FILE COPY

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY
7ROCEEDINGS AGAINST

BERNHARD I. SCHUMACHER, M.D., :
RESPONDENT.

FINAL DECISION
AND ORDER
LS9005253MED

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

ORDER

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

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

Dated this 25th day of August, 1991.

Michael P. Mehm MD

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	PROPOSED DECISION
BERNHARD J. SCHUMACHER, M.D., RESPONDENT.	:	Case No. LS9005253MED

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

Bernhard J. Schumacher, M.D.
915 East Summit Avenue
Oconomowoc, WI 53066

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

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
Madison, WI 53708

A hearing was held in the above-captioned matter on April 17-18, 1991. The respondent, Dr. Bernhard J. Schumacher, appeared personally and by his attorney, Michael P. Malone, KLUWIN, DUNPHY, HINSHAW, CULBERTSON, Attorneys at Law, Suite 500, 788 North Jefferson Street, Milwaukee, Wisconsin 53202. The complainant appeared by Attorney Judith Mills Ohm, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8935. Subsequent to the evidentiary hearing, a transcript of the proceedings was prepared, which was received on May 7, 1991.

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. Bernhard J. Schumacher, M.D., respondent herein, date of birth September 15, 1926, is a physician licensed and registered to practice medicine and surgery in the State of Wisconsin pursuant to license #12234, which was granted on August 10, 1955.

2. Respondent specializes in internal medicine. His practice includes treating patients for cardiac problems. Respondent has practiced at the Wilkerson Clinic in Oconomowoc, Wisconsin since 1958.

3. On March 5, 1977, Patient A presented at respondent's office for a physical examination. Respondent's office record for March 5, 1977 indicates that Patient A was a 50 year-old male, weighed 237 1/2 pounds, was 6'1" tall and had a blood pressure of 132/90, with a repeat blood pressure of 144/104 (x2). The record also indicates Patient A had gained weight after quitting smoking in January, 1977 and that he admitted having exertional shortness of breath. Respondent ordered an electrocardiogram (EKG), a chest x-ray and a stress test for Patient A. Respondent's office record for March 11, 1977, indicates that he and Patient A discussed weight reduction (most important), the stress test (arrhythmias) and a colon x-ray.

4. Patient A's next visit to respondent's office was on April 15, 1980. At that time, Patient A's weight was 234 1/2 pounds and his height was recorded a 6'2". His blood pressure was elevated [recorded as 170/112, 172/110 (standing), 164/100 (right) and 164/104 (left)]. Respondent told Patient A to return for a blood pressure check in two weeks and gave Patient A an informational pamphlet on high blood pressure. On April 29, 1980, Patient A's blood pressure was recorded as 164/110, and 140/100 (right) and 146/100 (left). Respondent prescribed chlorthalidone #50 for Patient A's high blood pressure and told him to return in six weeks.

5. Patient A reported to Respondent's office for blood pressure checks on June 10, 1980 (160/98 x2, 152/92 and 140/98; weight 243 pounds) and July 22, 1980 (148/90 and 140/90; weight 240 1/2 pounds). On July 23, 1980, respondent noted that Patient A's serum potassium level was 3.1 which is abnormally low. Respondent instructed Patient A to use up the remaining chlorthalidone and then begin using dyazide, one tablet daily. The change from chlorthalidone to dyazide was due to the fact that the former has a greater tendency to cause low serum potassium levels than the latter.

6. On September 4, 1980, respondent prescribed 100 dyazide for Patient A (six months). Respondent's office records for February 10, 1981, indicate that the dyazide prescription was refilled.

7. Respondent next saw Patient A on June 2, 1981. Patient A weighed 250 pounds and his blood pressure was recorded as 148/90 and 142/94. Respondent ordered that the dyazide be increased to two tablets per day and that Patient A return for a blood pressure check in one month. On June 30, 1981, Patient A's blood pressure was 140/94 and his weight was 249 1/2 pounds. Respondent told Patient A to continue the dyazide, two tablets daily and to return in six months.

8. On July 24, 1981, Patient A presented at the clinic and reported that he had felt light-headed while urinating and had passed out that morning. Patient A was examined by another doctor in the clinic because respondent was not there that day. A serum potassium test indicated that Patient A's level was 4.5, which is normal.

9. Respondent examined Patient A on July 27, 1981. At that office visit, respondent became aware of the syncopal episode from three days earlier. Patient A told respondent he had a similar syncopal event while voiding 20 years ago and that it was diagnosed at that time as "micturition syncope", which means fainting while urinating. Respondent told Patient A to return in three months for a complete blood count and sedimentation rate.

