 247-248).

Dr. Pagels stated that a minimally competent physician would have gotten the routine chest x-rays suggested by the radiologist, or he would have looked at that film himself, discussed it with the radiologist and documented why he wasn't getting a chest x-ray. Dr. Pagels further stated that if the patient refused to go for subsequent chest x-ray studies, a minimally competent physician should document that in the record, and he should explain the significance of the initial findings and explain to the patient that he should have that x-ray (Tran. p. 249-250; 315-316).

Finally, Dr. Pagels testified, in reference to unacceptable risks created by Dr. Varona's failure to follow up on the recommendations made by the radiologist, that if the patient had an infectious process that would have been easily treated, he was put at risk for progression of the infection. Dr. Pagels stated that if it was an early malignancy the patient was put at risk "for not being able to cure what otherwise might be a curable lesion" (Tran. p.250).

Dr. Varona testified that he talked to the patient about the thoracic spine x-ray and that he "told the patient that you need further studies as recommended by the radiologist to find out if you have metastatic. And he felt he really didn't -- he didn't want to do that. First of all, he couldn't afford it, he said. And he said again, 'What are you looking for? What are you going to do if it's cancer? I already have cancer to my spine'. See, you can only recommend. If the patient refuses, there's nothing I can do." (Tran. p. 71-72; 152-153). Dr. Varona stated that the risks to Patient A if there was a lesion is that it would be "the same if he has a metastasis to the spine. It just indicates that if it's malignant that the skeletal spread is more. It's going out into more bones than just the spine (Tran. p.72).

Dr. Merry testified that it is always the patient's prerogative to refuse or to cooperate with respect to examinations. Dr. Merry stated that Dr. Varona's office note on April 25, 1985, states that the patient is still hesitant to enter the hospital for a complete evaluation, and there are numerous references in the notes that Dr. Varona recommended hospitalization. Dr. Merry stated that chest x-ray is normally a routine part of hospitalization. (Tran. p.489-491; 523-524). Dr. Merry stated, in reference to risks for the patient, that if the patient had a legion which was malignant it would be a serious risk to the patient (Tran. p.490, 523-524).

Dr. Riesch testified that it ultimately is the patient's decision to go into the hospital and get a chest x-ray. (Tran. p. 644-646, 715).

Dr. Herman testified in reference to the patient taking a chest x-ray, that the ultimate decision is made by the patient (Tran. p.370-371; 554-555).

The evidence presented does not establish that Dr. Varona failed to obtain routine chest x-rays for the Patient A. The evidence establishes that Dr. Varona recommended to Patient A that he go to a hospital for further evaluation, but that Patient A did not follow his recommendation. As noted previously, Dr. Merry testified that chest x-ray is normally a routine part of hospitalization. The evidence presented also does not establish that Dr. Varona did not look at the thoracic spine films taken for the patient on April 2, 1985, or that he did not discuss the thoracic spine films with the radiologist.

5. Failure to Maintain Adequate Medical Records

A. Determination

The evidence presented does not establish that the respondent failed to maintain adequate medical records.

B. Analysis

Dr. Pagels' fifth criticism of Dr. Varona's treatment of Patient A is that Dr. Varona failed to maintain adequate medical records. Dr. Pagels stated that "I believe that the documentation in this record is inadequate to provide minimally -- minimal acceptable standards of care because the record in fact become an integral part of care of the patient. And without pertinent positives and negatives recorded, I don't believe that a physician has a good enough memory, given many physicians seeing 20 or 30 patients a day, to remember all the pertinent positive/negatives on an individual patient without recording those in the records. So I think that the record keeping does become an issue here, as well as all the other things we've said." (Tran. p. 250-251; 290; 314-315; 346-347).

Dr. Varona testified that he was remiss in his recordkeeping, and that recordkeeping is difficult for a doctor. Dr. Varona stated that "in family practice we know our patients. I know my patients after being with them, I know his diagnosis, I already know what he wants. But sometimes you take this for granted and you don't document them anymore. It's a difficult situation, documentation, for a doctor".

Dr. Varona further stated, in reference to his role as chief resident for family practice residency at St. Michael's Hospital, that "we emphasized to my residents ... record keeping. And I was the first one to violate my own rule, because when you're actually in practice you see a lot of patients. You don't have time to be so detailed that you ... write things that will guide you to remember what you did ...". (Tran. p.23, line 22; p.25, line 2; p.42, lines 20-25; p.43, lines 1-13).

Dr. Merry testified that Dr. Varona's notes are very minimal; that they are very poorly legible, and that he hoped that they do not record the entire content of the office visits. Dr. Merry stated that these types of notes are not uncommon with solo practitioners or with family practitioners or other physicians, and that to say that these are below minimum standards, you would be losing a large number of physicians from the practice of medicine in the state of Wisconsin, because this is a common practice to have minimal office notes. (Tran. p. 412-413).

Dr. Merry further stated that it is customary for doctors to document positive findings from a physical examination, but if the findings are negative, there may not be anything recorded. Dr. Merry stated that unfortunately the practice of many physicians is that they don't have more complete recordings of office visits; that you will find complete recordings of histories and physicals in a hospital admission, and that rarely will you find complete recordings of histories and physicals in a physician's office, particularly a family practice physician. (Tran. p. 438-439).

Dr. Riesch testified that Dr. Varona's recordkeeping was competent for a "family practitioner in a solo practice in a solo office without the availability of dictating machines, etcetera." (Tran. p. 642-643, 669).

6) Prescribing of Controlled Substances

A. Determination

The evidence presented does not establish that the respondent's prescribing of Dilaudid to Patient A was below minimal standards of care or otherwise than in the course of legitimate professional practice.

B. Analysis

Dr. Pagels testified that Dr. Varona's prescribing of controlled substances to Patient A was below minimal standards because Dr. Varona gave the narcotics before adequately evaluating the patient to determine that the patient needed that narcotic. (Tran. p. 251-254).

Dr. Pagels testified that beginning with Patient A's second office visit on September 7, 1982, Dr. Varona initiated the use of Dilaudid, 4 milligrams every four hours, for pain. Dr. Pagels stated that given how Dr. Varona reached the diagnosis that he reached in this case it was inappropriate for Dr. Varona to initiate treatment with Dilaudid. Dr. Pagels further stated that a minimally competent physician may be justified in prescribing narcotics to a patient who is in severe pain before confirming the underlying diagnosis of prostate cancer with metastatic disease until he had been able to make a diagnosis. Dr. Pagels stated that a minimally competent physician should be able to confirm the diagnosis within the "next one to two visits". (Tran. p. 212-213, 218-219; 301).

