# WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

LS9110011MED

RICHARD EDER, M.D.,

Respondent

FINAL DECISION AND ORDER

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

Richard Eder, M.D.
Brooks Building
Hayward, WI 54843

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

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

A hearing was conducted in the above-captioned matter on March 17th and 18th, 1992. Dr. Richard Eder, respondent herein, appeared in person and without legal counsel. The complainant was represented by Attorney Pamela M. Stach.

The administrative law judge (hereinafter, ALJ) filed his Proposed Decision on September 14, 1992. Dr. Eder filed his objections to the Proposed Decision on or about September 30, 1992; Ms. Stach filed her objections on October 8, 1992. No oral arguments on the objections were heard. The board considered the matter on October 21, 1992.

Based upon 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 Richard Eder, M.D., is and was at the time of the facts set forth below a physician licensed to practice medicine and surgery in the state of Wisconsin, under license number 16796-5, originally granted on July 9, 1969.

2. Dr. Eder practices what he characterizes as adult general medicine, by which he means general practice minus pediatrics, obstetrics and surgery. Dr. Eder also practices ophthalmology to the extent of doing refractions.

3. Dr. Eder has hospital privileges at Hayward Area Memorial Hospital, and had hospital privileges there at the time of the facts set forth below.

With regard to Patient I

4. Beginning in approximately September 1973 Dr. Eder provided medical care and treatment for Patient I, d.o.b. 8/20/1898.

5. Hemoglobin levels and hematocrits for Patient I in Dr. Eder's office records from 1985 on are as follow:

| Date | Hemoglobin | Hematocrit |
|---|---|---|
| 3-19-85 | 12.3 | 34 |
| 4-16-85 | (not reported) | 35 |
| 6-14-85 | 12.5 | 37 |
| 9-9-85 | 12.1 | 34 |
| 12-4-85 | 11.6 | 32 |
| 10-2-86 | 11.4 | 32 |
| 3-24-87 | 11.6 | 30 |
| 12-11-87 | 11.2 | 25 |
| 4-11-88 | 8.7 | (not reported) |

6. On 12-11-87, the day on which Patient I's hematocrit was reported as 25, the following notation appears in Dr. Eder's office records: "Routine. Check cholesterol, potassium, hemoglobin, hematocrit. 120/60. Not feeling as good as normal. Heart OK. 106 pounds. Lab OK. Needs iron. Will use multiple vitamins and iron. May use Fero B." Dr. Eder did not perform tests to make a diagnosis of the patient's anemia, but concluded that she had an iron deficiency anemia based on her report to him that while on vacation in Florida she had been hospitalized following a nosebleed, and that a hematologist there had given her a prescription, which Dr. Eder saw, for supplemental iron.

7. On March 7, 1988 Dr. Eder gave Patient I an injection of Fero B, an iron supplement.

8. On March 21, 1988 Dr. Eder ordered a urinalysis on Patient I, noted that she had a urinary tract infection, and ordered a ten-day supply of Azo-Gantanol, an antibiotic.

9. On April 11, 1988, the day on which Patient I's hemoglobin level was reported as 8.7, Dr. Eder gave Patient I another injection of Fero B, and a urinalysis indicated a continuing infection.

10. On April 14, 1998 Patient I was admitted to Hayward Area Memorial Hospital via the emergency room, complaining of edema in both legs and feet, and feeling a need to urinate but being unable to do so. At the time of admission, her blood urea nitrogen level (BUN) was 90 (high), her hemoglobin level was 6.9 grams (low), and her hematocrit was 26.5 (low).

11. At the time of admission, Dr. Eder performed a history and physical exam on Patient I, summarizing it with the following: "Impressions: 1. Acute and chronic heart failure secondary to severe rheumatic valvular disease. 2. Anemia, etiology undetermined."

12. On 4/14/88 Dr. Eder ordered that Patient I's stool be checked for blood and he offered her a transfusion, which she refused. He did not order a serum iron test during her hospitalization.

13. At the time of Patient I's admission, Dr. Eder did not perform a urinalysis and did not provide any treatment for her urinary tract infection until April 16th, when he ordered Macrodantin as an antibiotic.

14. Upon admission, Dr. Eder ordered a test of the digoxin level in her blood. When informed later that day that her digoxin level was 2.9 (high), he discontinued an order for Lanoxin.

<u>With regard to Patient II</u>

15. Dr. Eder provided medical care and treatment for Patient II, d.o.b. 6-11-13, beginning in approximately February 1979.

16. On November 4, 1988 Patient II visited Dr. Eder complaining of nausea. Dr. Eder diagnosed influenza and prescribed Ceclor.