10. On October 27, 1981, Patient A presented at respondent's office and reported having dull pain in his left shoulder and chest, which was intermittent and not related to activity. Patient blamed the pain on poor posture while driving an automobile. Respondent's examination of Patient A's heart, lungs and shoulder was negative. Respondent's record also reveals that a shoulder x-ray was reviewed, which was negative. Patient A was advised to use heat and aspirin.

11. Respondent's office record for February 6, 1982, indicates that the dyazide prescription was refilled.

12. On February 16, 1982, Patient A reported that he had felt light-headed and passed out in the shower that morning, similar to the episode in July, 1981 except that it had not occurred while urinating. Respondent noted that this was Patient A's second episode of syncope, that there was no warning except for the light-headedness and that the episode lasted one minute, with no chest pain or palpitation. Patient A's weight was 251 pounds and his blood pressure was 152/94 and 164/110 (standing). Respondent ordered a complete blood count, sedimentation rate, SMA-12, potassium test and EKG, and scheduled an electroencephalogram.

13. On February 20, 1982, Patient A's wife called respondent's office to report that Patient A was light-headed that morning. Respondent discussed with Patient A by telephone that all of the lab reports were normal and that "some people have their blood vessels checked". Respondent recommended that Patient A have a stress test done.

14. On March 8, 1982, Patient A underwent a stress test at Oconomowoc Memorial Hospital. Respondent discussed the stress test results, which were positive, with Patient A at an office visit on March 10, 1982. At that time, Patient A's weight was 254 1/2 pounds and his blood pressure was 156/90 (right) and 144/84 (left). Respondent continued to treat Patient A's high blood pressure with dyazide. Patient A admitted being in poor physical condition. Respondent recommended an exercise program and weight reduction plan (1500-calorie diet) for Patient A. Respondent directed Patient A to return in one month for a blood pressure and weight check.

15. A CAT scan was performed on Patient A on March 22, 1982, the results of which were negative.

16. Patient A presented at respondent's office to have his weight and blood pressure checked on March 31, 1982 (weight 238 1/2, blood pressure 146/90), April 28, 1982 (weight 231 1/2, blood pressure 134/86), and June 9,

1982 (weight 222 1/2, blood pressure 134/80 and 124/80). On June 9, 1982, respondent noted that Patient A was "feeling great" and respondent decreased Patient A's dosage of dyazide from two tablets daily to one tablet daily.

17. On July 2, 1982, Patient A was admitted to Riverview Hospital in Wisconsin Rapids after collapsing while taking a shower at a local hotel where he was staying while on a business trip. Patient A had been found by a co-worker, who initiated cardiopulmonary resuscitation (CPR) and called an Emergency Squad. Patient A was admitted to the Emergency Room in fine ventricular fibrillation. After approximately twenty minutes of CPR, Patient A developed a rhythm adequate to maintain blood pressure. Patient A responded to DC counter shock only after he was given a dose of 5 mg per kilogram of bretylium. Patient A was intubated and transferred to the coronary care unit. At the time of the transfer, Patient A was deeply comatose and required assisted ventilation. Electrocardiograms taken subsequent to Patient A's admission revealed only minor ST depression and no changes suggestive of myocardial infarction. Patient A became responsive after about 24 hours and was markedly confused for the next one to two days, but made steady progress in his degree of mental alertness and awareness. Because of Patient A's previous history of syncopal episodes and the episode of ventricular fibrillation without clear evidence of acute myocardial infarction, he was placed on procainamide 250 mg, every six hours on July 7, 1982, to control Patient's arrhythmia. Patient A was discharged on that dosage of procainamide on July 14, 1982. The discharge summary states that Patient A was to be followed on an out-patient basis by his regular physician, the respondent, who would determine the necessity of further evaluation of Patient A's apparent ventricular irritability.

18. On July 19, 1982, Patient A presented at respondent's office. Patient A's weight was 208 1/4 pounds and his blood pressure was 118/80. Respondent's office record indicates that the visit was a "follow-up after stay in Riverview Hospital". Respondent reviewed the discharge summary from that hospitalization and noted as follows: "syncope due to ventricular fibrillation. Arrest with central nervous system changes". Respondent examined Patient A, noted he was stable and with improving cerebration, continued Patient A on procainamide every six hours and ordered an EKG.

19. Respondent's office record for July 22, 1982, indicates that the procainamide prescription was refilled, 500 mg, one tablet every six hours, #200 x 6 months.

