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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

(Case No. LS 9310115 MED)

GEORGE E. FARLEY, M.D.,
RESPONDENT.

FINAL DECISION AND ORDER

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

George E. Farley, M.D.
30791 Eldora Court
Evergreen, CO 80439

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

State of Wisconsin
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

A hearing in this matter was conducted on March 28, 29 and 30, 1995. The respondent, George E. Farley, M.D., appeared personally and by his attorney, Michael P. Malone, Hinshaw & Culbertson, 100 East Wisconsin Avenue, Suite 2600, Milwaukee, Wisconsin 53202-4115. The complainant appeared by attorney, Roger R. Hall, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708. A transcript of each day of the hearing was prepared and filed, the last of which was received on April 19, 1995.

The administrative law judge filed his Proposed Decision on October 26, 1995. Complainant filed his Objections to Proposed decision and Brief in Support of Objections to Proposed Decision on November 10, 1995, and Respondent filed his

Response to Complainant's Objections to Proposed Decision on November 16, 1995. The parties appeared for oral arguments on the objections on December 14, 1995, and the board considered the matter on that date.

On the basis of the entire record, the Medical Examining Board makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. George E. Farley, M.D., 30791 Eldora Court, Evergreen, CO 80439, the respondent herein, is a physician duly licensed and currently registered to practice medicine and surgery in the state of Wisconsin, pursuant to license #19844, which was granted on April 30, 1976.

2. Dr. Farley specializes in radiology.

PATIENT A

3. On October 14, 1987, Patient A, a 61 year old male, was transported to the emergency department at St. Michael Hospital, Milwaukee, Wisconsin, for injuries sustained in a moped accident. Among other problems, Patient A suffered scraping and bruising of his left knee and complained of left knee pain.

4. X-rays were ordered for Patient A. Patient A's x-rays were interpreted by Dr. Farley. The x-ray report regarding Patient A's left knee indicates as follows: "The views of the left knee suggest a small joint effusion. The study indicates no evidence of fracture."

5. However, the x-ray of Patient A interpreted by Dr. Farley did show an abnormality suggestive of a fracture which Dr. Farley failed to detect. The abnormality should be detected by the average radiologist.

6. Patient A was discharged from St. Michael Hospital on October 15, 1987.

7. On November 2, 1987, Patient A presented at the office of David Mellencamp, M.D., in Milwaukee. Dr. Mellencamp is an orthopedic surgeon. Patient A complained that his left knee was swollen and painful and that he was unable to move it well.

8. Dr. Mellencamp examined Patient A on November 2, 1987, and interpreted the x-rays from St. Michael Hospital, which the patient brought with him to Dr. Mellencamp's office. Dr. Mellencamp interpreted the x-rays to show a large free fragment, probably off the medial femoral condyle. Dr. Mellencamp's plan was to evaluate the patient with arthroscopy and possibly arthrotomy. He noted that "it looks like he's going to have to have this pinned."

9. On November 4, 1987, Dr. Mellencamp performed diagnostic arthroscopy on Patient A, then proceeded to do a partial medial lateral meniscectomy, proceeded to do an arthrotomy, a medial collateral ligament repair and replacement of the lateral femoral condyle. The patient was placed in a cast and discharged home to be followed in Dr. Mellencamp's office.

10. Patient A saw Dr. Mellencamp for follow-up care following his knee surgery from November, 1987 through at least June, 1988.

PATIENT B

11. On December 5, 1986, Patient B, a 38 year old male, was referred to Dr. Farley for a barium enema single-contrast at St. Michael Hospital, Milwaukee, Wisconsin. Dr. Farley was informed that Patient B had a history of abdominal pain.

12. Dr. Farley interpreted the colon x-ray of Patient B to be normal and noted as follows: "The haustral pattern is normal. No obstruction or constricting lesions are identified. No constant intraluminal filling defects are identified. The post-evacuation film shows good emptying of the colon and the visualized mucosal pattern is normal."

13. However, the colon x-ray of Patient B interpreted by Dr. Farley did show a contour abnormality in the medial wall of the proximal descending colon just below the splenic flexure, which Dr. Farley failed to detect. The abnormality should be detected by the average radiologist.

14. On February 12, 1988, Patient B underwent a colonoscopy at St. Luke's Hospital, Milwaukee, Wisconsin, for continuous problems with abdominal pain and weight loss. The colonoscopy revealed a stricture at 60 cm., most likely in the descending colon. The physician performing the colonoscopy determined that the stricture was most compatible with a malignancy and recommended that the patient have a surgical resection because of potential for obstruction.

15. On February 19, 1988, Patient B underwent colon resection for suspected carcinoma of the colon. The surgeon found a large tumor just below the splenic flexure of the colon with aggressive growth and contiguous spread. This included spread into the mesentery of the colon, into the adjoining lymph nodes and direct extension into the tail of the pancreas. The surgeon did a subtotal colon resection, a primary reanastomosis of the colon, a caudal pancreatectomy, splenectomy and excision of the entire greater omentum.

16. Patient B underwent follow-up treatment for colon cancer, but died on January 20, 1990.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this proceeding pursuant to ch. 448, Stats.

2. There is insufficient evidence in this record to establish by a preponderance of the evidence that the failure of Dr. George E. Farley to observe that Patient A's knee x-ray taken on October 14, 1987, showed an abnormal bone density in the knee joint constituted negligence in treatment, under sec. 448.02(3), Stats.

3. There is insufficient evidence in this record to establish by a preponderance of the evidence that the failure of Dr. George E. Farley to observe that Patient B's barium enema colon x-ray taken in December, 1986, indicated a significant contour abnormality in the descending colon, consistent with colon cancer, constituted negligence in treatment, under sec. 448.02(3), Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that the disciplinary proceedings against George E. Farley, M.D., be, and hereby are, dismissed.

EXPLANATION OF VARIANCE

The Medical Examining Board has made two modifications to the ALJ's Findings of Fact. Finding of Fact #5 of the Proposed Decision states as follows:

> 5. However, the x-ray of Patient A interpreted by Dr. Farley did show an abnormality suggestive of a fracture which Dr. Farley failed to detect. The abnormality was not obvious; but rather, extremely subtle and difficult to detect by the average radiologist.

The testimony of complainant's expert witness, George F. Roggensack, M.D., included the following:

> This is a -- this is an osteochondral fracture and what has happened here is a piece of bone with the cartilage that overlies it, which we support our weight on, has been sheared off at the lateral femoral condyle, this area out here. And the fragment of bone is just now essentially free in the joint cavity.
>
> Osteochondral fractures are described as not uncommon but frequently missed by clinicians and radiologists. And the reason for that is that they are usually very tiny. So that in most cases the -- you may only have a tiny sliver of bone, just a little -- because most of it -- I mean most of the time its the cartilage, but you may have a little sliver of bone that's pulled off. And in this case, it is more than a sliver of bone. It's a fairly large bone fragment. So I believe it's apparent

on these radiographs that there is an abnormality that can be perceived. (Transcript, pp. 87-88)

The board, after having reviewed all of the expert testimony and after reviewing the relevant radiographic exhibits, accepts the testimony of Dr. Roggensack, and finds that the defect should have been detected by the average radiologist. Accordingly, Finding of Fact #5 has been modified to read as follows:

> 5. However, the x-ray of Patient A interpreted by Dr. Farley did show an abnormality suggestive of a fracture which Dr. Farley failed to detect. The abnormality should be detected by the average radiologist.

