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Exhibit A

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

FILE COPY

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

Case No. LS-9103071-MED

ALONZO R. GIMENEZ, M.D.,

Respondent

FINAL DECISION AND ORDER

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

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

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

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

The rights of a party to petition the board for rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal Information."

A hearing was conducted in the above-captioned matter on February 10, 1992. Dr. Gimenez appeared in person and represented by Attorney Milton Spoehr. The respondent was represented by Attorney Gilbert C. Lubcke. The Administrative Law Judge submitted his Proposed Decision on August 14, 1992. Mr. Lubcke filed his objections to the Proposed Decision on September 8, 1992. Respondent, by Attorney Spoehr, also filed objections.

The parties appeared for oral arguments on their respective objections at the board's meeting of October 21, 1992, and the board considered the matter on that date.

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

FINDINGS OF FACT

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

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

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

With regard to Count I of the Complaint:

Initial symptoms, diagnoses and treatment.

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

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

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

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

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

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

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

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

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

13. The Clinical Record for Patient I shows the following temperatures:
April 16: 98.4, 101.6, 100.2, 101.2
April 17: 100.4, 101.0, 97.4, 98.8
April 18: 100.4, 98.6, 98.8, 99.8
April 19: 100.2, 99.4, 98.2
April 20: 98.6, 97.4, 100.2
April 21: 100.4, 97.0, 100.8
April 22: 99.2, 98.2, 101.4
April 23: 98.0, 98.8, 99.0
April 24: 99.2, 96.8, 102.6
April 25: 101.6, 100.4, 101.8

14. The medication administration record for Patient I shows that narcotic analgesics, either Tylenol #3 or Demerol & Vistaril, were administered at the following times:
April 16: 0645, 1010, 1510, 1515
April 17: 0130, 0925, 1030, 1715
April 18: 0145, 1430
April 19: 0015, 0500, 1430
April 20: 1240, 2030
April 21: 2130
April 22: 1000, 1400, 1815, 2315
April 23: 0320, 0900, 1315, 1725
April 24: 0345, 1100, 2040
April 25: 0600, 1200, 2000

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

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

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

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

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

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

Surgery.

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

20. The pathologist's report for the tissue removed during the exploratory laparotomy states "Gross Specimen is labeled omentum and abscess consists of five irregular hemorrhagic tissue fragments total weighing 180 grams and measures 3.5, 5.6, 7.0, 6.0, and 14.0 cm in maximum measurement respectively. The tissue fragments appear to be mesenteric fat all of which contains area of fibrosis and hemorrhage. One of this fatty tissue covered with blood and fibrous tissue contains appendix which measures approximately 6 cm. in length and appears to be perforated. Multiple representative sections submitted for microscopic examination. Microscopic: Microscopic sections demonstrate ruptured acute gangrenous appendicitis with extensive inflammatory reaction on the mesenteric fat forming abscesses. There is evidence of hemorrhage and acute inflammation on the mesenteric omentum. No malignancy is noted. Diagnosis: Appendix, fragments of omentum: Ruptured acute gangrenous appendicitis with extensive inflammatory reaction in the omentum and abscess formation."

With regard to Count II of the Complaint:

Initial symptoms, diagnoses, and treatment.

21. Patient II, d.o.b. 5/19/09, appeared for an office visit with Dr. Gimenez on June 23, 1988 complaining of urinary pain, urinary frequency, and pains in her left

flank. A urinalysis disclosed bacteria and white blood cells, but no red blood cells, in her urine. Dr. Gimenez diagnosed an acute urinary tract infection and prescribed Septra DS.

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

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

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

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

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

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

28. The IVP was performed on September 7, 1988, and the report stated "IMPRESSION: An approximately 2x4 cm. diameter filling defect involving the right lateral bladder. This may represent either a bladder neoplasm or an indentation secondary to an extrinsic mass. There is moderate right hydronephrosis and

hydroureter secondary to this. If clinically indicated, a CT scan of the abdomen and pelvis may be of additional help."