20. On August 2, 1982, Patient A presented at respondent's office. Patient A's weight was 209 1/2 pounds and his blood pressure was 114/66. Patient A asked respondent whether he could return to work. Respondent noted that "patient tends to be passive". Respondent advised Patient A that he could work at his desk beginning August 15, 1982. Respondent told Patient A to return in three or four weeks and continue with procainamide every six hours.

21. On September 2, 1982, Patient A presented at respondent's office for a follow-up exam. His weight had increased to 220 pounds and his blood pressure was 140/88. The examination was negative and respondent noted that Patient A was "comfortable" and "walking". Respondent told Patient A to continue with his prescription.

22. On September 28, 1982, Patient A presented at respondent's office complaining of several weeks of stiffness, aching and edema in his fingers, wrists and shoulders. Patient A reported he was active in bowling, but was "unable to throw ball" and reported no chest pain or dyspnea with bowling. Respondent examined Patient A's heart and noted a regular rhythm with no ectopics and no S3 or S4. Respondent ordered an ANA, which was positive at a titer of 1:640.

23. On October 5, 1982, respondent called Patient A by telephone and told him to discontinue the procainamide. Respondent instead prescribed norpace, 150 mg every eight hours, #150, refillable for six months. Respondent instructed Patient A to call if he had any irregularity of pulse or light-headedness.

24. On November 3, 1982, Patient A was admitted to Community Memorial Hospital in Menomonee Falls. Patient A had been driving an automobile on the highway when he suddenly collapsed at the wheel. The passenger was able to maneuver the car to the roadside but did not know how to administer CPR. An ambulance arrived after about 10-15 minutes and CPR was administered while Patient A was transported to the hospital. Patient A was admitted to the hospital room in ventricular tachycardia, which developed into ventricular fibrillation, leading to cerebral hypoxia. Patient A was resuscitated with cardioversion but was comatose and decerebrate. Despite good blood pressure and pulse, Patient A did not show evidence of neurological recovery. Patient A was treated with nasogastric feedings and maintained with a respirator. He was eventually weaned from the respirator and given supportive care. He developed difficulty with respiratory secretions and a fever despite broad spectrum antibiotic coverage. On December 12, 1982, Patient A had a respiratory arrest and died.

CONCLUSIONS OF LAW

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

2. It has not been clearly and convincingly established that the failure of respondent to test the patient's serum potassium level during the time he was prescribing dyazide, despite the patient's low potassium level on July 23, 1980, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

3. It has not been clearly and convincingly established that the failure to place a Holter monitor on the patient in late February 1982, despite his having fainted after feeling light-headed on July 24, 1981 and February 16, 1982; and having felt light-headed on February 20, 1982, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

4. The failure to refer the patient to a cardiologist or to place a Holter monitor on the patient after the patient's positive stress test on March 8, 1982, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

5. The recommendation that the patient begin an exercise program, despite the patient's positive stress test on March 8, 1982, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

6. The failure to refer the patient to a cardiologist for evaluation after the patient's cardiac arrest and hospitalization from July 2-14, 1982, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

7. The failure to place a Holter monitor on the patient in late July 1982 in order to determine whether procainamide was an appropriate treatment for patient's cardiac problems, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

8. The failure to determine whether the change in medication from procainamide to norpace in October 1982 was appropriate treatment for the patient's cardiac problems by failing to place a Holter monitor on the patient, or otherwise monitor him, demonstrated unprofessional conduct by tending to constitute a danger to the health, welfare and safety of the patient or public within the meaning of Wis. Stats. sec. 448.02(3), and Wis. Adm. Code sec. Med 10.02(2)(h).

ORDER

NOW, THEREFORE, IT IS ORDERED that Bernhard J. Schumacher, M.D., shall be, and hereby is, reprimanded.

FURTHERMORE, IT IS ORDERED that Bernhard J. Schumacher, M.D., shall pay the assessable costs of this proceeding, pursuant to Wis. Stats. sec. 440.22.

OPINION

The Findings of Fact in this case are primarily derived from the allegations contained within the Complaint, as admitted in respondent's Answer. The issue, stated in legal terms, is whether or not those facts clearly and convincingly establish that respondent engaged in unprofessional conduct through his care and treatment of Patient A by exposing him to unacceptable risks to his health, safety or welfare which a minimally competent physician would have avoided. See, Gilbert v. Medical Examining Board, 119 Wis. 2d 168 (1984).