Finding of Fact #13, as proposed by the ALJ, reads as follows:

> 13. However, the colon x-ray of Patient B interpreted by Dr. Farley did show a contour abnormality in the medial wall of the proximal descending colon just below the splenic flexure, which Dr. Farley failed to detect. The abnormality was not obvious; but rather, subtle and difficult to detect by the average radiologist. Its detection upon the x-ray was made more difficult by virtue of the location of the abnormality and the physically large size of Patient B.

Again, the board has accepted the expert opinion of Dr. Roggensack after having reviewed all of the expert testimony and the radiographs in question. Accordingly, the board has modified Finding of Fact #13. to read as follows:

> 13. However, the colon x-ray of Patient B interpreted by Dr. Farley did show a contour abnormality in the medial wall of the proximal descending colon just below the splenic flexure, which Dr. Farley failed to detect. The abnormality should be detected by the average radiologist.

Dr. Roggensack's testimony, which the board finds the more persuasive, includes the following:

> "What we see here is a filling defect or a contour abnormality in the wall of the colon. And it extends -- it's in the proximal descending colon here on the medial wall, just below the splenic flexure, in this area here. It's characterized by -- when I say a contour abnormality, if you look at the walls of the colon in adjacent areas, you see a relatively smooth, slightly serrated normal-looking anatomic pattern, and here suddenly you see a defect. It's characterized by an indentation here with a very sharply marginated base and a surrounding lucid filling defect, which is faintly seen here, extending into the lumen of the colon. It also demonstrates what we call overhanging margins. The defect, of course, is best seen here at the superior portion, and you can see that it protrudes or extends or overhangs the wall of the colon in this -- in this area here, less apparent on the lower end. . . . (The abnormality measures) about five and a half centimeters. . . . And the radiologic features are, I think, very suggestive of a malignant colon lesion. The contour deformity, the flattened ulcerated

appearance of the wall here, the overhanging margins, the mass that is present protruding into the lumen." (Transcript, pp. 69-71)

* * * *

"The least common area for a missed lesion is the area that this lesion is located in the case under question. That is the proximal descending colon, about three to four percent of lesions, in retrospect, are located in that area as compared to the rest of the colon. So that obviously it is going to be easier to perceive a lesion in this location, in the vast majority of cases, than in the sigmoid." (Transcript, p. 83).

* * * *

"I think that the radiologic findings that we see in this lesion are very typical of a malignant lesion of the colon. I think it's a fairly obvious lesion; I think it's a fairly large lesion, and I believe (it) meets many of the classic radiologic findings for a malignant cancer or malignant lesion of the colon." (Transcript, p. 75).

But while the board has modified the foregoing Findings of Fact, the board has not disturbed the ALJ's proposed Conclusions of Law or his recommended Order. For while the board concludes that the average radiologist should have been able to detect these defects, the board also concludes that Dr. Farley's failure to detect them in this instance did not constitute negligence in treatment. Stated another way, Dr. Farley's failures to detect the defects in these radiographs were mistakes, but they were not mistakes based upon negligence.

This record is devoid of any evidence or suggestion that Dr. Farley is anything but a fully competent, careful and conscientious radiologist, or that he was not competent, careful and conscientious in his examination of the affected radiographs in this case. Dr. Richard Rozran practiced radiology at St. Michael Hospital at the time in question. His testimony as to Dr. Farley's abilities and work habits included the following:

I found George to be an excellent radiologist, and he was reliable, showed up on time every day, and did his work, was accurate as far as I could tell, and gave good assistance to me on a number of situations -- or many situations. You know, if I'm doing an angiogram and I need help, I could count on George. He could help me out. When I had interesting cases or confusing cases, I felt confident in showing cases to George, and as I do to all my partners. And, you know, we worked well together. And I think George is a fine radiologist.

* * * *

I think certain people read at different speeds, and everybody has a comfort level. I don't think George was exceptionally fast or exceptionally slow. I think he worked at a fine pace, a good pace.

* * * *

I really don't remember any complaints about George. I think most people sought out George, you know, for guidance on cases. I know you've received letters to confirm that. And I think you could ask a lot more, and you'd find a lot

more people willing to write such letters and to say George helped out a lot, did a good job, and was reliable in his interpretations.

The radiology Quality Assurance program at St. Michael Hospital is detailed on Exhibit 27. Approximately 35 cases are evaluated on a monthly basis using a blend cross read format on a random basis. An additional review and second interpretation of a particular type of exam is performed on a monthly basis in random with 30 cases or five percent of the cases, whichever is greater. Significant findings are reported to referring physicians at the time of exam. Douglas A. Reasa, M.D., Medical Director for the Department of Radiology at St. Michael, in a letter dated March 17, 1993, reported that during the 12 years Dr. Reasa served as Director, "[Dr. Farley's] professional conduct has been exemplary," and "no problems have surfaced regarding Dr. Farley's interpretive skills" (Exhibit 26). There is thus no pattern of errors in Dr. Farley's professional practice from which negligence in practice could be inferred.

The thrust of the expert testimony in this case went to whether the defects in these radiographs were obvious or subtle, and whether the "average" radiologist should have detected them. There is no evidence in this record, however, to establish that Dr. Farley's errors in having failed to detect those defects came as a result of his failure to conform to the accepted standard of care in the field of radiology, other than the conclusory testimony of Dr. Roggensack. In terms of his testimony in that regard relating to patient B, the exchange was as follows:

> Q. (by Mr. Hall) I think that I'm going to ask you, Dr. Roggensack, do you have an opinion to a reasonable degree of medical probability whether Dr. George Farley's practice as a radiologist in performing the radiology studies on patient Lozoff failed to conform to that degree of care, skill and judgment which is ordinarily exercised by the average radiologist under like or similar circumstances in Wisconsin?
>
> A. Yes, I do.
>
> Q. And what is that opinion?
>
> A. I feel this falls below the standard of the average radiologist in those circumstances.
>
> Q. And is that because of his failure to diagnose the colon lesion?
>
> A. Yes, it is. (Transcript, pp. 75-76)

The problem with that testimony, and with Dr. Roggensack's similar testimony concerning patient A (Transcript, p. 88), is that the simple fact of Dr. Farley's having failed to perceive defects that could have been perceived in these radiographs does not establish that he failed to conform to acceptable standards of practice in the manner in which he read them. As stated in *Francois v. Mokrohisky*, 67 Wis. 2d 196 (1974):

> A physician is not an insurer of the results of his diagnosis or procedures. He is obliged to conform to the accepted standard of reasonable care, but he is not liable for failing to exercise an extraordinary degree of care.
>
> True, physicians too often have attempted to encourage the aurae of infallibility they do not possess. Theirs is not an exact science, and even the best of them can be wrong in diagnosis or procedure. The question, however, is not whether a physician made a mistake; rather, the question is whether he was negligent. Unless the untoward result was caused by a failure to conform to the accepted standard of care, he is not liable for negligence in damages. *Mokrohisky, supra,* at 201

There is insufficient evidence in the record of this case to establish that Dr. Farley failed to conform to the accepted standard of care for radiologists in reading the radiographs of patients A and B, and no finding of negligence may therefore be made.