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

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

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

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

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

Surgery.

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

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

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

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

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

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

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

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

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

43. Analysis of the biopsied tissues showed (1) metastatic cells in the lymph nodes consistent with stage IV transitional cell carcinoma, (2) an infiltrating transitional cell carcinoma, either stage III or stage IV, inside the bladder, and (3) a simple cyst without evidence of malignancy in the right ovary.

With regard to Count III of the Complaint:

Initial symptoms, diagnoses and treatment.

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

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

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

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

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

Surgery.

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

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

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

With regard to Count IV of the Complaint:

First surgery and subsequent progress.

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

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

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

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

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

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

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

58. Dr. Gimenez did not intervene surgically, but on September 13th he ordered a change in the antibiotics Patient IV was receiving from Mefoxin to gentamycin, Flagyl, and Zinacef. Patient IV's white blood count on 9/7/88 was 11,400, on 9/8 it was 16,400, on 9/10 it was 17,000, on 9/13 it was 13,000, on 9/14 it was 22,200, on 9/15 it was 23,100 and later 23,000, and on 9/16 it was 17,000.

Second surgery.

59. On September 16th Dr. Gimenez was called out of town. He turned the care of Patient IV over to Dr. Barry Rogers. Patient IV was afebrile but later that day she developed increased abdominal pain. Dr. Rogers discussed an operation with Patient IV's daughter, estimating that a 20 percent cardiac risk existed. He then operated on Patient IV and found that one of the anastomoses had been disrupted and that about 10 ccs of stool had entered the abdominal cavity but that it had been completely walled off

by the omentum. He also found the fluid collection shown on the CT scan to be cloudy serosanguinous fluid and aspirated it. He created a colostomy to replace the disrupted anastomosis.

With regard to Count VI of the Complaint:

Initial symptoms, diagnoses and treatment.

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

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

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

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

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

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

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

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

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

With regard to Count VII of the Complaint:

Initial symptoms, diagnoses and treatment.

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

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

71. On June 5, 1988, Patient VII was admitted to the emergency room of Berlin Memorial Hospital, complaining of shortness of breath, especially upon exertion, and occasional sharp chest pains from where he had injured his right chest. Dr. Gimenez examined him and noted rapid shallow breathing with bluish lips, a contusion on the

right side of his chest, and marked edema of the legs, scrotum and penis. An electrocardiogram was run which showed atrial fibrillation. Dr. Gimenez diagnosed congestive heart failure and ordered digoxin and a different diuretic, Lasix, 40 mg/day.

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

73. Dr. Gimenez then ordered a CT scan, which was done on June 16th, disclosing a "huge" pericardial effusion. Dr. Gimenez examined Patient VII for signs of tamponade and found none. His investigation covered whether the veins in the neck were distended and whether the blood pressure lowered upon taking a deep breath.

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

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

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

CONCLUSIONS OF LAW

1. The Medical Examining Board has personal jurisdiction over the Respondent based on fact #1 above and paragraph A above under "Posture of Case".

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

3. With regard to his treatment of Patient I, Respondent violated sec. MED 10.02(2)(h), Wis. Admin. Code and sec. 448.02(3), Wis. Stats. by delaying an exploratory laparotomy beyond April 24, 1988 in the presence of one or more diagnosable abdominal abscesses. Respondent did not violate any rule or statute by performing a diverticulectomy during the exploratory laparotomy.

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

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

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

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

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

ORDER

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

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

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

EXPLANATION OF VARIANCE

The Medical Examining Board has accepted the administrative law judge's Findings of Fact in their entirety, and has accepted all but one of the proposed Conclusions of Law. The administrative law judge (ALJ) found at his Conclusion of Law VIII that Dr. Gimenez' treatment of Patient VII fell below minimum standards of competence because he continued the patient on a diuretic after becoming aware of the patient's pericardial effusion. The board finds insufficient evidence to support that conclusion, and has therefore found no violation as to this Count.