The Complaint lays out the specific course of respondent's regular treatment over the two-plus years prior to Patient A's death, and points out the various times during that treatment in which it is alleged that a minimally competent physician would have taken additional action in order to avoid unacceptable risks to the health of the patient. Complainant contends that respondent missed several warning signals regarding the possibly of heart disease which a minimally competent physician would not have. It is argued that a minimally competent physician would have recognized the need for a cardiac evaluation early in the patient's treatment given the number of risk factors and symptoms suggestive of a diagnosis of cardiac disease.

Respondent argues that the evolutionary course of the patient's treatment was not such as to alert him to the patient's serious heart condition, although he admits to an "error in judgment" in failing to refer Patient A to a cardiologist after the patient's cardiac arrest in July 1982. However, he contends that that singular misjudgment was not so egregious as to warrant a finding that he is not minimally competent to practice medicine.

More specifically, the Complaint charges that the following acts of respondent, set forth in chronological order, led to the creation of unacceptable risks for the patient:

1. The failure to adequately monitor the patient's serum potassium level during the time respondent was prescribing dyazide, despite the patient's low serum potassium level (3.1) on July 23, 1980.

2. The failure to place a Holter monitor on the patient in late 1982, despite his having fainted after feeling light-headed on July 24, 1981 and February 16, 1982; and having felt light-headed on February 20, 1982; and despite the presence of other symptoms and risk factors suggesting the patient had heart disease.

3. The failure to place a Holter monitor on the patient or refer the patient to a cardiologist, despite the patient's positive stress test on March 8, 1982 and the presence of other symptoms and risk factors suggesting the patient had heart disease.

4. The recommendation that the patient begin an exercise program, despite the patient's positive stress test on March 8, 1982 and the presence of other symptoms and risk factors suggesting the patient had heart disease.

5. The failure to refer the patient to a cardiologist for evaluation in late July 1982, despite the patient's cardiac arrest and hospitalization from July 2-14, 1982.

6. The failure to place a Holter monitor on the patient in late July 1982 in order to determine whether procainamide was an appropriate treatment for the patient's cardiac problems.

7. The failure to determine whether the change in medication from procainamide to norpace in October 1982 was appropriate treatment for the patient's cardiac problems by failing to place a Holter monitor on the patient, or otherwise monitor him.

In establishing its case, the complainant is not required to submit "continued or repeated acts" by respondent in order to prove a violation of Wis. Adm. Code sec. Med 10.02(2)(h). Cf., Vivian v. Examining Board of Architects, 61 Wis. 2d 627, 635 (1974). Rather, the question is whether or not respondent engaged in conduct constituting a danger to the health, welfare, or safety of the patient, as those terms are used within the rule and as interpreted in Gilbert, supra.

In my opinion, the complainant has clearly and convincingly established that a minimally competent physician would have realized that Patient A suffered from a cardiac condition necessitating either referral to a cardiologist or the use of a Holter monitor after the patient's abnormal stress test on March 8, 1982. Furthermore, such a physician would have made such a referral after the patient's serious cardiac incident on July 2, 1982 or, when he did not refer, at least have monitored the patient to assure that the anti-arrhythmia medications were satisfactorily controlling the patient's irregular heart beat. Respondent's failure to take these steps resulted in the unacceptable risk to Patient A that his condition would remain undiagnosed, thereby causing grave danger to his health and safety.

HISTORY

On March 5, 1977, Patient A visited respondent for an examination. His history indicated that he was 50 years old, 6'1" tall, and weighed 237 1/2 pounds. Patient A informed respondent that he had experienced shortness of breath while engaged in physical activity and that he had just quit smoking in January. His blood pressure was measured at 132/90, repeated at 144/104 (x2). Respondent ordered an EKG, chest x-ray and stress test. It appears that the results of these tests were normal, and that respondent primarily informed Patient A of his need to lose weight during the follow-up office visit on March 11, 1977.

Respondent next saw Patient A three years later on April 15, 1980. The office records indicated an elevated blood pressure. Respondent told Patient A to return in two weeks, which he did on April 29. Patient A's blood pressure remained high, measuring 164/110, and 140/100 right and 146/100 left. At that time respondent prescribed chlorthalidone #50 and told Patient A to return at six weeks intervals, which he did on June 10 and July 22, 1980.

MONITORING SERUM POTASSIUM

On July 23, 1980, respondent found Patient A's serum potassium level to be 3.1, which is abnormally low. Given that chlorthalidone, which is a diuretic, has a high propensity to cause a loss of potassium, respondent switched Patient A to dyazide which tends to spare potassium.