Dated this 21st day of December, 1995.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by W.R. Schwartz MD
W.R. Schwartz
Secretary

WRA:9512191.doc

NOTICE OF APPEAL INFORMATION

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

Serve Petition for Rehearing or Judicial Review on:

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

The Date of Mailing this Decision is:

January 2, 1996

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

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

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

2. JUDICIAL REVIEW.

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

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

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

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	NOTICE OF FILING PROPOSED DECISION LS9310115MED
GEORGE E. FARLEY, M.D., RESPONDENT.	:	

TO: Michael P. Malone, Attorney
100 East Wisconsin Avenue
Suite 2600
Milwaukee, WI 53202-4115
Certified Z 091 396 613

Roger R. Hall, Attorney
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, Donald R. Rittel. 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. If your objections or argument relate to evidence in the record, please cite the specific exhibit and page number in the record. Your objections and argument must be received at the office of the Medical Examining Board, Room 174, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before November 13, 1995. 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, the Medical Examining Board will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 26th day of October, 1995.

Donald R. Rittel

Donald R. Rittel
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	PROPOSED DECISION
GEORGE E. FARLEY, M.D., RESPONDENT.	:	(Case No. LS 9310115 MED)

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

George E. Farley, M.D.
30791 Eldora Court
Evergreen, CO 80439

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

State of Wisconsin
Department of Regulation and Licensing
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1400 East Washington Avenue
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A hearing in this matter was conducted on March 28, 29 and 30, 1995. The respondent, George E. Farley, M.D., appeared personally and by his attorney, Michael P. Malone, Hinshaw & Culbertson, 100 East Wisconsin Avenue, Suite 2600, Milwaukee, Wisconsin 53202-4115. The complainant appeared by attorney, Roger R. Hall, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708. A transcript of each day of the hearing was prepared and filed, the last of which was received on April 19, 1995.

On the basis of the entire record, the administrative law judge recommends that the Medical Examining Board adopt as its final decision in this proceeding the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. George E. Farley, M.D., 30791 Eldora Court, Evergreen, CO 80439, the respondent herein, is a physician duly licensed and currently registered to practice medicine and surgery in the state of Wisconsin, pursuant to license #19844, which was granted on April 30, 1976.

2. Dr. Farley specializes in radiology.

PATIENT A

3. On October 14, 1987, Patient A, a 61 year old male, was transported to the emergency department at St. Michael Hospital, Milwaukee, Wisconsin, for injuries sustained in a moped accident. Among other problems, Patient A suffered scraping and bruising of his left knee and complained of left knee pain.

4. X-rays were ordered for Patient A. Patient A's x-rays were interpreted by Dr. Farley. The x-ray report regarding Patient A's left knee indicates as follows: "The views of the left knee suggest a small joint effusion. The study indicates no evidence of fracture."

5. However, the x-ray of Patient A interpreted by Dr. Farley did show an abnormality suggestive of a fracture which Dr. Farley failed to detect. The abnormality was not obvious; but rather, extremely subtle and difficult to detect by the average radiologist.

6. Patient A was discharged from St. Michael Hospital on October 15, 1987.

7. On November 2, 1987, Patient A presented at the office of David Mellencamp, M.D., in Milwaukee. Dr. Mellencamp is an orthopedic surgeon. Patient A complained that his left knee was swollen and painful and that he was unable to move it well.

8. Dr. Mellencamp examined Patient A on November 2, 1987, and interpreted the x-rays from St. Michael Hospital, which the patient brought with him to Dr. Mellencamp's office. Dr. Mellencamp interpreted the x-rays to show a large free fragment, probably off the medial femoral condyle. Dr. Mellencamp's plan was to evaluate the patient with arthroscopy and possibly arthrotomy. He noted that "it looks like he's going to have to have this pinned."

9. On November 4, 1987, Dr. Mellencamp performed diagnostic arthroscopy on Patient A, then proceeded to do a partial medial lateral meniscectomy, proceeded to do an arthrotomy, a medial collateral ligament repair and replacement of the lateral femoral condyle. The patient was placed in a cast and discharged home to be followed in Dr. Mellencamp's office.

10. Patient A saw Dr. Mellencamp for follow-up care following his knee surgery from November, 1987 through at least June, 1988.

PATIENT B

11. On December 5, 1986, Patient B, a 38 year old male, was referred to Dr. Farley for a barium enema single-contrast at St. Michael Hospital, Milwaukee, Wisconsin. Dr. Farley was informed that Patient B had a history of abdominal pain.

12. Dr. Farley interpreted the colon x-ray of Patient B to be normal and noted as follows: "The haustral pattern is normal. No obstruction or constricting lesions are identified. No constant intraluminal filling defects are identified. The post-evacuation film shows good emptying of the colon and the visualized mucosal pattern is normal."

13. However, the colon x-ray of Patient B interpreted by Dr. Farley did show a contour abnormality in the medial wall of the proximal descending colon just below the splenic flexure, which Dr. Farley failed to detect. The abnormality was not obvious; but rather, subtle and difficult to detect by the average radiologist. Its detection upon the x-ray was made more difficult by virtue of the location of the abnormality and the physically large size of Patient B.

14. On February 12, 1988, Patient B underwent a colonoscopy at St. Luke's Hospital, Milwaukee, Wisconsin, for continuous problems with abdominal pain and weight loss. The colonoscopy revealed a stricture at 60 cm., most likely in the descending colon. The physician performing the colonoscopy determined that the stricture was most compatible with a malignancy and recommended that the patient have a surgical resection because of potential for obstruction.

15. On February 19, 1988, Patient B underwent colon resection for suspected carcinoma of the colon. The surgeon found a large tumor just below the splenic flexure of the colon with aggressive growth and contiguous spread. This included spread into the mesentery of the colon, into the adjoining lymph nodes and direct extension into the tail of the pancreas. The surgeon did a subtotal colon resection, a primary reanastomosis of the colon, a caudal pancreatectomy, splenectomy and excision of the entire greater omentum.