17. At 12:50 P.M. on November 5, 1988 Patient II was admitted to Hayward Area Memorial Hospital via the emergency room, complaining of vomiting and diarrhea. At the time she entered the emergency room, her blood pressure was 82/50 (low) and her white blood count was 14,600 (high).

18. An x-ray taken at the time of admission showed right upper lobe pneumonia. The emergency room physician had ordered tetracycline, and Dr. Eder changed the order to Cefobid. Dr. Eder also ordered a sputum culture to verify the appropriate antibiotic for the pneumonia.

19. Patient II's blood pressure following admission was as follows:

| | | |
|---|---|---|
| 11-5 at | 1250 | 82/50 |
| | 1325 | 60/52 |
| | 1600 | 68/50 |
| | 1730 | 90/50 |
| | 2000 | 84/50 |
| 11-6 at | 0000 | 66/48 |
| | 0600 | 58/50 |
| | 0800 | 70/52 |
| | 1000 | 80/60 |
| | 1015 | 88/55 |
| | 1200 | 90/52 |
| | 1400 | 94/62 |
| | 1600 | 88/50 |

20. Patient II's urine output during the first 1 1/2 days of her hospitalization was as follows:

| | |
|---|---|
| from 1250 on 11-5 to 1500 | 0 cc |
| from 1500 to 2300 | 80 cc |
| from 2300 to 0700 on 11-6 | 50 cc |
| from 0700 to 1500 | 400 cc |
| from 1500 to 2300 | 1250 cc |

21. At 1345 on the date of admission Dr. Eder ordered that Patient II be given fluids intravenously, and he directed the nurses to recheck her blood pressure and notify him. Dr. Eder was notified that her blood pressure at 1700 was 68/50, and he was notified that at 1730 it was 90/50.

<u>With regard to Count IV</u>

22. On August 19, 1983, Dr. Eder ordered three schedule II controlled substances: 200 25 mg tablets of Preludin; 400 5 mg tablets of Dexedrine; and 2 20 ml vials of injectable Demerol, 100 mg/ml. Dr. Eder received the Preludin and the Demerol; he did not receive the Dexedrine.

23. On January 11, 1984, Dr. Eder ordered 500 25 mg tablets of Preludin and 200 75 mg tablets of Preludin. Dr. Eder received the Preludin as ordered.

24. On March 27, 1986, Dr. Eder ordered 100 75 mg tablets of Preludin; 200 5mg tablets of Dexedrine; and 50 15 mg tablets of Dexedrine. Dr. Eder received the Preludin and the Dexedrine as ordered.

25. At the time Dr. Eder ordered and dispensed all the schedule II controlled substances listed above he did not maintain a separate controlled substances log.

## CONCLUSIONS OF LAW

1. The Medical Examining Board has personal jurisdiction over the Respondent, based on fact #1 above and paragraph A under "Procedural History".

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

3. With regard to Patient I, Dr. Eder's decision not to order a serum iron test when Patient I was admitted to Hayward Area Memorial Hospital on April 14, 1988 did not fall below minimum standards of competence established in the profession. Dr. Eder's decision not to order a urinalysis for Patient I did not fall below minimum standards of competence established in the profession. Dr. Eder's failure to treat Patient I's urinary tract infection until April 16, 1988, did not fall below minimum standards of competence established in the profession.

4. With regard to Patient II, Dr. Eder's lack of inquiry into the cause of Patient II's low blood pressure when she was admitted to Hayward Area Memorial Hospital on November 5, 1988, fell below minimum standards of competence established in the profession, and constituted unprofessional conduct under Wis. Adm. Code sec. 10.02(2)(h). Dr. Eder's lack of inquiry to determine whether Patient II was septic did not fall below minimum standards of competence established in the profession.

5. With regard to Count IV of the complaint, Dr. Eder's actions in failing to maintain a separate controlled substances log constituted unprofessional conduct under sec. MED 10.02(2)(a), Wis Admin. Code.

## ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Richard L. Eder, M.D., to practice medicine and surgery in the state of Wisconsin be suspended for a period of 60 days, effective 10 days following the date hereof.

IT IS FURTHER ORDERED that during the period of suspension, Dr. Eder shall complete not less than 25 hours of continuing medical education approved by an officer of the board in risk management and general medicine. The continuing education ordered hereby shall be in addition to requirements for continuing medical education under ch. MED 13, Wis. Admin. Code.

IT IS FURTHER ORDERED that pursuant to Wis. Stats. sec. 440.22(2), the costs of this proceeding shall be assessed against Dr. Eder.

## EXPLANATION OF VARIANCE

The board has accepted the ALJ's Findings of Fact in this matter, but has modified his recommended Conclusions of Law, and has modified as well the proposed discipline.