Complainant contends that respondent failed to adequately monitor Patient A's serum potassium level during the time he was taking dyazide, which was up until July 2, 1982. The record indicates that this test was performed on the following dates:

1. On July 24, 1981, by another physician in the clinic when Patient A came in after having fainted while urinating that morning. The level was found to be 4.5, normal.

2. On February 16, 1982, ordered by respondent after Patient A had fainted in the shower that morning. Respondent indicated the level was normal.

Complainant's expert, Dr. Hisgen, testified that the switch in July, 1980 from chlorthalidone to dyazide was appropriate, since the latter tends to spare potassium. However, he stated that a minimally competent physician would check to assure themselves that the potassium level had stabilized at an acceptable level after the change in medication. Although conceding that in a healthy individual no significant risks are posed by failing to regularly monitor potassium levels--since symptoms such as dizziness or fatigue will sufficiently tend to alert the physician of the problem--Dr. Hisgen stated low potassium can aggravate and produce arrhythmias (irregular heart beat) in individuals with cardiac problems, thus posing a significant health risk to those patients. (Trans., pp. 210-211). Dr. Hisgen indicated level tests should be taken within a month after the change and at least yearly thereafter. (Trans., pp. 208-209, 233).

Respondent's expert, Dr. Charles Junkerman, testified that Patient A's condition did not become "suggestive" of coronary disease until at least the time of his abnormal stress test on March 8, 1982. (Trans., p. 321). Accordingly, during the time in which Patient A was on dyazide there was insufficient indication to alert a minimally competent physician that Patient A was suffering from a possible heart condition. Although it is clear that patients with a suspected or known heart condition must be closely monitored for their potassium levels, especially those taking digitalis, Patient A was not such an individual at the time in question. (Trans., p. 372-375).

Additionally, in this case, Patient A's potassium level was checked on July 24, 1981 by a colleague of respondent's and found to be at a normal level of 4.5, and again found to be normal by respondent pursuant to a test on February 16. 1982.

In my opinion, the failure of respondent to formally check the patient's potassium level on a more frequent basis during the time he was taking dyazide has not been adequately established to constitute a failure to meet minimum standards of conduct in the profession under the circumstances presented.

HOLTER MONITOR IN LATE FEBRUARY 1982 AFTER FAINTING

On July 24, 1981, Patient A fainted while urinating. This was referred to as a "micturition syncope", or fainting due to straining while urinating. However, on February 16, 1982, Patient A again fainted, this time the incident occurred while he was taking a shower. Noting this second incident, which was not reported to have been accompanied by any chest pain or palpitations, respondent ordered a complete blood count, sedimentation rate, SMA-12, potassium test, EKG and electroencephalogram.

Four days later, on February 20, 1982, Patient A's wife contacted respondent and informed him that Patient A had felt light-headed that morning. Respondent indicated that the prior lab tests had been normal. At this time it is apparent that respondent was at least beginning to suspect that Patient A could be suffering from a heart condition, as he did mention that "some people have their blood vessels checked", which was a reference to the coronary arteriography performed by cardiologists, and did schedule Patient A for a stress test on March 8, 1982.

Complainant argues that a minimally competent physician would have placed Patient A on a Holter monitor at the end of February, 1982. Unlike an EKG which monitors the heart for only a few minutes, a Holter monitor is actually worn by the patient, and enables monitoring for a 24 hour period, and is thus more likely to detect patients with an arrhythmia (i.e., irregular heart beat).

There is some question in this record as to whether or not Holter monitors were easily accessible for use in the respondent's area at this time. In addition, patients with an arrhythmia will not always have an episode on a daily basis. These factors suggest that respondent's decision not to place Patient A upon a Holter monitor were not below that expected of a minimally competent physician, especially in light of respondent's decision that a stress test should be undertaken.

As stated above, respondent recognized at the time of the telephone call from Patient A's wife on February 20, 1982 that the patient could be suffering from a heart condition. Patient A's fainting spells and history, which included smoking, obesity, age and gender, suggested that a heart condition could be present to the extent that further follow-up on this possibility was necessary.

The issue on this count is whether or not the specific employment of a Holter monitor at this time was mandated of minimally competent physicians. I do not believe that to be the case. Rather, a minimally competent physician would have recognized a significant possibility of cardiac problems in Patient A and have acted accordingly regarding the various options available, one of which was that Patient A undergo a stress test.