16. Patient B underwent follow-up treatment for colon cancer, but died on January 20, 1990.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this proceeding pursuant to ch. 448, Stats.

2. There is insufficient evidence in this record to establish by a preponderance of the evidence that the failure of Dr. George E. Farley to observe that Patient A's knee x-ray taken on October 14, 1987, showed an abnormal bone density in the knee joint constituted negligence in treatment, under sec. 448.02(3), Stats.

3. There is insufficient evidence in this record to establish by a preponderance of the evidence that the failure of Dr. George E. Farley to observe that Patient B's barium enema colon x-ray taken in December, 1986, indicated a significant contour abnormality in the descending colon, consistent with colon cancer, constituted negligence in treatment, under sec. 448.02(3), Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that the disciplinary proceedings against George E. Farley, M.D., be, and hereby are, dismissed.

OPINION

Dr. George E. Farley is charged with having engaged in "negligence in treatment" in two separate instances respecting his practice as a radiologist. Count 1 of the Complaint alleges that Dr. Farley failed to observe an abnormal bone density in the knee joint of a patient upon an x-ray in October, 1987. Count 2 charges that he failed to observe a significant abnormality in the descending colon of a patient, produced by a barium enema colon x-ray taken in December, 1986. Dr. Farley denies that his reading of either or both of the x-rays constituted negligence.

Neither the board nor the case law appear to have previously considered the precise meaning of the phrase "negligence in treatment" as it applies within this disciplinary context, as contrasted to a civil malpractice action. Accordingly, substantial discussion between the parties occurred prior to and during the hearing as to the legal definition of "negligence in treatment" within the context of the medical licensing and practice act in Chapter 448 of the Wisconsin Statutes. The relevant portions of the statute provide as follows:

> 448.02(3) INVESTIGATION; HEARING; ACTION. (a) The (medical examining) board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license, certificate or limited permit granted by the board. . . .
>
> (b) After an investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct or negligence in treatment, the board shall hold a hearing on such conduct. . . .

> (c) After a disciplinary hearing, the board may . . . when it finds a person guilty of unprofessional conduct or negligence in treatment, do one or more of the following: warn or reprimand that person, or limit, suspend or revoke any license, certificate or limited permit granted by the board to that person. . . .
>
> * * * * *
>
> (h) Nothing in this subsection prohibits the board, in its discretion, from investigating and conducting disciplinary proceedings on allegations of unprofessional conduct by persons holding a license, certificate or limited permit granted by the board when the allegations of unprofessional conduct may also constitute allegations of negligence in treatment.

As the parties recognized, the statute clearly distinguishes between disciplinary actions which are based upon "unprofessional conduct" and those founded on "negligence in treatment". Dr. Farley was not charged with "unprofessional conduct" which, generally and simplistically stated, concerns whether patient services have been provided in a "minimally competent" manner[1]. Rather, he is charged with negligence, which evokes a standard of an "average" practitioner.

It seems intuitively logical that an "average" physician is more than "minimally competent"; and a "minimally competent" practitioner is not necessarily as skilled as the "average" physician." The difference in the required competency levels between the two standards is reflected in the opinion of the state's expert radiologist, Dr. George F. Roggensack. During the investigation of these matters Dr Roggensack indicated to the attorney handling the case at the time his belief that Dr. Farley's reading of the two x-rays at issue was "minimally competent". Therefore, Dr. Roggensack did not believe that Dr. Farley had engaged in unprofessional conduct. (Transcript, pp. 114-115). However, he did believe that Dr. Farley had been "negligent in treatment", which Dr. Roggensack viewed as being a "lesser standard". (Transcript, p. 116).

Neither party introduced any legislative history, or case law, to assist in drawing the legal distinction intended between "unprofessional conduct" and "negligence in treatment" under the statute, nor are there any administrative rules that have been promulgated which might be of assistance[2]. The statutory authority to take action for "negligence in treatment" exists alongside language alluding to the Patient's Compensation Panel (PCP) under sec. 655.02, Stats. Although the statute has not been amended to reflect that the PCP no longer exists under law, there appears to be no question but that the authority to take action for "negligence in treatment" remains operative, even though the PCP does not.

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[1] *Gilbert v. Medical Examining Board*, 119 Wis. 2d 168, 191-194, 205 (1984).

[2] The portions of the quoted statute relating to "negligence in treatment" were added to the statute as part of a state budget bill. See, 1985 Wis. Act 29, ss. 2238p - 2238u, effective July 20, 1985.

The parties have viewed the standard to be applied in determining whether Dr. Farley engaged in "negligence in treatment", as being governed by the medical malpractice cases concerning physician negligence. The issue revolves around the interpretation of, or diagnoses stemming from, the x-rays taken of two patients. As stated by the Wisconsin Supreme Court on several occasions respecting cases involving incorrect medical diagnoses:

> "The law governing this case is well settled. A doctor is not an insurer or guarantor of the correctness of his diagnosis; the requirement is that he use proper care and skill. *Knief v. Sargent*, 40 Wis.2d 4, 8, 161 N.W.2d 232 (1968). The question is not whether the physician made a mistake in diagnosis, but rather whether he failed to conform to the accepted standard of care. *Francois v. Mokrohisky*, 67 Wis.2d 196, 201, 226 N.W.2d 470 (1975)." *Christianson v. Downs*, 90 Wis. 2d 332, 338 (1979).[3]

In this case, Dr. Farley and the testifying experts are in agreement that, in retrospect, respondent's radiological diagnoses in the two cases considered were incorrect. The films reviewed by Dr. Farley regarding both patients show abnormalities. There is no claim that the films taken were of poor quality, or that inadequate procedures were utilized by Dr. Farley in obtaining them. Accordingly, the negligence claimed here does not relate to diagnostic technique employed by Dr. Farley. Rather, the issue revolves around whether Dr. Farley's failure to see or perceive the abnormalities upon the x-rays were proven by the state, through a preponderance of the evidence, to be due to respondent's failure to exercise that degree of care and skill which is exercised by the average radiologist, acting in the same or similar circumstances, in reviewing the films.[4]

In considering whether the "average radiologist" would have missed the abnormalities presented upon the radiographs in the two cases presented, it should be noted that the experts agree, and candidly admit, that they and all other experienced radiologists have "missed" abnormal features on x-rays. With respect to cancers of the colon, substantial testimony and literature was introduced into this record which indicates that the "miss" rate of such cancers by radiologists, which are in fact reflected on x-rays, may range between as much as 20-30%. The phenomenon is such that the standards of the American College of Radiology for the performance of barium enema examinations, (such as was performed respecting Patient B) only expect that ". . . the detection rate should exceed 90%." (Exhibit 9-9).

Although the above statistics are unsettling to the layperson and clearly disturbing to the radiologists who testified, they are not totally dispositive of the question as to

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[3] See also, *Ehlinger v. Sipes*, 155 Wis. 2d 1, 14 (1990), *Carson v. Beloit*, 32 Wis. 2d 282, 291 (1966).