Dr. Pagels testified, in reference to unacceptable risks, that by prescribing the drug Dr. Varona may have "masked other symptoms that would have helped to make the proper diagnosis. Second of all, by prescribing the drug, he may have been treating inappropriately. Third of all, the patient clearly was at risk for injury from side effects. And fourth, the patient seemed to be addicted to the drug". (Tran. p.252-254).

Dr. Varona testified that given his working diagnosis of prostate cancer with metastasis to the spine, there was no available treatment for Patient A, and that he just gave him the pain medication. Dr. Varona stated that he did not hesitate to give Patient A Dilaudid because he believed that Patient A was terminally ill. Dr. Varona stated that the purpose of giving the patient Dilaudid was to make him more comfortable during the time he had left to live. Dr. Varona stated that in 1982, he thought the patient had from six months to a year to live. (Tran.45-46).

Dr. Varona further stated that the first time that he saw Patient A at his office he knew that Patient A was addicted to Dilaudid. Dr. Varona stated, in reference to taking a person addicted to Dilaudid off the drug, that "the withdrawal effect is enormous, and they develop severe -- again the pain gets worse. They develop tremors all over their body, sometimes uncontrollable tremors, sweating, headache, dizziness, their blood pressure might shoot up". Dr. Varona testified that if you wanted to wean someone off Dilaudid, you would have to have them go to a hospital for a drug dependency-type program. Dr. Varona stated that he indicated to Patient A, on December 1, 1983, that he should be institutionalized for drug addition. (Tran. p.43, 109, 111, 148, 153-154).

Dr. Merry testified that Dr. Varona's prescribing of Dilaudid to Patient A comported with the minimum standards of care given the history and physical examination done on Patient A. Dr. Merry stated that there is evidence that Patient A did have cancer of the prostate, and that the patient previously was on Dilaudid. Dr. Merry stated that Dr. Varona compassionately continued the Dilaudid, and that unfortunately the patient was resistant to further evaluation and possible alternative treatment. Dr. Merry stated that it may have been very dangerous for Dr. Varona to simply stop prescribing Dilaudid for Patient A, because it may have resulted in severe withdrawal symptoms, which might have included seizures, myocardial arrhythmias, and which might have included death. (Tran. p. 409-411).

Dr. Merry further stated that based upon his reading of Dr. Varona's notes, his impression was that Patient A was resistant to adopting or following through on any advice that Dr. Varona was giving him. Dr. Merry stated that "I think that Mr. A ... was a drug-seeking individual. I have had experience with these individuals and they are extremely resistant to further evaluation. They are extremely resistant to alternative methods of treatments. And Mr. A ... followed this pattern that I've observed very frequently in these types of individuals". (Tran. p. 403-405; 470-480).

Finally, Dr. Merry testified in reference to whether Dr. Varona's prescribing of Dilaudid to Patient A was other than in the course of legitimate professional practice, that in his opinion it was not. Dr. Merry stated that "Both of these patients have severe pain syndromes. They are difficult patient, difficult to evaluate. He very much depended on the patients' statements. They are also ... patients that have previously been treated and evaluated, and that were resistant to additional treatment in the manner that Dr. Varona had usually followed. That is, they resisted hospitalization; they resisted referrals to other medical centers. And this is not an incompetent course that he treated these patients with, but they are difficult patients". (Tran. p. 427, 480-483).

Dr. Riesch testified that Dr. Varona's prescribing of Dilaudid for Patient A was above minimum standards of care. Dr. Riesch stated that "He was treating the patient's pain, and I think this was acceptable". (Tran. p. 635, 639; 647-648; 701-703; 716-717; 721-722).

Dr. Herman testified that in his opinion, Dr. Varona's prescribing of Dilaudid was not below minimum standards of care (Tran. p. 569, 572-573).

PATIENT B

Dr. Pagels testified that Dr. Varona failed to meet minimum standards in providing medical care to Patient B because he did not do an adequate history and evaluation of the patient. In addition, Dr. Pagels stated that Dr. Varona failed to evaluate laboratory data that was available to him and he failed to evaluate subsequent complaints or symptoms of the patient (Tran. p.254-255).

1) Inadequate History and Evaluation

A. Determination

The evidence presented does not establish that the respondent failed to obtain an adequate history and physical evaluation of Patient B.

B. Analysis

Dr. Pagels' first criticism of the medical care provided by Dr. Varona to Patient B is that he failed to do an adequate history and evaluation of the patient.

Dr. Pagels testified in reference to the patient's first visit with Dr. Varona on August 24, 1982, that the history consists of three lines, "Severe pain, lower back area. Two laminectomies for spinal traumatic injuries. Ambulatory with difficulty. Using a walker. Has left artificial hip also due to injury". Dr. Pagels stated that there is no other past medical or surgical history; there is no allergy evaluation; there is no information about other medications she might be using; nothing about her habits, and no review of systems. (Tran. p.255).

Dr. Pagels stated that a minimally competent physician would have elicited information regarding "description of the pain, those things which make the pain worse or better; the quality of the pain; the actual areas involved in some detail; the severity of the pain, and again the temporal relations of the pain -- how long it lasts, how long she'd had it in total duration, how long each episode lasted or whether it was continuous. That would have been the minimal amount of information that should have been elicited with respect to that pain". (Tran. p.258-259).

Dr. Pagels stated that there is no evidence in the record that after the first examination Dr. Varona elicited any more extensive medical history of Patient B, and that Dr. Varona basically "describes symptoms but does not go into ... the history of these things". Dr. Pagels stated that a minimally competent physician would have obtained past medical records if the records were available. (Tran. p. 259).

In reference to the physical examination, Dr. Pagels stated that the examination "includes a blood pressure; a weight but no pulse; and then looks at just a few areas, the head -- or the ears, eyes, nose throat; heart, lungs and abdomen. However, there is no physical examination of the back. There's no neurologic examination or examination of the lower extremities. The omission of the pulse is actually relevant to this case in that the patient turns out to be hyperthyroid and pulse might have been a clue to that". (Tran. p.255-256).

Dr. Pagels stated, in reference to the patient's complaint of severe pain in the back, that the minimally competent physician would have examined "the patient's back visually, would have looked at the range of motion of the back, would have felt the back for muscle spasm, would have done straight leg-raising testing, and would have done a neurologic examination of the lower extremities as well as the back, looking at the patient's reflexes, the patient's strengths ... and the patient's sensory perception. The patient would also have been assessed for balance". (Tran. p.257-258, 260).

Dr. Pagels further testified that he did not believe subsequent physical examinations conduct by Dr. Varona of Patient B were any more extensive than the first exam that he did, or that the physical examinations were adequate to assess the cause of her pain (Tran. p.259-260).