In my opinion from this record, a minimally competent physician had at least three options to recommend to Patient A at that time. First, and most radical, was the performance of a coronary arteriography by a cardiologist. Respondent did, in fact, mention that option over the telephone on February 20th. Second, he could secure a Holter monitor for Patient A, which might or might not establish the existence of an irregular heart beat, if it occurred during the 24 hour period Patient A wore it. Third, he could recommend a stress test to determine the operation of Patient A's heart activity. Respondent recommended the stress test.

The fact that respondent recognized and responded to possible cardiac problems of Patient A by setting forth the various options, in my opinion, is sufficient to establish that respondent's conduct was minimally competent at that time. There is nothing in the record to suggest that the ordering of a stress test was inappropriate medical practice. That respondent did order such a test is sufficient to establish he was responding in a minimally competent manner to the situation. Although it clearly would have been reasonable and prudent practice for respondent to have also used a Holter monitor at that time, I do not believe his failure to do so under these circumstances fell below minimal standards of competency.

STRESS TEST--EXERCISE PROGRAM

The stress test performed upon Patient A on March 8, 1982 was abnormal. Both Dr. Hisgen and Dr. Junkerman testified that the results were "suggestive" of the presence of a heart problem with the patient, with Dr. Hisgen indicating that the test provided an 80 percent certainty of the existence of such a problem. (Trans., pp. 177-179, 331).

Dr. Junkerman conceded:

> "...If you suspect coronary disease on the basis of a stress test, the logical follow-up is referral to a cardiologist so that cardiac catherization or radionucleide studies can be done." (Trans., pp. 338-339).

In my opinion, the positive stress test, when viewed in light of the other risk factors presented by Patient A such as his age, sex, status as a former smoker, weight, and fainting spells, necessitated follow-up action by respondent other than merely placing the patient upon an exercise program. Dr. Hisgen was questioned as to how a minimally competent physician would have proceeded:

"A. I think at this point a cardiology consult would be in order. General internists can't do angiograms or arteriograms or catheterization. Those are all equivalent terms, in the venacular at least. But at this point I would have called my--and I believe the minimally competent physician would have called a cardiologist who does invasive cardiology, meaning he does these catheterizations, and ask him to review the case, at least let him make the decision whether or not a catheterization should be performed. I personally would have leaned towards it no matter what the cardiologist would have said, but you have to leave that up to them because they make the decisions.

"Q. If Dr. Schumacher chose not to do that, is there anything else that he could have done to follow up on this abnormal stress report?

"A. Again, the Holter monitor as part of that, if he didn't get the Holter monitor, he might want to do it at this point also, just to see does this gentleman have any rhythm--abnormal rhythm that might occur sporadically and unpredictably. So that is another opportunity for him to, you know, try to make a diagnosis....

"Q. So that given the previous two syncopal episodes and the abnormal stress test for this patient, do you believe that any minimally competent physician would have suggested an exercise program for (Patient A) on that date?

"A. No.

"Q. Even if the program had been monitored?

"A. Right.

"Q. And just so it's clear on the record, your answer is that a minimally competent physician would not have referred--suggested such a program to a patient even if the program was monitored?

"A. Given the constellation of symptoms and problems prior to that stress test, probably not." (Trans., pp. 179-180, 184).

Dr. Hisgen then testified that the primary unacceptable risk in failing to refer Patient A to a cardiologist or employ the use of a Holter monitor is that a proper diagnosis of his condition would not be made, thereby posing a risk to his health and safety. He also stated that the employment of an exercise program by respondent created the additional unacceptable risk that such exercise could cause an aggravation of a cardiac condition. (Trans., pp. 185-186).

In my opinion, it is after the receipt of the positive stress test that the respondent failed to meet the responsibility of minimal competence regarding his treatment of Patient A. As discussed in the previous section, respondent was already aware that the patient might have a coronary problem, as indicated by his informing the patient that "some people have their blood vessels checked", prior to opting for the stress test. One must conclude that respondent should have had his concerns confirmed after receiving the positive stress test, which was demonstrably at least "suggestive" of a heart problem. A minimally competent physician would have seen the necessity for following up in such a manner as to further determine whether a cardiac condition existed, and thereby addressing the unacceptable risks to the patient generated by an undiagnosed problem. Respondent did not; but rather, essentially ignored the additional warning signs of a possible cardiac problem provided by the results of the stress test. In my opinion such failure constituted unprofessional conduct.

POST JULY 2, 1982 CONDUCT

Subsequent to placing Patient A upon an exercise program, as well as a conjunctive diet, the patient reported to respondent on June 9, 1982 that he was "feeling great". He had lost weight and his blood pressure appeared under control.