[4] *Zintek v. Perchik*, 163 Wis. 2d 439, 461 (Ct. App. 1991), citing *Shier v. Freedman*, 58 Wis 2d 269, 283-284 (1973).

whether the "misses" by Dr. Farley in these specific cases were due to his failure to exercise the degree of care and skill utilized by the average radiologist. Respondent and the expert witnesses appeared to recognize this and primarily focused their testimony and opinions upon whether the abnormalities found on the radiographs were "obvious" or "subtle". This is an appropriate and useful approach in resolving the underlying issues in this case. In fact, it is reflective of the manner in which the issue is phrased within the Complaint regarding Patient B, where it is alleged that respondent was negligent in failing to observe "a *significant* contour abnormality in the descending colon . . ." (Emphasis, added). For our purposes it suggests that it is more likely than not that the "average radiologist" will be capable of detecting "obvious" abnormalities; whereas that may not be the case in all circumstances in which the abnormality is "subtle".

Framed within the above analytical context, Complainant's position is that the abnormalities presented to Dr. Farley were "obvious", and no special circumstances existed such as would detract from a finding that they probably would have been noted by the average radiologist. Respondent, on the hand contends that the abnormalities were "subtle" and that the surrounding circumstances in each case were such that it has not been established by the state that the "average radiologist" probably would have detected them.

Dr. Farley's professional background should be presented briefly by way of background prior to discussing the individual cases. He was first licensed to practice medicine and surgery in this state in 1976, and also possesses medical licenses in the states of Nebraska, Texas, Colorado, Nevada and Tennessee. He specializes in radiology, having received board certification from the American Board of Radiology in 1974. Dr. Farley initially practiced in this state at the Medical College of Wisconsin under a neuroradiology fellowship, from May 1976 to May 1977. Between May 1977 and September 1993, which includes the period relevant to this proceeding, Dr. Farley practiced at St. Michael Hospital in Milwaukee, Wisconsin. Since the end of 1993, he has resided in the state of Colorado and is currently practicing radiology at the Vail Valley Medical Center in Vail, Colorado. (Exhibit 40). Accordingly, Dr. Farley's credentials are clearly commendable, and there was nothing presented in this proceeding to suggest that he has practiced in other than a competent manner regarding services provided to other patients, or is not respected by his peers for his conscientiousness and expertise in his field.

Respecting the specific cases presented here, the circumstances surrounding Count 2 of the Complaint regarding Patient B are discussed first, as they are prior in time to the those involved in Count 1, and it was in the context of the testimony supplied in relationship to this matter that most of the diagnostic issues in this proceeding were provided.

On December 5, 1986, Dr. Farley performed a barium enema examination upon Patient B at the request of the patient's physician. Dr. Farley indicated that he has performed in excess of 2,000 barium enema studies over the course of his practice and that he probably performed approximately 200 such procedures during 1986. (Transcript, p. 51). Regarding the procedure here, Dr. Farley testified that Patient B's physician:

> ". . . ordered an I.V.P., that's x-rays of the kidney, and a single contrast barium enema exam. The patient is then supplied with a cleansing material, enemas and laxatives to clean the colon. And then on the day of the exam the patient presents to our department. My technologist would then see the patient, get additional history from the patient. And when I come into the room, the patient -- the barium is already mixed, and the technologist will hand me the request sheet. I'll read it and talk with the patient, ask why we're doing the exam, see if that matches what I have in the written information from my techs and the doctor. And then under fluoroscopic control, that's where I can watch the flow of barium, I will let the barium then flow through the colon, taking pictures called spot films, and a viewing of that fluoroscopy. When I'm finished, the technologist will take these type of films, called overhead films, and then afterwards I will review that." (Transcript, p. 30).

Dr. Farley testified that after performing the above procedures, he reviewed the x-rays, and rendered a written report. The portion of the report regarding the findings of Dr. Farley respecting Patient B's colon reads as follows:

> "COLON: Barium contrast material was introduced per rectum and flowed in an unobstructed retrograde fashion filling the entire colon with reflux into the terminal ileum. The haustral pattern is normal. No obstructing or constricting lesions are identified. No constant intraluminal filling defects are identified. The post-evacuation film shows good emptying of the colon and the visualized mucosal pattern is normal.
>
> "CONC: Normal colon." (Exhibit 6).

Eight separate x-rays were taken during the barium enema procedure. (Exhibits 1A through 1H). Exhibit 1G shows the abnormality, and was a "spot film" taken during the fluoroscopic portion of the examination. Dr. Farley described the radiograph as follows:

> "And film 1G, this is a film where the patient is turned, if you look -- laying on his back, turning the left side up. And this would be -- the spleen is sitting here.

> This is the stomach. So this would be the splenic flexure. And what this film shows is some contrast in the kidney from the I.V.P. that was done; air sitting in this area, it's called the splenic flexure. And the area we found later to be an abnormality is along the left side. And you can see it somewhat simulates this gas. But in retrospect, that's the area in question." (Transcript, p. 33).

Dr. Farley also testified that even upon rechecking that x-ray upon learning that Patient B developed colon cancer a couple years later, it took him five to six minutes to see the abnormality, which he characterized as a "subtle abnormality". (Transcript, pp. 38-39).

The allegation that Dr. Farley engaged in negligence in treatment in failing to observe the abnormality depicted on Exhibit 1G (and to a lesser extent upon Exhibit 1B) is predicated upon the expert testimony of Dr. George F. Roggensack. Dr. Roggensack is imminently qualified to provide expert testimony in this area. He has been licensed in this state since 1970, and board certified in radiology since 1971. (Exhibit 10). Dr. Roggensack testified to having performed at least 5,000 barium enema studies during his 25 years of practice in his specialty of diagnostic radiology. (Transcript, pp. 58-60). In referring to the x-ray Exhibit 1G, Dr. Roggensack described what he saw as follows:

> "What we see here is a filling defect or a contour abnormality in the wall of the colon. And it extends -- it's in the proximal descending colon here on the medial wall, just below the splenic flexure, in this area here. It's characterized by -- when I say a contour abnormality, if you look at the walls of the colon in adjacent areas, you see a relatively smooth, slightly serrated normal-looking anatomic pattern, and here suddenly you see a defect. It's characterized by an indentation here with a very sharply marginated base and a surrounding lucid filling defect, which is faintly seen here, extending into the lumen of the colon. It also demonstrates what we call overhanging margins. The defect, of course, is best seen here at the superior portion, and you can see that it protrudes or extends or overhangs the wall of the colon in this -- in this area here, less apparent on the lower end. . . . (The abnormality measures) about five and a half centimeters. . . . And the radiologic features are, I think, very suggestive of a malignant colon lesion. The contour deformity, the flattened ulcerated appearance of the wall here, the overhanging margins, the mass that is present protruding into the lumen." (Transcript, pp. 69-71).