In reference to whether Dr. Varona's failure to adequately assess the cause of the patient's pain created unacceptable risks, Dr. Pagels stated that "initially the potential to find a correctable reason for the pain was missed, and therefore the treatment may or may not have been appropriate until one knows what the cause of the pain is. So she was at risk for having missed the diagnosis that otherwise might have been treatable. Again, she was at risk of injury secondary to side effects from the treatment that was given, which in this case was the Dilaudid. And third of all, in this case the Dilaudid may in fact have masked symptoms of other diseases that she had."

Dr. Pagels further stated that the "patient could have had another disc somewhere else that might have responded to surgical intervention. She may have had a benign spinal cord tumor. She may have had some sort of an intra-abdominal process that was causing her low back pain that was unrelated to the original problem. So there's a variety of things. She could have had a pelvic malignancy. And any of those things could have caused back pain" (Tran. p.264-265).

Dr. Varona testified that he began treating Patient B on August 24, 1982; that her chief complaint was "severe pain over the lower back", and that his office note for August 24, 1982, states "Severe pain lower back area. Two laminectomies for spinal traumatic injuries. Ambulatory with difficulty using walker. Has left artificial hip also due to injuries. Physical examination: EENT normal. Heart and lungs clear. Abdomen negative. Dilaudid 4 milligrams No. 20, one tablet every four hours -- every six hours."

Dr. Varona further stated that he obtained additional history from Patient B which included information "that she had been on medication for a long time since the operation, that she's always had severe pain. And she feels weak. And had poor balance". Dr. Varona testified that usually with new patients, especially the elderly, he might take 30 minutes or an hour to elicit the history. (Tran. p.75-79; 116-117).

In reference to previous medical records, Dr. Varona stated that Patient B did not present any medical records at the first visit to confirm whether she'd had previous back surgery, and that he tried several times without success to obtain medical records from Patient B to confirm whether she had undergone laminectomies in the past (Tran. p.77-78).

In reference to physical examination, Dr. Varona testified that he would describe a typical physical examination for Patient B to be about the same as what he would do for Patient A. Dr. Varona stated that he would "sit her down, take her blood pressure, pulse, ask my secretary to take her temperature if I needed one. Do an examination of the eyes, ear, nose and throat. Heart and lungs clear, everything, down to the feet and the back". Dr. Varona stated that he would "just look at her back and feel that and see how much pain she has". Dr. Varona further stated, in reference to examination of the patient's back, that his examination was fairly extensive and that "there were scars ... from operations usually indicative of laminectomy or spinal operation, and ... she was markedly tender on the back. Could hardly touch her back". (Tran. p.76, lines 17-25; 77, lines 8-20; 78, 82-83; 117-120, 130; 135-136).

Dr. Merry testified that an adequate history of Patient B would contain the same areas as that for Patient A. Dr. Merry stated that "The complaints of back pain are very similar, ... the adequate history and physical would include the same areas, which would include ... cursory examination of the head, eyes, ears, nose and throat, lungs, cardiac examination, abdominal examination, and examination of the back and lower extremities. Dr. Merry stated that because Dr. Varona's office notes for August 24, 1982, were very limited, he could not determine whether Dr. Varona took an adequate history of Patient B, and that his conclusion that Dr. Varona's medical history was minimally competent is based upon the assumption that he conducted a more complete medical history than what he documented. (Tran. p.392-393;395-396; 413-415; 491-496; 498-499; 518, 532-533).

In reference to previous medical records, Dr. Merry testified that it is not required under minimum standards to obtain old records on a patient who has had laminectomies. Dr. Merry further stated that "the past records would not be as likely to be as helpful, in that the surgical operation, description of the operation, is not very likely to be helpful for a primary care physician. What she needed more was further evaluation and possible alternative treatments. I don't believe that he thought that the old records would be of great value for her." Dr. Merry stated that Dr. Varona's notes for November 4, 1982, indicate that "he attempted to have her further evaluated. Again, she had indicated that she was going to a clinic in Indiana in November ...".(Tran. p.416-417; 497-498; 522-523).

Dr. Riesch testified, that Dr. Varona's physical examination of Patient B was above the minimum standards of care. Dr. Riesch stated, in reference to the physical examination done on a patient at the first office visit, that a medically competent doctor would examine the head, eyes, ears, nose throat, heart, lungs, breasts, abdomen, musculoskeletal, neurological. Dr. Riesch stated that the musculoskeletal examination is a visual examination and "that you would either stand the patient if they can stand, or have them sitting on an examining table. You examine the range of motion. You would check the reflexes. You probably would have them lie down, have them straight leg raise to see how far they can go. Check their hip rotation, abduction and adduction activity." (Tran. p.592-594; 603; 657-659; 719-720).

In reference to history, Dr. Riesch stated that "you have to separate what this patient is in for. If the patient is in for an office visitation, you will take a minimal history appropriate and adroitly concerned with their complaints. If the patient is coming in and is scheduled for and is looking for a complete history and physical examination, you begin to ... dig into depth in detail. This is not that type of visitation, as best I can ascertain from the interpretation. This is a patient who presented herself in the office looking for relief from pain, and stating the sources of her pain, and this is recorded. I think this is acceptable. I think this is within the realm of acceptance as far as practice levels are concerned". (Tran. p.594-595; 604; 659-660).

2) Failure to Evaluate Lab Data

A. Determination

The evidence presented does not establish that the respondent failed to evaluate laboratory data obtained for Patient B, in March, 1984, relating to a findings of anemia or hypothyroidism.

B. Analysis

Dr. Pagels' second criticism with regard to the care that Dr. Varona provided to Patient B is that Dr. Varona failed to evaluate lab data available to him (Tran. p.265).

Dr. Pagels stated that "the patient had lab ordered first in March of '84, by Dr. Varona's partner, Dr. Kraft, and this lab was not responded to by either physician. I would draw your attention to the fact that the note by Dr. Kraft was on the top of the page where he said he was ordering the lab, and Dr. Varona's note was also on the same page, so it would seem to be at least careless of Dr. Varona not to have been aware of this lab being ordered. And in any case, it was not responded to. And there were several abnormalities in that lab". (Tran. p.266).

Dr. Pagels stated, in reference to abnormalities noted in the lab report, that "the patient was found to be anemic. ... With a hemoglobin of 9.2 grams, an MCV of 121.8"; that "the patient was found to have a low T4, a low T3 resin uptake and a very low free T4, calculated", and that "also germane is the fact that the patient's iron study was normal, the patient's folate study was normal and the patient's vitamin B-12 level was normal". Dr. Pagels further stated that the thyroid function was clearly abnormal and indicated hypothyroidism. (Tran. p.266-267).