Dr. Green's expert testimony on this aspect of the case was in part as follows:

> Q. Do you have an opinion to a reasonable degree of medical certainty in what respects, if any, Dr. Gimenez' handling of this matter fell below minimum standards of competence accepted in the profession?
>
> A. The patient either had to have an echocardiogram as an emergency procedure or he should have been transferred to a hospital where an echocardiogram could be done.
>
> Q. And why is it important in terms of -- in terms of a minimally competent response to this situation?

A. Because if there was evidence of tamponade, then the patient needed to have a periocardial tap and shouldn't have been sent home on diuretics. On the other hand, if there was no evidence of tamponade, the use of diuretics may not be wise in the dosages that we use, but it's not absolutely contraindicated.

The board concludes that the clinical evidence in this case, as set forth in the record, was adequate to preclude a diagnosis of cardiac tamponade. The board agrees with the complainant's expert that absent evidence of tamponade, to have continued to order diuretics for this patient in the particular situation presented did not fall below minimum standards of competence established in the profession, and Conclusion of Law #8 has therefore been amended to find that no violation occurred.

The second variance from the ALJ's Proposed Decision may be found in the Order. While the board agrees that a six month suspension of Dr. Gimenez' license is appropriate in subserving the disciplinary objective of deterrence, it is not sufficient in terms of rehabilitation or public protection. To the extent that Dr. Gimemez' conduct in this case raises questions as to his current competency, witholding his privilege to practice for six months, without more, will do nothing to ensure that remediation has taken place. The board therefore orders that Dr. Gimenez submit to an assessment by Dr. Thomas Meyer to determine what remedial program, if any, is necessary, and to complete any such program recommended by Dr. Meyer. The board also orders that until Dr. Gimenez completes whatever program is recommended by Dr. Meyer, his license to practice be limited consistent with recommendations made by Dr. Meyer and approved by the board.

Finally, the board finds the ALJ's basis for failing to order that costs be assessed against Dr. Gimenez in this case unpursuasive. The ALJ reasons that because Dr. Gimenez' conduct was well-intentioned and inadvertant, and because an order for costs would constitute a financial burden on him, no costs should be assessed. The board considers the clear purpose of Wis. Stats. sec. 440.22(2) to be to permit the recovery of costs expended in prosecuting disciplinary matters regardless of the nature of the unprofessional conduct found, and regardless of the financial situation of the respondent. By assessing less than the full amount of the costs, however, the board

has recognized the not inconsiderable expense involved in undergoing an evaluation and education program through the continuing medical education department at the University of Wisconsin. If assessing less than full costs encourages Dr. Gimenez to undertake whatever program is recommended by Dr. Meyer, the public's interest will be well served.

Dated this 10 day of November, 1992.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by B. Ann Neviaser
B. Ann Neviaser
Secretary

WRA:BDLS2:2418

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 November 11, 1992.

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

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

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

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

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

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

1. The tax appeals commission, the department of reven

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

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

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

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

(d) The agency (except in the case of the tax appe commission a review board, the consum credit revi n review board, and savings and loan review board) and all parties to the proce ing before it, shall have the right to participate in proceedings for review. The court may permit other int ested persons to intervene. Any person petitioning the co to intervene shall serve a copy of the petition on each pa who appeared before the agency and any additional parties the judicial review at least 5 days prior to the date set hearing on the petition.

(2) Every person served with the petition for revie v provided in this section and who desires to parti in proceedings for review thereby instituted shall serve upon petitioner, within 20 days after service of the petition u such person, a notice of appearance clearly stating person's position with reference to each material allegation the petition and to the affirmance, vacation or modificati of the order or decision under review. Such notice, other th by the named respondent, shall also be served on the nam respondent and the attorney general, and shall be file together with proof of required service thereof, with the cle of the reviewing court within 10 days after such servi Service of all subsequent papers or notices in such proceedi need be made only upon the petitioner and such other perso as have served and filed the notice as provided in t subsection or have been permitted to intervene in said pr ceeding, as parties thereto, by order of the reviewing cour