Dr. Roggensack further testified that colon lesions in the location of Patient B's are seldom missed by radiologists:

> "The least common area for a missed lesion is the area that this lesion is located in the case under question. That is the proximal descending colon, about three to

> four percent of lesions, in retrospect, are located in that area as compared to the rest of the colon. So that obviously it is going to be easier to perceive a lesion in this location, in the vast majority of cases, than in the sigmoid." (Transcript, p. 83).

Dr. Roggensack was of the opinion that the lesion was also shown on another x-ray, Exhibit 1B, but was less apparent. (Transcript, p. 71). He further testified that:

> "I think that the radiologic findings that we see in this lesion are very typical of a malignant lesion of the colon. I think it's a fairly obvious lesion; I think it's a fairly large lesion, and I believe (it) meets many of the classic radiologic findings for a malignant cancer or malignant lesion of the colon." (Transcript, p. 75).

Based upon his review of the x-rays, as well as literature on the subject, Dr. Roggensack indicated that it was his opinion that Dr. Farley's failure to diagnose the colon lesion of Patient B under the circumstances failed to conform to the degree of care, skill and judgment ordinarily exercised by the average radiologist. Transcript, pp. 75-76. More specifically, he stated:

> "I would -- in reviewing this case, it seemed to me that the location of the lesion, its radiologic features and its size, to me formed the basis of my decision that this is a lesion that would not have been missed by the average radiologist." (Transcript, p. 85).

Accordingly, the expert opinion of Dr. Roggensack that Dr. Farley's reading of Patient B's x-rays was below that of the average radiologist may be summarized as being founded upon three factors. First, the size of the lesion, which he measured as 5.5 cm.; second, its location in a region in which it is least common for a radiologist to miss a lesion, and; three, the characteristics of the "contour abnormality" depicted on the x-ray (Exhibit 1G).

Respondent's experts disagreed with Dr. Roggensack's opinions. Dr. Edward T. Stewart specializes in radiology, became board certified in 1971, and since that time has taught radiology at the Medical College of Wisconsin in Milwaukee. Since 1969 Dr. Stewart has authored or co-authored over 100 professional articles in his field. (Exhibit 20). He testified that his "subspecialty" is in gastrointestinal radiology. (Transcript, p. 229). Dr. Stewart is also involved in clinical practice within the Department of Radiology at Froedtert Memorial Lutheran Hospital in Milwaukee, and is in charge of supervising the performance and interpretation of barium enemas performed at that

facility. (Transcript, p. 230). As is the case with Dr. Roggensack, Dr. Stewart's credentials as an expert in radiology are extremely impressive.

Dr. Stewart agreed that two of the x-rays of Patient B (Exhibits 1B & 1G) show a lesion. However, it was his opinion that Dr. Farley's interpretation of the films conformed to the degree of care, skill and judgment ordinarily exercised by the average radiologist. He stated:

> "From what I know of this case, and from what I can tell from the films, I think that the performance of this examination was well within the standards of the community in which he practiced, not only across town but in the other institutions within the city of Milwaukee and the state of Wisconsin. I think he -- I think this fell well within the parameters of this type of exam. . . . I have no indication, from what I've seen. All I have seen is the films, and based on the films I'm not -- I don't think I've seen the report. I mean, based on what I can see of the films, I have no reason to think that there was any carelessness in there." (Transcript, pp. 264-265).

Another board certified radiologist, Dr. Richard S. Rozran, who indicated that he performs approximately 500 barium enema studies a year (Transcript, p. 330), testified that the lesion as shown on Exhibit 1G could be missed because of what it does *not* show:

> "A. Well, I don't see mucosal abnormalities, as far as ulcerations. It's not a lobulated appearing mass. Typically, or more frequently at least, colon carcinomas have an apple core appearance, so you'd see a similar finding on both sides. And I don't see those findings on this case. So, there aren't some of the other things. It also doesn't cause obstruction, which -- it's not large enough in the sense to cause that obstruction at this point. But you'll frequently see dilatation of the bowel behind the area of obstruction, which we don't see in this case.
>
> "Q. (Mr. Malone) Would you have missed that lesion?
>
> "A. I don't know. I mean, you know, certainly now that I've seen it, I wouldn't miss it. And it's very easy to point it out. I would hope I wouldn't miss it. We all hope to do the best and not miss cases. And certainly realizing that there is a significant error in perception, you know, I can't answer that with certainty." (Transcript, p. 324).

The testimony of Dr. Lawrence Muroff, was taken at his offices in Clearwater, Florida, and received in transcribed form as Exhibit 34. The credentials of Dr. Muroff also

appear extremely impressive in the area of diagnostic radiology. (Exhibits 35 & 32A). They include having been one of the panel of radiologists which gives the oral examination to candidates for board certification by the American Board of Radiology since 1977. His description of "errors in perception" by radiologists is clear and compelling:

> "(The phrase is) meant to describe that when you have large numbers of observations to make, and every film contains hundreds of potential observations and every series of films, therefore, contains the number of films times those observations, you will not appreciate some of those findings and it appears to be independent of your training. Now, there are people who will habitually miss because they are inattentive or they are poorly trained and those people need to be differentiated from those well trained people who are missing because of the statistical phenomena of sensory overload." (Exhibit 34, pp. 18-19).

Dr. Muroff, agreeing with Dr. Rozran, also found the question of whether or not respondent had been negligent to turn upon a consideration of what the x-rays of Patient B did not show:

> "I think that the colon case shows no apple coring or marked narrowing of the lumen of the colon. It shows no demonstrable mass. It does show a change in the appearance of the colonic wall compared to the normal adjacent wall. But that appearance could be seen with spasm, it could be seen with a peristaltic wave and therefore would not necessarily register on the conscious search pattern for abnormalities of all radiologists. I think that there would be a significant number of radiologists that would make each observation but there would be a number of radiologists that would not make those observations. . . ." (Exhibit 34, p. 30).
>
> * * * * *
>
> "If you look at the other part of the bowel you'll see a more serrated or segmented appearance. As you then get into the splenic flexure region this is less of a segmented appearance and that is presumably where the cancer is. Basically cancers can have a variety of appearances. They can narrow the colon significantly and in fact can partially obstruct the colon proximal to the obstruction dilates up. That is not present in this case. Cancers can show as a defined, discrete, lobulated mass. That does not show up in this case." (Exhibit 34, p. 35).