A) Findings Relating To Anemia

Dr. Pagels testified, in reference to the report which relates to the lab work ordered by Dr. Kraft, that "It doesn't really give me much information just looking at the blood counts, that is, the anemia data. If I just look at the RBC's, hemoglobin, hematocrit, MCV and MCH, it would appear that the patient probably has a megaloblastic anemia, meaning a B-12 or folate deficiency, except that when I look at the folate and B-12 levels, they're both normal, so that essentially rules those two things out. So you're left with sort of an unusual anemia. Dr. Pagels stated further that "Then if I look at the iron, I find out the iron studies are normal as well. And so it doesn't look like the patient's iron-deficient as well, so we need to look for other reasons. If I look at the thyroid function, which is clearly abnormal and clearly low, and indicates hypothyroidism, the anemia could in fact be related to the hypothyroidism. However, it could be related to other things and there's not enough information to discover that from the data that's here." (Tran. p. 266-267).

Dr. Pagels stated that given the data reported in the lab report, a minimally competent physician would have two choices, the physician could "elect to further evaluate this anemia himself or he might ask a hematologist to look at this patient, because this is really sort of an unusual anemia". Dr. Pagels testified Dr. Varona had identified that the patient was "pale" many times prior to the lab work, but he had not specifically mentioned anemia. Dr. Pagels stated that "pale patients often are anemic, and it's a soft sign". (Tran. p. 267,342).

Finally, Dr. Pagels stated, in reference to unacceptable risks, that "you can treat anemia before you know the cause in some cases; however, anemia is often a symptom of a significant underlying correctable disease, so to treat without knowing why the patient has anemia is very detrimental to the patient". Dr. Pagels testified that "giving narcotics to somebody that's anemic like this could exacerbate the inability to maintain balance, so that I think that the anemia in itself can be detrimental. If the patient has other underlying diseases like heart disease, an anemia of this degree could be detrimental to the patient as well". (Tran. p. 269-270).

Dr. Varona testified that he did not recall if he reviewed the lab report in March. 1984, relating to the lab work ordered by Dr. Kraft. Dr. Varona stated that based upon a review of the lab report the patient's hemoglobin was 9.2 grams and the hematocrit was 29, and that the readings indicated "definitely" that the patient was anemic. Dr. Varona testified that on April 6, 1984, in response to the lab report, he prescribed Feosol for the patient even thou the lab report indicated that her iron value was normal. (Tran. p.100-103; 192).

Dr. Varona further testified that he advised the patient to go to the hospital based upon her "pale and weak appearance". Dr. Varona stated that he ordered a complete blood count be done for the patient because he wanted to "see how far her anemia was", and that the test results indicated that "it went down from previous ones to 8.6 grams", which meant that she was getting more anemic. Dr. Varona stated that he sent the patient to the outpatient facility at St. Francis for two units of cell mass or blood transfusion to bring it up and make her feel ... better, feel stronger." (Tran. p. 158-159, 188). Dr. Varona stated that he ordered another blood count to "see how much anemia she has"; that the report, dated August 7, 1984, indicated that the hemoglobin was down to 8.5 grams and the hematocrit was 26.4; that the readings indicated that the patient was anemic, and that he prescribed iron pills in response to the report. (Tran. p.160-161; 188-191).

Dr. Merry testified that "anemia is documented by a hemoglobin, and the first hemoglobin that I can determine that has been drawn was by Dr. Kraft in March of 1984". Dr. Merry stated that Dr. Varona did document at the first office visit that Patient B was "pale", but that pale and anemia are not synonymous. Dr. Merry stated that if a patient is continually pale, a minimally competent physician should consider that the patient might be anemic and should conduct some sort of test to determine whether the patient is anemic. Dr. Merry stated that Patient B was anemic and that anemia could be a symptom associated with hypothyroidism. (Tran. p.503).

In reference to when Dr. Varona first conducted a test to determine whether Patient B was anemic, Dr. Merry testified that "He again had relied on his previous practice pattern that was to hospitalize patients that were not doing well. He had depended on the patient's word that she was going to a clinic in Terre Haute in ... October of 1982, and subsequently her word that she was going to the Mayo Clinic, and finally, eventually she did go to the Froedtert Hospital. This is how these things were generally done by Dr. Varona. The anemia was first documented by Dr. Kraft in ... March, 1984". Dr. Merry stated that a lab test done by Dr. Varona in June, 1984, also indicated that Patient B was anemic. (Tran. p.503-504).

In reference to treatment of Patient B for her anemia, Dr. Merry stated that apparently Dr. Varona prescribed iron, Vitamin B-12 and folic acid; that Patient B's iron levels were normal; that he did not think prescribing iron was the best treatment for her anemia, and that it was not below minimal standards of care for Dr. Varona to treat the patient with iron without making any effort to determine what was causing her anemia. Dr. Merry testified that Dr. Varona "attempted to treat it. He did not succeed in his treatment. But again, part of his practice pattern was to hospitalize patients, and such evaluations were carried out in the hospital. So his attempt to diagnose the cause for the anemia was thwarted because the patient did not allow for a hospitalization". (Tran. p.504-505).

Finally, Dr. Merry testified, in reference to Dr. Kraft's office note for March 28, 1984, which contained an order for a CBC, chem screen, folic acid level and B-12 level, that a minimally competent physician would have reviewed Dr. Kraft's office note and would have looked at the lab test results, if the lab results were in the chart and available to him. (Tran. p.511-515;519-520).

Dr. Riesch testified that the records for Patient B did show that she had anemia; that the anemia was found by Dr. Kraft; that Dr. Varona put the patient on an iron supplement and some Vitamin B, and that Dr. Varona's office note for 6/24/84 indicates that he offered the patient evaluation to try to identify the source of her anemia, and "again she said no, no, a thousand times, no". (Tran. p.616-621; 624-631). Dr. Riesch stated that Dr. Varona's handling of the patient's anemia problem was above minimum standards of care. Dr. Riesch stated that "I think his patience is to be applauded -- his patience in handling this patient. Repeatedly he's offered things to this patient. The patient has turned him down. This is a team, it's a team approach". (Tran. p. 631-632; 703-710; 715-716).

Dr. Herman stated that he did not have an opinion regarding Dr. Varona's treatment of Patient A for anemia. (Tran. 574).

B) Findings Relating to Hypothyroidism

Dr. Pagels testified, in reference to the results of lab work ordered by Dr. Kraft in March, 1984, that "If I look at the thyroid function, which is clearly abnormal and clearly low, and indicates hypothyroidism, the anemia could in fact be related to the hypothyroidism. Dr. Pagels stated that as far as he knew, based on the patient records, the hypothyroidism was never identified by Dr. Varona, and that it was below minimun standards of care for Dr. Varona to fail to identify it as a problem. (Tran. p. 265-267; 270-271).