Unfortunately, the patient's general sense and appearance of well-being was deceptive. Whether or not he was suffering from an undiagnosed heart problem remained unexamined and, thus, unknown.

Less than a month later, on July 2, 1982, Patient A collapsed while taking a shower. He was taken to the emergency room at Riverview Hospital in Wisconsin Rapids. Upon admittance, he was in "fine ventricular fibrulation". After about 20 minutes of CPR, his heart rhythm was sufficient to sustain blood pressure. He responded to DC counter shock only after he was given 5 mg per kilogram of bretylium. Patient A was transferred to the coronary care unit in a deeply comatose state and required assisted ventilation. EKG's revealed only minor ST depression and nothing suggestive of a myocardial infarction.

Patient A responded after about twenty four hours. Given his history of fainting and the lack of any clear indication that he had suffered a myocardial infarction, Patient A was placed on procainamide 250 mg, every six hours, in order to control his arrhythmia. He was discharged on that medication on July 14, 1982, with the discharge summary indicating that the respondent was to determine the necessary further evaluation of the patient's condition.

Given the foregoing occurrence and circumstances, it is clear that a minimally competent physician would have been aware that Patient A had a "malignant arrhythmia" (Trans., p. 341), which had been extremely difficult to bring under control, as shown by the necessity of employing the use of the dangerous drug, bretylium (Trans., p. 401).

Respondent saw Patient A at the clinic for follow-up after hospitalization on July 19, 1982. Respondent continued the patient on procainamide and ordered an EKG. He did not refer Patient A to a cardiologist nor employ the use of a Holter monitor in an attempt to determine whether or not the medication was controlling the patient's arrhythmia.

Dr. Hisgen testified that at this point in time respondent's failure to refer Patient A to a cardiologist clearly constituted unprofessional conduct; Dr. Junkerman believes respondent's inaction was a singular error in judgment. I agree with Dr. Hisgen.

According to Dr. Junkerman:

> "...In what we call the sudden death syndrome these malignant arrhythmias such as (Patient A) had, about 75 percent of those patients have significant coronary disease. That means 25 percent do not have coronary disease. We don't know the degree of coronary disease that (Patient A) might have had and so I think it's--the question remains unanswered as to whether his arrhythmias were indeed part of his coronary disease or not." (Trans., p. 322).

The major reason why it is not known whether Patient A fell into that 75% of arrhythmics having coronary disease, or for that matter whether or not such coronary disease was treatable by surgical intervention if present, is because respondent never referred Patient A to a cardiologist.

In my opinion, a minimally competent physician had the obligation to take steps to evaluate, or have evaluated, the relationship between Patient A's arrhythmia and possible coronary disease. The failure to do so, again, led to the unacceptable risk that Patient A's underlying medical problem would remain undiagnosed, untreated or mismanaged, all of which posed significant unacceptable risks to the health and safety of Patient A.

Even if one assumes that Patient A fell into the 25% of individuals with arrhythmia unrelated to coronary disease--the only apparent treatment for which at that time were medications to control the irregularities, Trans., p. 323--merely placing him upon antiarrhythmic drugs without monitoring the effectiveness of the drug in controlling the arrhythmia was below minimal levels of conduct. Dr. Hisgen testified as to the necessity for using a Holter monitor in such situations, as follows:

> "A. Well, as I said, if you have this kind of a clinical situation, you want to establish control of the arrhythmia and make sure that the rhythm disturbance is controlled as best as possible. The only measure of reassurance that we have that a rhythm is controlled is to get one, two, three, four, five of these Holter monitors that say--that show no sign of a rhythm disturbance. That gives us 80 percent certainty. But not probably more than that.

"Q. So I don't know if you answered my question about what risks would be created by the failure to put a Holter monitor on?

"A. By not establishing control, the person could continue having his arrhythmia. He might have, as I said, five minutes per day that would just give you a clue that this rhythm wasn't under control. That would be a good--I mean, that would tell you then that you needed higher does of the drug or you should switch to another drug. So it would give you--so by not establishing control, you were left--you are back to ground zero. You don't know if this person is going to have another lethal attack. You have no way of predicting." (Trans., pp. 200-201).

In addition to failing to monitor the extent to which procainamide was sufficiently controlling Patient A's arrhythmia, after the switch in medication to norpace in October, 1982--which, in itself was appropriate due to the patient's developing lupus-like syndrome--respondent failed to monitor whether norpace was effectively controlling Patient A's problem. As stated by Dr. Hisgen:

"...(W)e have this lethal arrhythmia. You switch to a different drug. It might not be as good as the procainamide and so you want--and as the previous testimony indicated, we didn't have a good blood test for norpace. So the only means of really determining whether the norpace was effective was to do a Holter monitor...." (Trans., p. 202).