Dr. Muroff further disagreed with Dr. Roggensack as the significance to attach to the size of a lesion in determining whether a radiologist has been negligent in observing films:

> "Where size comes into play is when I show you where the lesion is and you say, my goodness, I see it. It's that big. But in fact in either the McMasters, which is the Canadian study, or the Swedish study, the average size of the miss was about three and half centimeters. So, you're well within a quarter of an inch of what this lesion is, and if we're talking about average size, then they've missed larger lesions and missed smaller lesions. Obviously if something is microscopic in size you're not going to see it. But I think where size comes into play more is your retrospective approach to it, particularly if this something that you're not familiar with. If you're a lay person or a physician of a different specialty and you say, well, my God, it's that big. But if you're not going to see it or if your mind is telling you that it is a peristaltic wave, peristaltic waves can be much larger than that or your mind tells you it is feces within the colon or something along that line, once you've not made that connection with cancer in your perception situation, size plays a little role. It probably plays some role but not a major role." (Exhibit 34, pp. 35-36).

Testimony of the experts also indicated that another highly important portion of the barium enema procedure is the fluoroscopy, during which Dr. Farley would have turned Patient B at various times and watched via a monitor as the barium flowed through different parts of the bowel. The fluoroscopic procedure normally is not video taped and was not in this case. Dr. Muroff testified, however, that he did not believe that the lesion in this case would likely be detected during that phase of the examination since,

> ". . . the lesion does not appear to be constrictive or obstructive and therefore I don't believe that a retrospective review of any video would show an alteration of the flow of barium through the colon". (Exhibit 34, p. 41).

Additionally, in this specific case there was testimony that the important fluoroscopic portion of the barium enema study was made significantly more difficult due to the size and weight of the patient. Dr. James Youker testifying via deposition, stated that Patient B was a very obese patient, making even the film copies very difficult to interpret. (Transcript, pp. 350, 353-354).

Dr. Youker testified:

> "The obesity results in necessary film techniques which make it more difficult. I'm sure that, because of the patient's obesity, that they had to increase the

> kilovoltage, which is the penetrating power of the x-ray beam going through the patient. The lower the kilovoltage, the easier it is to detect the differences between the barium and a soft tissue density within the barium. And in this particular sort of situation you just don't see the difference. Now, you also can use a high KV technique which will burn through the barium. But in this particular case I think that patient's obesity made it difficult to really see what's going on. . . . I think it's a very hard lesion to see." (Transcript, pp. 365-367).

The difficulty in performing the fluoroscopy upon an obese patient was also articulately confirmed by Dr. Leonard Berlin in his testimony. (Transcript, pp. 397).

Dr. Youker further indicated that when he was first shown the x-rays "cold" (i.e., without any guidance as to what to look for), he missed the abnormality on Exhibit 1G at issue. (Transcript, p. 370). He was further of the opinion that the size of the abnormality was approximately 3½ centimeters (Transcript, p. 365), rather than the 5½ centimeters measured by Dr. Roggensack.

A second basis for the state's conclusion that Dr. Farley had been negligent, was its expert's belief that lesions located in the splenic flexure region, such as was the circumstance regarding Patient B, are rarely missed by radiologists. However, that appears to be a reflection of the fact that lesions rarely appear in that area. Dr. Berlin explained:

> "Errors and misses -- misses in the splenic flexure are not reported very common, probably only about two or three percent. And that's simple -- there's a reason for that. And that is that the incidence of cancer of the splenic flexure is not reported very often, and that's probably about two or three percent. So I think that the fact is that the error rate in the splenic flexure is the same as the error rate anywhere in the colon. Obviously, in the big scheme of things, there are fewer errors in the splenic flexure because there are fewer cancers in the splenic flexure. But for a given amount of cancers, there's the same error rate." (Transcript, pp. 402-403).

Dr. Stewart agreed, saying: "Because there's not many that occur up there . . . you don't miss too many up there because not too many occur up there anyway." (Transcript, p. 286).

With respect to the argument that the characteristics of the contour abnormality depicted on the x-ray were such that the average radiologist would not have missed it, Dr. Berlin disagreed. The difficulty in viewing colon x-rays, according to Dr. Berlin is as follows:

"The problem is that in the colon in particular, unlike the bone, where -- you know, we know there's only one tibia and one fibula and there's only one femur. However, in the colon, there's many parts of the colon. It overlaps each other, and may parts obscure other parts. And we try our best to analyze each part. So, with that as a background, we now look at the colon in question. And, yes, now that I know and after I found out that this patient had a tumor of the splenic flexure of the colon, in retrospect, as I look back, I think I can put my finger on an area in the splenic flexure that looks slightly out of the ordinary as far as normality goes, and say well, knowing that this patient had the tumor, I think this is the tumor. But it is my firm opinion that in looking at all the films and in putting myself in the place of a radiologist looking at this case prospectively, I think that that's a very subtle finding. And I believe that a radiologist who fails to note an abnormality in that splenic flexure is acting well within the standards." (Transcript, pp. 398-399).

* * * *

"Well, I don't see anything distinct or unusual about it. I mean, it is a subtle cancer. Listen, we have cancers that are very -- that are very obvious and cancers which are very subtle. And this is a subtle cancer. It is the most common type of miss that's made. That isn't to say that there aren't misses in very obvious cases, too. But, you know, most of the cases that are missed are very subtle cases. And this certainly falls into that category." (Transcript, p. 404).

Dr. Muroff was of the same opinion as Dr. Berlin and offered the following conclusions:

"To just explain that if you discipline Dr. Farley for that miss, then you are basically saying that the faculties at McMasters in Canada, which is a superb university, are somehow negligent and deserving of censure because they have also missed a significant number of similar colonic cancers. You must then censure the radiologists at Mayo (Clinic) who missed far more in a percentage basis than we are aware of Dr. Farley's missing. So, if you're asking me whether a miss constitutes a breach in responsibility or a breaching of standard of care, it does not. Now, having said that, let me also say that does not excuse any radiologist from censure because radiologists can intentionally, through ignorance or otherwise, harm patients. Radiologists can miss things through inattention or insufficient education and there is no evidence that Dr. Farley falls into any of those categories. Radiologists can misperform studies and (do) harm to patients. So there are a variety of reasons why radiologists can and should be disciplined. I just don't see Dr. Farley falling into those categories." (Exhibit 34, pp. 32-33).

In reviewing the testimony provided, it is my opinion that it has not been established that Dr. Farley engaged in "negligence in treatment" respecting Patient B. The subtlety of the colon abnormality, in combination with the difficulties in diagnosis presented by Patient B's size, lead to the conclusion that it has not been shown that Dr. Farley failed to exercise that degree of care and skill which is exercised by the average radiologist, acting in the same or similar circumstances, in reviewing the films.