Dr. Pagels stated that the patient "may have had" clinical symptoms of hypothyroidism; that she had fatigue and weakness, which could have been secondary to hypothyroidism; that Dr. Kraft's note states "chronic myalgia", which also could have been secondary to hypothyroidism. Dr. Pagels testified that he thought "fundamentally the history of fatigue that was not evaluated was what was below the minimum standards of care". Dr. Pagels stated that in his opinion, the patient's "fatigue was related to the narcotic", and that "it may have been made worse by some of the other things going on". (Tran. p.334; 344-345; 351-353).

Dr. Pagels further stated that the March, 1984, lab test results were not "absolutely 100 percent conclusive because there's one piece of data missing, which would be a thyroid stimulating hormone level. However, the interpretation that was in the deposition by Dr. Varona clearly was incorrect, because this patient in fact has a high thyroid binding globulin level, not a low thyroid binding globulin level. Therefore this is a very low thyroid function. And I think 99 times out of 100 this is going to indicate severe hypothyroidism." (Tran. p.271; 339-342; 344-345; 351-353).

Dr. Pagels further stated that if Dr. Varona knew the results of the March, 1984, lab test ordered by Dr. Kraft, and he did not make any sort of diagnosis regarding Patient B's problem with regard to hypothyroidism, his conduct was below minimum standards of care. Dr. Pagels stated that hypothyroidism should have been in Dr. Varona's differential diagnosis of fatigue, that Dr. Varona was aware of the patient's fatigue, and that chronic "fatigability" is a symptom of hypothyroidism (Tran. p.274-277; 344-345).

Finally, Dr. Pagels stated that if one assumes that the laboratory data from the March, 1984 lab results was not included in the records, then Dr. Varona should have been assessing the patient's "fatigability", and that would have included getting data and further assessing the patient. Dr. Pagels stated, in reference to unacceptable risks, that "hypothyroidism at this degree can cause death. It can cause psychosis. It causes weight gain, lethargy and eventually death. It's a serious disease. And also the treatment of it at this point is more difficult as well in that you have to be very careful how you start to replace the thyroid hormone". (Tran. p. 279, 340-341).

Dr. Varona testified that he did not recall if he reviewed the lab report in March, 1984, relating to the tests ordered by Dr. Kraft; that the lab results for Patient B indicated that she had hypothyroidism, and that there is no record that he pursued whether the patient had hypothyroidism in March or April of 1984. Dr. Varona stated that he saw that Dr. Kraft "ordered those tests"; that, in reference to his effort to determine what could be causing the patient's low thyroid level, he "must have tried", but he has no documentation that he did. Dr. Varona stated that based upon his clinical observation of the patient regarding the symptoms of hypothyroidism, the clinical findings would not support a finding of hypothyroidism. (Tran. p.103-106; 163-167, 192).

Dr. Varona further stated that the main treatment for hypothyroidism is to give thyroid supplements, and that the risks to a patient who has hypothyroidism that is not treated are "a slower heart rate. Inability to adjust to changes in temperature. Weight gain. Fluid imbalance. ... " (Tran. p.104-105).

Dr. Merry testified that the symptoms of hypothyroidism might include slow pulse, lethargy, being cold, slow thought sequence, constipation, hair changes, dry skin, and weight gain; that the patient chief complaint in this case appeared to be back pain, and evaluating the thyroid would not be an initial consideration for a patient presenting with back pain; that there is not specific symptoms in the patient's record that he was aware of with regard to hypothyroidism, other than possibly the patient's falls. Dr. Merry admitted during cross examination that the patient record documented that the patient complained of being weak and tired and that Dr. Kraft documented in the office notes for August, 1984, that the patient was lethargic. Dr. Merry further stated that if Dr. Varona had not seen the thyroid report of March, 1984, he would not have been acting below minimum standards of care by not treating the thyroid problem. (Tran. p.421-426; 500-503; 519-522).

Dr. Merry further stated that a minimally competent physician would have reviewed Dr. Kraft office note of March 28, 1984, which indicated that Dr. Kraft had ordered a CBC, chem screen, folic acid level and B-12 level, and which appears on the same page as one of Dr. Varona's office notes. Dr. Merry stated that if the lab report was in the chart or available to Dr. Varona his failure to take action based upon the lab test result which indicated that the patient had hypothyroidism was below minimum standards of care. (Tran. p. 507-515).

Dr. Riesch testified, in reference to March, 1984 lab report, that if Dr. Varona had seen the report and failed to treat the patient's hypothyroid condition, his conduct would have been below minimum standards. Dr. Riesch stated that the treatment of hypothyroidism is a matter of prescribing a pill and then monitoring the effectiveness of the pill. Dr. Riesch stated that he did not fault Dr. Varona for not ordering the tests, and that Dr. Varona was not acting below minimum standards of care by not having the patient's thyroid checked. (Tran. p.621-624; 707-708).

Dr. Herman testified that he did not have an opinion regarding Dr. Varona's treatment of Patient B for hypothyroidism (Tran. p.574).

According to the testimony of Drs. Pagels, Merry and Riesch, if Dr. Varona saw the lab report which contained the findings relating to Patient B's hypothyroid condition, his conduct would have been below minimum standards of care if he failed to take action based upon the report.

The evidence establishes that Dr. Kraft's March 28, 1984, office note for Patient B contained an order for lab work which included "CBC, Chem screen, folic acid level, B12 level"; that the test results were reported in a lab report dated March 31, 1984, and that the findings relating to anemia and hypothyroidism are contained in the same lab report. (Exs. #2, p.41-43; #2A).

It is not clear from the evidence whether Dr. Varona saw the March, 1984 lab report or, if he did see the report, when he actually saw the report. Dr. Varona testified that he did not recall if he reviewed the lab report in March, 1984, relating to the lab work ordered by Kraft; however, he also testified that he prescribed iron pills for the patient on April 6, 1984, in response to the report. (Tran. p.100, lines 1-13; p.102, lines 11-13).

3) Prescribing of Controlled Substances

A. Determination

The evidence presented does not establish that the respondent's conduct in prescribing Dilaudid to Patient B was other than in the course of legitimate professional practice.

B. Analysis

Dr. Pagels testified that in his opinion, Dr. Varona's prescribing of Dilaudid to Patient B was otherwise than in the course of legitimate professional practice. Dr. Pagels stated that "the use of Dilaudid without an appropriate evaluation may in fact mask other significant symptoms, which again may result in failure to diagnose correctable diseases, failure to treat appropriately, and again puts the patient at risk for injury secondary to the use of the narcotic. (Tran. p.279-280; 331-334; 350).