The collection of testimony quoted above indicates that there is no question but that Patient A suffered from a "malignant arrhythmia", given the circumstances surrounding his cardiac incident in July, 1982. There would seem to be no real question but that the way to determine whether that condition was cardiac related and treatable, was through a referral to a cardiologist. Respondent failed to make such a referral.

Furthermore, given the serious nature of Patient A's arrhythmia, and the possible fatal consequences if the medications were insufficient to control it, there also seems to be no real question but that a minimally competent physician would have taken steps to monitor the degree to which the drugs were successfully performing that function. Again, respondent failed to perform such monitoring.

These inactions by respondent led to the unacceptable risks that Patient A's condition would remain undiagnosed and improperly treated, thereby endangering the health and safety of the patient.

* * * * *

On November 3, 1982, Patient A collapsed at the wheel of the car he was driving. The passenger was able to grab the wheel and steer it to the roadside. An ambulance arrived within 15 minutes. The ambulance personnel

administered CPR during transportation of Patient A to a hospital in Menomonee Falls, Wisconsin. According to the Complaint, Patient A was "resuscitated with cardioversion but was comatose and decerebrate. Despite good blood pressure and pulse, Patient A did not show evidence of neurological recovery." The decision was made to remove the respirator from Patient A. He died on December 12, 1982.

DISCIPLINE

The final issue to be addressed is the appropriate discipline, if any, to be imposed against respondent. In determining this issue, it must be noted that the interrelated purposes for applying disciplinary measures are: 1) to promote the rehabilitation of the licensee, 2) to protect the public, and 3) deter other licensees from engaging in similar misconduct. State v. Aldrich, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. State v. MacIntyre, 41 Wis. 2d 481, 485 (1969).

Complainant has recommended that respondent be reprimanded. I have accepted that recommendation, believing that it is a sufficient and necessary sanction to impose in order to deter other licensees from engaging in similar conduct and in order to rehabilitate the licensee under the circumstances of this case.

In making this recommendation, I have taken into consideration several mitigating circumstances. Throughout this proceeding, the respondent has stressed the diagnostic difficulties presented by Patient A, as well as the fact that his arrhythmia may have been such as to render any medical efforts ineffectual in altering the ultimate outcome for Patient A. He has also stressed that he performed numerous appropriate tests upon Patient A, many of which were directed toward his belief that the patient's condition was neurological in nature, which clearly demonstrates that this is not a case in which the well-being of the patient was essentially ignored or wantonly disregarded. He also points to the fact that he has practiced medicine for over 33 years without prior disciplinary complaint before this board or similar proceedings before hospital or peer groups. It should also be recognized that nearly nine years have passed since the death of Patient A, which represents a considerable amount of time during which respondent has had to deal with, what he admits to being an "error in judgment". (Trans., pp. 433-434).

From a disciplinary standpoint, I was also impressed not only with the credentials, but the candor of both expert witnesses. Dr. Hisgen forthrightly testified as to the difficult judgment calls which often must be made by physicians in cases such as represented here, and how many of those decisions are not "axiomatic" to minimally competent professionals. There was nothing in his testimony suggesting that respondent's conduct flowed from a lack of concern for Patient A's well-being. Dr. Junkerman, on the other hand, echoed

Dr. Hisgen's opinion in this regard, and candidly conceded that he believed that respondent had made an error in judgment in this case. The determination of this matter benefits greatly from the quality of such testimony.

Given all the facts and circumstances in this case, I believe a reprimand, combined with the imposition of the costs of this proceeding, is sufficient discipline. I have not accepted, however, complainant's recommendation that respondent be required to undertake education in the area of heart disease. In my opinion, respondent's conduct did not represent a lack of knowledge, but rather a failure to implement the knowledge possessed in a minimally competent fashion in this case. In this sense, I agree with respondent that his conduct was a product of judgment, rather than a lack of knowledge. I do not believe that education is necessary in order to assure that a similar situation will not happen again. Rather, I believe that the adverse consequences which have befallen respondent since Patient A's death, their impact upon his family, the reprimand ordered herein, as well as the imposition of costs, will all adequately serve this purpose.

Dated: July 25, 1991.

Respectfully submitted,

Donald R. Rittel
Administrative Law Judge

BDLS2-405

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 September 2, 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) Exc[illegible] 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.