In reaching this conclusion, reliance upon expert testimony is necessary. In this case, all of the experts are highly qualified, and one must conclude "minimally qualified" to practice and well above "average" radiologists. However, each expert candidly admitted to having made "mistakes" in interpreting x-rays. In fact, Dr. Rozran testified that any radiologist who had practiced for more than a year and claimed not to have missed abnormalities on x-rays was not being intellectually honest. (Transcript, p. 330). Under a literal interpretation of the standard of "negligence in treatment", each is subject to discipline for the individual "mistake" made, because the average radiologist would not have made the mistake in the specific instance. However, such an approach elevates the "average" physician to the perfect physician in a given case. Although an average physician will make mistakes, it would not have been made in this one, so the argument must go. However, as stated in the context of a negligent misrepresentation malpractice case:

> "Perfection is a standard to which no profession can possibly adhere. Doctors are required to exercise reasonable care, they are not required to be perfect. The threat of legally-mandated negligence for any possible inaccuracy will result in equivocal advice by doctors to their patients. Furthermore, such a conclusion would accept the principle of strict liability, in fact, if not in name." *Black v. Gunderson Clinic, Ltd.*, 152 Wis. 2d 210, 215-216 (Ct. App. 1989).

Under the circumstances and testimony presented, Dr. Farley's "inaccuracy" or "miss" respecting his failure to detect the abnormality within the colon of Patient B has not been shown to be due to his failure to exercise due care.

The second instance of alleged negligence in treatment by Dr. Farley occurred in October, 1987 and involved x-rays interpreted by Dr. Farley relating to Patient A who had been involved in a moped accident, resulting in his scrapping and bruising his left knee and experiencing pain in that knee. Dr. Farley's x-ray report stated:

> "The views of the left knee suggest a small joint effusion. The study indicates no evidence of fracture."

However, Patient A continued to experience pain and a follow-up x-ray performed by another physician a little over two weeks later showed a large free fragment from the medial femoral condyle which necessitated surgical intervention.

The expert testimony again approached the issue of negligence in treatment in this case as being largely influenced by whether the abnormality shown upon the x-ray was "obvious" or "subtle", as that factor impacts upon the ability or likelihood of the average radiologist's detecting the problem area.

Dr. Roggansack provided testimony in support of a finding that Dr. Farley had been negligent. His testimony, which included references to the x-rays taken, indicates that the radiographs show an abnormality in the left knee area of Patient B. (Transcript, pp. 85-88). However, he does concede that the "radiologic findings here are more subtle than on the colon x-ray" involving the previously discussed case regarding Patient A. (Transcript, p. 85).

Additionally, the testimony presented by the respondent's experts are even more emphatic regarding the subtlety of the abnormality presented on Patient A's knee x-rays than in was in respect to the colon x-rays of Patient B. For example, Dr. Berlin stated:

> "My opinion is that very definitely that neither case would constitute negligence in any respect. I think from -- based on my own experience in reviewing so many of these cases, these are very, very subtle changes. I would say that the bone case where -- *the alleged missed fracture of the femur, is extremely subtle, and I would venture to say very few radiologists would make that diagnosis.*
>
> "I think that the colon case is perhaps one notch less subtle, but nevertheless extremely subtle as well. And I believe it's a very difficult diagnosis to make. That isn't to say that certain radiologists won't make the diagnosis." (Transcript, p. 387; Emphasis added).

Dr. Rozran also indicated that he had more difficulty in finding the abnormality respecting the knee of Patient A, than the colon abnormality in Patient B:

> "The (colon abnormality in the) barium enema case took awhile, but I found it and was able to confirm it because I could see it. You know, I mean it was -- it's there. The knee case, I took a long time. I really -- I really did. And while I -- you asked me before would I make this diagnosis on the colon case, and I said I hoped I would. For the knee case, I very well could have missed it. And I really am trying to be honest there, because it did take me awhile, and I knew there was pathology there." (Transcript, pp. 329-330).

Perhaps the frankest comment regarding the ability to detect the abnormality on the knee x-ray was made by Dr. Younker. He stated, flatly:

> "I saw those knee x-rays, and I would not have made the diagnosis here, too." (Transcript, p. 356).

In my opinion, Dr. Farley was not negligent in his treatment of Patient A.

Conclusion

The cases presented in this proceeding involve a radiologist who did not detect abnormalities upon x-rays which all of the experts agree after retrospective review and scrutiny, were capable of observation. Additionally, both parties agree that Dr. Farley meets the standards of a "minimally competent" radiologist under the standard applicable to charges of "unprofessional conduct". However, they disagree as to whether or not he achieves that of an "average" radiologist, pursuant to the "negligence" standard.

There is a temptation to succumb to a literal reading of the "negligence in treatment" as being that if the mythical "average" radiologist would be likely to have observed the abnormality in the case under consideration, negligence is irrefutably established. The problem with this approach is that its application elevates the "average" radiologist to the level of "perfect" radiologist in any given case. The record here strongly suggests that every radiologist in this state -- no matter how competent, well-trained, experienced or conscientious -- has missed an abnormality on a radiograph which in retrospect the "average" radiologist would not have missed. Accepting the state's theory in this case would result in the inevitable conclusion that every radiologist in this state is subject to discipline if the specific incident is discovered and brought to the attention of the board. In my opinion, this is not the result desired nor intended by the Legislature in making "negligence in treatment" grounds for revocation of a physician's license in a disciplinary proceeding.[5]

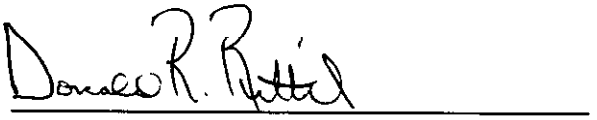
[5] Similarly, an issue arising immediately prior to the hearing was whether or not the state also has the burden of establishing that the negligence caused harm to a patient in order to meet the disciplinary standard required to find that "negligence in treatment" occurred. Somewhat ironically, the state contended that it must show "causation", as in civil malpractice case, whereas the respondent claimed it did not.. Again, there was no clear authority presented by counsel on the issue of the Legislative intent on this issue. It appears that the "causation" factor necessary to establishing a civil negligence case, might be considered equivalent to the concept of "aggravating circumstances" bearing upon appropriate sanctions to be imposed once professional misconduct has been determined to have occurred in a disciplinary case. In any event, the hearing did not consider evidence of "causation" given that to permit respondent adequate time for discovery on that issue would have necessitated a postponement of the dates set for hearing, which neither side desired. Accordingly, if the board determines that negligence has occurred in either or both of the counts in this case, the matter should be remanded for additional proceedings on the issue of whether that negligence was causative of patient harm.

The ultimate issue to be decided in a disciplinary proceeding is whether the physician should be permitted to continue in practice. The issue is not who should bear the *economic* burden of a "mistake", unlike the goal of the fault-based civil malpractice system. Here, the abnormalities were subtle, although capable of observation. In both cases, the average radiologist, in my opinion, could have missed them. In Dr. Farley's case, he did. However, it is my opinion a finding that Dr. Farley engaged in negligence in this case would only serve to deprive the citizens of this state of a conscientious and extremely competent physician.

This case should be dismissed.

Dated this 26th day of October, 1995.

Respectfully submitted,



Donald R. Rittel
Administrative Law Judge

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