Dr. Varona testified that he prescribed Dilaudid and Doriden to Patient B from 1982 through 1985; that he prescribed Dilaudid and Doriden to Patient B approximately every ten days to two weeks from 1982 through 1985, and that the combined effect of Dilaudid and Doriden could be dangerous for the patient in that the patient could "become more dizzy, weak or lethargic. Coordination could be poor". Dr. Varona further stated that he prescribed Dilaudid for Patient B because she was already taking it and was addicted to it. Dr. Varona stated that "when your're already addicted, it's a difficult thing to wean them off. You have to put them in a pain clinic, rehabilitation center. And if you see Mrs. A... during that time she was pale, could hardly walk, and weak, and I know that she was addicted. She was dependent on Dilaudid for her to be able to survive or to survive the pain, and I don't see the reason why I should torture her to go through a pain clinic." (Tran. p.81-83; 84-91; 109-111, 150; 186-187).

Dr. Merry testified that Dr. Varona was not prescribing Dilaudid to Patient B in other than the course of legitimate professional practice. Dr. Merry stated that "Both of these patients have severe pain syndromes. They are difficult patients, difficult to evaluate. He was very dependent on the patients' statements. They are also -- have been patients that have previously been treated and evaluated, and that were resistant to additional treatment in the manner that Dr. Varona had usually followed. That is, they resisted hospitalization; they resisted referrals to other medical centers. And this is not an incompetent course that he treated these patients with, but they are difficult patients." (Tran. p.427; 478-483; 499-500).

Dr. Riesch testified that it was not below minimum standards for Dr. Varona to continue the patient on Dilaudid prior to confirming his diagnosis. Dr. Riesch stated that "in the scenario that's evolved, if you look at the time sequence, she kept putting him off, and even when we can see definitely recorded in the chart that she put him off for another 5 months before she ever did see the consultant that he requested her to see. So I think it's apparent by substantiation and documentation that this woman was putting him off." (Tran. p.611-615; 661,673).

Dr. Herman testified that in his opinion, Dr. Varona's prescribing of Dilaudid to Patient B was within the legitimate medical practice and indications. (Tran. p.552, 573-574; 577).

III. RECOMMENDATIONS

Based upon the evidence presented and the discussions herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin, this 19th day of March, 1991.

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	**AFFIDAVIT OF COSTS**
GUILLERMO VARONA, JR., M.D., RESPONDENT.	:	LS8903202MED

STATE OF WISCONSIN)
) ss.
COUNTY OF DANE)

Ruby Jefferson-Moore, being first duly sworn on oath deposes and states:

1. That affiant is an attorney licensed to practice law in the State of Wisconsin, and employed by the Wisconsin Department of Regulation and Licensing, Office of Board Legal Services to provide legal services.

2. That in the course of her employment, she was appointed administrative law judge in the above-captioned matter. That to the best of affiant's knowledge and belief the costs for services provided by affiant are as follows:

DATE	ACTIVITY	TIME
05/10/89	Review of file/prehearing conference	30 min.
01/05/90	Review of file/prehearing conference	30 min.
01/18/90	Preparation/motion hearing	30 min.
04/09/90	Preparation/hearing	2 hrs.
04/10/90	Preparation/conduct of hearing	9 hrs.
04/11/90	Preparation/conduct of hearing	7 1/2 hrs.
04/12/90	Preparation/conduct of hearing	6 hrs.
12/19/90	Review of record	4 hrs.
01/09/91	Review of record	4 hrs.
01/11/91	Review of record	4 hrs.
02/08/91	Review of record	4 hrs.
02/12/91	Review of record	4 hrs.
02/26/91	Draft/proposed decision	2 hrs.
02/28/91	Draft/proposed decision	4 hrs.
03/08/91	Draft/proposed decision	4 hrs.
03/13/91	Draft/proposed decision	5 hrs.
03/15/91	Draft/proposed decision	2 hrs.
03/19/91	Revisions/proposed decision	2 hrs.

Total costs for Administrative Law Judge: $1,235.00.

3. That upon information and belief the costs for court reporting services provided by Magne-Script are as follows: $2,894.20.

Total costs for Office of Board Legal Services: $4,129.20.

Ruby Jefferson-Moore
Ruby Jefferson-Moore

Sworn to and subscribed to before me
this 20th day of October, 1992.

Donald R. Rittel
Notary Public
My Commission: as Permanent

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST GUILLERMO VARONA, JR., M.D., RESPONDENT.	: : : : :	COMPLAINANT'S AFFIDAVIT OF COSTS

STATE OF WISCONSIN)
) ss
COUNTY OF DANE)

Judith Mills Ohm, being duly sworn on oath, deposes and states as follows:

1. Your affiant is an attorney licensed to practice law in the State of Wisconsin and is employed by the Wisconsin Department of Regulation and Licensing, Division of Enforcement.

2. In the course of those duties, your affiant was assigned as the prosecutor in the above-captioned matter.

3. Set out below are the costs for the proceeding for the Division of Enforcement in this matter:

PROSECUTING ATTORNEY EXPENSE

DATE	ACTIVITY	TIME SPENT
7/13/88	Reviewed file	4.5 hr.
7/14/88	Reviewed file; survey of discipline in similar cases	2.0 hr.
8/2/88	Reviewed file; telephone call to Board Advisor; memo	6.0 hr.
8/10/88	Worked on possible stipulation	3.0 hr.
8/25/88	Consulted with Board Advisor; telephone call to Thomas Meyers, M.D.	1.5 hr.
8/26/88	Memos regarding contacts with Board Advisor and Dr. Meyers	1.0 hr.
8/29/88	Reviewed medical records	5.0 hr.
8/30/88	Reviewed medical records	6.0 hr.
8/31/88	Reviewed file; meeting with Dr. Meyers	3.0 hr.
9/1/88	Call to Board Advisor; memo; memo regarding meeting with Dr. Meyers	3.0 hr.

DATE	ACTIVITY	TIME SPENT
9/2/88	Telephone calls to Respondent, Respondent's attorney and Dr. Meyers; memos	2.5 hr.
9/6/88	Letter to Respondent's attorney	1.0 hr.
9/26/88	Telephone calls to Dr. Meyer and Board Advisor; memos	2.0 hr.
10/6/88	Meeting with Board Advisor	1.0 hr.
10/11/88	Reviewed medical records; retained expert witness, George Pagels, M.D.	3.0 hr.
10/14/88	Letter to Respondent's attorney; letter to Dr. Pagels	3.0 hr.
10/19/88	Materials prepared and sent to Dr. Pagels	0.5 hr.
10/20/88	Letter sent to Respondent's attorney	0.25 hr.
11/29/88	Telephone call with Dr. Pagels; memo	0.5 hr.
12/1/88	Letter to Dr. Pagels dictated	0.5 hr.
12/2/88	Letter to Dr. Pagels proofed and revised	0.25 hr.
12/16/88	Preparation for meeting with Dr. Pagels	1.0 hr.
12/19/88	Preparation for meeting with Dr. Pagels	1.0 hr.
12/20/88	Meeting with Dr. Pagels (including travel to and from Marshfield)	8.0 hr.
1/4/89	Memo regarding meeting with Dr. Pagels	3.5 hr.
1/31/89	Worked on Disciplinary Complaint	1.0 hr.
2/1/89	Worked on Disciplinary Complaint	1.0 hr.
2/2/89	Worked on Disciplinary Complaint; called Dr. Pagels	3.5 hr.
2/3/89	Worked on Disciplinary Complaint; memo regarding telephone call to Dr. Pagels; letter to Dr. Pagels	3.5 hr.
2/9/89	Proofed and revised Disciplinary Complaint; mailed letter and Complaint to Dr. Pagels	0.5 hr.

DATE	ACTIVITY	TIME SPENT
2/16/89	Telephone call from Dr. Pagels	0.25 hr.
2/17/89	Revised Disciplinary Complaint; memo regarding telephone call from Dr. Pagels; letter to Board Advisor	4.5 hr.
2/21/89	Disciplinary Complaint filed with Medical Examining Board	0.25 hr.
3/1/89	Notice of Hearing and Orders dictated	0.5 hr.
3/10/89	Notice of Hearing and Orders submitted for filing	0.25 hr.
4/24/89	Letter to Respondent's attorney dictated; pre-hearing conference scheduled	0.5 hr.
5/10/89	Pre-hearing conference held (including preparation); letter to Hearing Examiner dictated	1.0 hr.
5/15/89	Preparation for Respondent's deposition	3.0 hr.
5/16/89	Preparation for Respondent's deposition	4.5 hr.
5/17/89	Deposition of Respondent (including preparation and travel to and from Milwaukee)	8.0 hr.
10/2/89	Read transcript of Respondent's deposition	1.5 hr.
10/10/89	Drafted Identification of Patients; drafted Limited Stipulation; drafted letters to Respondent's attorney and Hearing Examiner	3.0 hr.
10/30/89	Reviewed letter from Dr. Varona (with attachments)	0.5 hr.
11/6/89	Telephone call to Respondent's attorney; memo	0.75 hr.
11/7/89	Prepared summary of Respondent's deposition transcript; conducted research regarding Requests for Admissions and Production of Documents; drafted letter to Dr. Pagels regarding Respondent's deposition	4.0 hr.
11/8/89	Drafted Request for Admissions, Request for Production of Documents, Interrogatories, Stipulation for Production of Documents and letter to Respondent's attorney	4.0 hr.

DATE	ACTIVITY	TIME SPENT
11/13/89	Drafted Amended Complaint and letters to Respondent's attorney and Medical Examining Board	1.5 hr.
11/21/89	Telephone call from Dr. Pagels; memo	1.0 hr.
11/22/89	Prepared final witness list	0.5 hr.
11/27/89	Telephone call to Board Advisor; memo; hearing preparation regarding which witnesses to call to testify	2.0 hr.
11/29/89	Letter to Respondent dictated	0.75 hr.
12/4/89	Amended Final Witness List prepared; letter to Hearing Examiner	0.75 hr.
12/12/89	Telephone call from new attorney for Respondent; memo	0.75 hr.
12/21/89	Drafted Motion to Compel Production of Documents, Motion to Preclude certain testimony, Motion to Admit and accompanying Affidavits	3.5 hr.
12/27/89	Revised Motions, drafted letter	1.5 hr.
12/28/89	Telephone call from Respondent's attorney; memo; Amended Complaint to Hearing Examiner	0.75 hr.
1/2/90	Call to Dr. Pagels and Respondent's attorney; memos	1.0 hr.
1/4/90	Telephone calls to Respondent's attorney and Dr. Pagels regarding scheduling of depositions; memos	0.5 hr.
1/5/90	Pre-hearing Conference Call to set up Motion Hearing on Complainant's Motions (Respondent's oral Motion to Adjourn Hearing granted); memo	1.0 hr.
1/9/90	Telephone call to Dr. Pagels regarding adjournment of hearing; memo	0.5 hr.
1/16/90	Telephone call to Respondent's attorney; memo	0.5 hr.
1/17/90	Telephone call to Dr. Pagels regarding his deposition; memo	0.5 hr.

DATE	ACTIVITY	TIME SPENT
1/18/90	Motion hearing held (including preparation); letter to Dr. Pagels	0.75 hr.
2/5/90	Call to Dr. Pagels regarding preparation for his deposition	1.5 hr.
2/6/90	Telephone call from Respondent's attorney regarding Dr. Pagels' deposition being postponed; call to Dr. Pagels	0.75 hr.
2/12/90	Letter to Respondent's attorney	0.75 hr.
2/27/90	Telephone call from Respondent's attorney; telephone call to Dr. Pagels; memos	0.75 hr.
3/7/90	Telephone calls regarding deposition of Dr. Pagels; memo	0.5 hr.
3/8/90	Telephone call to Dr. Pagels regarding preparation for his deposition	2.0 hr.
3/9/90	Deposition of Dr. Pagels (including preparation & travel to and from Marshfield)	8.0 hr.
3/12/90	Dictated Notice of Depositions and letter to Respondent's attorney	0.75 hr.
3/14/90	Preparation for deposition of Arveno Antonini	3.0 hr.
3/15/90	Conducted deposition of Arveno Antonini (including preparation & travel to and from Milwaukee)	5.0 hr.
3/16/90	Telephone call to Respondent's attorney; memo	0.25 hr.
3/19/90	Prepared Notice of Deposition for Dr. Herman	0.25 hr.
3/21/90	Preparation for deposition of Dr. Merry	4.0 hr.
3/22/90	Conducted deposition of Dr. Merry (including preparation & travel to and from Menomonee Falls)	7.0 hr.
3/23/90	Preparation for deposition of Dr. Herman	2.0 hr.
3/26/90	Conducted deposition of Dr. Herman (including preparation & travel to and from Waukesha)	8.0 hr.
3/27/90	Dictated letter to Dr. Pagels; materials organized and sent to Dr. Pagels	1.0 hr.

DATE	ACTIVITY	TIME SPENT
3/29/90	Conducted deposition of Dr. Riesch (including preparation & travel to and from Menomonee Falls)	13.0 hr.
3/30/90	Dictated summaries of deposition transcripts; telephone call to Dr. Pagels	3.0 hr.
4/2/90	Dictated summaries of deposition transcripts of Arveno Antonini and Dr. Pagels	4.0 hr.
4/3/90	Dictated summary of deposition transcript of Dr. Merry; prepared letter to Dr. Pagels	5.0 hr.
4/5/90	Reviewed deposition transcripts of Dr. Riesch and Dr. Herman	4.0 hr.
4/7/90	Hearing preparation (regarding direct examination of Dr. Pagels)	4.0 hr.
4/8/90	Hearing preparation (regarding direct examination of Dr. Pagels)	8.0 hr.
4/9/90	Hearing preparation (regarding adverse examination of Respondent, cross-examination of Dr. Merry, use of Dr. Herman's deposition testimony as part of the State's case, complainant's opening statement)	16.0 hr.
4/10/90	Hearing held (including preparation for 2nd day of hearing)	15.0 hr.
4/11/90	Hearing held (including preparation for 3rd day of hearing)	14.0 hr.
4/12/90	Hearing held	8.0 hr.
5/21/90	Revisions to Respondent's summaries of office records	4.0 hr.
5/22/90	Revisions to Respondent's summaries of office records; letter to Respondent's attorney	4.0 hr.
3/21/91	Reviewed Proposed Decision	1.5 hr.
3/23/91	Reviewed Hearing Transcript	7.5 hr.
3/24/91	Reviewed Hearing Transcript	6.5 hr.
3/25/91	Worked on Objections to Proposed Decision	9.0 hr.

DATE	ACTIVITY	TIME SPENT
3/26/91	Worked on Objections to Proposed Decision	4.0 hr.
3/27/91	Worked on Objections to Proposed Decision and supporting Brief	10.0 hr.
3/28/91	Worked on Objections to Proposed Decision and supporting Brief	11.5 hr.
3/29/91	Proofed and revised Objections and Brief	3.5 hr.
4/15/91	Reviewed Respondent's Response to my Objections	0.75 hr.
4/17/91	Preparation for Oral Arguments on Proposed Decision	1.0 hr.
4/18/91	Oral Arguments regarding Proposed Decision and Objections	0.75 hr.
5/2/91	Conducted research regarding Motion for Reconsideration	3.5 hr.
5/3/91	Drafted motion for Reconsideration, supporting Affidavits and letter; proofed and revised Motion for Reconsideration and Affidavits	5.5 hr.
5/6/91	Drafted Brief in Support of Motion for Reconsideration	6.0 hr.
5/7/91	Finished drafting and dictated Brief	3.5 hr.
5/8/91	Proofed and revised Brief, filed and mailed Brief	2.0 hr.
5/21/91	Preparation for Oral Arguments on Motion for Reconsideration	1.0 hr.
5/22/91	Oral Arguments on Motion for Reconsideration (including preparation)	3.0 hr.
6/14/91	Reviewed Final Decision and Order	0.75 hr.
7/10/91	Reviewed Respondent's Petition for Rehearing; conducted research regarding Reply to Petition	4.5 hr.
7/11/91	Began drafting Reply to Petition for Rehearing; drafted Motion for Costs and letter to Board	4.0 hr.

DATE	ACTIVITY	TIME SPENT
7/12/91	Finished drafting Reply to Petition for Rehearing	6.0 hr.
7/15/91	Proofed and revised Reply to Petition for Rehearing	1.5 hr.
TOTAL HOURS:		371.50 hr.

Total prosecuting attorney expense for 371.50 hours at $25.00 per hour, salary and benefits:

$9287.50

EXPERT WITNESS FEES

1. George A. Pagels, M.D.
(36.80 hours at $75.00 per hour) $2760.00

COSTS OF DEPOSITIONS

1. Depositions taken by Complainant (original and one copy):

   a. Deposition of Dr. Guillermo Varona, Jr. (5/17/89) $ 257.10

   b. Deposition of Arveno Antonini (3/15/90) $ 130.30

   c. Deposition of Dr. Steven Merry (3/22/90) $ 311.35

   d. Deposition of Dr. Lavern H. Herman (3/26/90) $ 206.80

   e. Deposition of Dr. John Riesch (3/29/90) $ 426.70

2. Deposition taken by Respondent:

   a. Deposition of Dr. George Pagels (3/9/90) $ 62.20

TOTAL DEPOSITION COSTS: $1394.45

MISCELLANEOUS DISBURSEMENTS

1. Certified copy of medical records, St. Anthony Hospital, Milwaukee $ 5.00

2. Certified copy of medical records, Health Information Management Services, Inc., DePere $ 65.80

3. Certified copy of medical records, Health Information Management Services, Inc., DePere $ 9.70

4.	Certified copy of medical records, Health Information Management Services, Inc., DePere	$ 9.30
5.	Copies of medical records, Neurological Associates of Waukesha, Ltd.	$ 15.00
6.	Certified copy of court documents regarding Clifford N. Lerand v. Dr. John D. Riesch and Medical Associates, from Washington County Court	$ 13.75
7.	Certified copy of court documents regarding Dr. John D. Riesch from Milwaukee County Circuit Court	$ 10.00
8.	Federal Express mail to Dr. Pagels (4/5/90)	$ 24.25

TOTAL MISCELLANEOUS COSTS: $ 152.80

TOTAL ASSESSABLE COSTS FOR DIVISION OF ENFORCEMENT: $13,594.75

Judith Mills Ohm

Judith Mills Ohm
Attorney for Complainant
Division of Enforcement

Subscribed and sworn to before me this
21ST day of August, 1991.

Steven M. Joe

Notary Public
State of Wisconsin
My Commission is permanent.

JMO:pp
ATTY-1718

State of Wisconsin \ DEPARTMENT OF REGULATION & LICENSING

Tommy G. Thompson
Governor

Marlene A. Cummin
Secretai

1400 E WASHINGTON AVENU
P.O. Box 89
MADISON, WISCONSIN 537
608 266-21

August 21, 1991

George Arndt, M.D.
Chair, Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

RE: Disciplinary Proceedings Against Guillermo Varona, Jr., M.D.

Dear Dr. Arndt and Members of the Medical Examining Board:

On August 2, 1991, the Medical Examining Board granted Complainant's Motion for Costs in the above-referenced matter and entered an Order assessing the costs of the proceeding against Dr. Varona. The Order requested the Administrative Law Judge and the Division of Enforcement to submit their Affidavits of Costs to the Board office within 20 days of the date of the Order. Enclosed is Complainant's Affidavit of Costs of the Division of Enforcement.

I note that the Order Granting Motion for Costs did not specify the date by which Dr. Varona must pay the costs of the proceeding to the Department of Regulation and Licensing. Therefore, once the Board office receives both Affidavits of Costs, I would suggest that the Board office notify Dr. Varona of the total amount of costs assessed against him and require him to pay that amount to the Department of Regulation and Licensing by no later than 30 days after the date of the letter of notification.

Very truly yours,

Judith Mills Ohm

Judith Mills Ohm
Attorney for Complainant
Division of Enforcement
(608) 266-2881

JMO:pp
T-28075

Enclosures

cc: Steven R. Kohn
Polland, Kohn and Knutson
Attorneys for Dr. Varona
1110 Old World Third Street, Suite 620
Milwaukee, WI 53203