The ALJ found as to patient 1 that Dr. Eder's failure to treat the urinary tract infection until two days after the patient's admission fell below minimum standards of competence established in the profession. Evidence in the record satisfactorily establishes that the bladder infection was a recurring condition and was asymptomatic at the time of admission. The board therefore agrees with the testimony of both Dr. Eder and complainant's expert witness, Dr. Beasley, that it was not inappropriate to withhold antibiotic treatment of that condition while treating the patient's acute heart failure and digitalis intoxication, in order to avoid aggravating the potential nausea problem associated with toxic levels of digoxin.

> Q. (by Dr. Eder) What I'm getting at, Doctor, is would it not be reasonable to wait a couple of days before administering the antibiotic in a patient that you are trying to detoxify from dig., when it is your clinical opinion that her urinary tract infection is a bladder infection and that it's been a common problem that you've treated many times over the years because you do happen to know this patient pretty well? Would that be reasonable to wait a couple of days?
>
> A. (by Dr. Beasley) I guess I'd have to say that yes, it is . . . reasonable, Doctor. [Tr., pp. 146-147]
>
> * * * *
>
> Q. (by Ms. Stach) . . . And I would ask you at this time to tell me that in weighing the risks of causing any nausea and in dealing with the digoxin toxicity, I would like you to weigh that against the need to keep this patient infection-free as much as possible and tell me whether or not a minimally competent physician would have prescribed the Macrodantin upon admission to the hospital.

A. (by Dr. Beasley) I think it was necessary to prescribe some antibiotic. I probably would not personally have used Macrodantin in here, although I don't think it's unreasonable to do so, or to have embarked on getting culture which would have documented what was causing the infection and what it was due to. Overall, my -- given what Dr. Eder has said about not wanting to cause nausea and the fact that she had tolerated this infection well, I would not at this point say that it was unreasonable to wait that two days. I would have to agree on that point. I think though still that a work-up should have been done [Tr., pp. 158-159].

The board cannot agree with the ALJ's conclusion that Dr. Eder's failure to inquire into the cause of Patient II's low blood pressure when she was admitted on November 5, 1988, did not fall below minimum standards of competence established in the profession. The board accepts the testimony of complainant's expert witness that where a patient is admitted with a blood pressure of 82/50, which drops in the first hour to 60/52 with decreased urine output, failure to investigate the cause of these dangerously low blood pressure levels constituted a danger to the safety of the patient in that there was a possibility, in the words of Dr. Beasley, of "stroke, a cerebral vascular accident, a myocardial infarction or simply failing to survive." The board also accepts Dr. Beasley's opinion that a minimally competent response to Patient II's acute hypotension was a fluid challenge, and that the medical order for one liter of fluids over the first eight hours following admission was insufficient in that regard [Tr., p.132].

In his testimony and in his cross-examination of Dr. Beasley, Dr. Eder suggested a number of possible conditions which could cumulatively account for this patient's hypotension. These included aortic stenosis and aortic insufficiency, mitral stenosis and mitral insufficiency, myocardial infarction, dehydration, pneumonia, and bed-rest. Dr. Eder is probably correct that one or more of these conditions contributed to the patient's low blood pressure. The problem is that Dr. Eder did not make the inquiry necessary to determine which of them in fact caused it. As a result, the event or events which accounted for the precipitous change from chronic hypotension to dangerously low blood pressure remains in question.

Q. (by Ms. Stach) Now, Doctor, assuming for a moment that this -- these conditions could cause hypotension in a patient, is that -- first of all, can these conditions cause low blood pressure in a patient?

A. (by Dr. Beasley) For clarification, by "these conditions," you mean the heart conditions themselves?

Q. Right. No -- well, again, the aortic stenosis, the aortic insufficiency, the mitral stenosis and the mitral insufficiency, which were specifically what Dr. Eder asked you about?

A. Yes, they can.

Q. They can. And is this a chronic condition?

A. Yes.

Q. Is it reasonable to assume then, Doctor, that the blood pressure would remain chronically low because of these conditions?

A. Unless there's some change in something and there -- there certainly could be. So if the conditions don't change much and the ventricle maintains the same quality, which would be questionable in the event of a myocardial infarction, yes, they should remain the same.

Q. Doctor, if I told you that the medical records for Dr. Eder between 1979 and 1988, prior to the hospitalization in 1988, reflected blood pressures of, for example, 120 over 70, 140 over 90, 115 over 65, 105 over 65, 110 over 60, then upon hospitalization the blood pressure was noted at 82 over 50 and subsequently dropped the same day to 60 over 52, would you find that in fact some event had occurred to change the blood pressure of this patient?

A. That, yes, would suggest to me and I -- I think would reasonably suggest that there is -- that something has happened to this patient, some event.

Q. Is it be reasonable to assume that something in addition to the chronic conditions that we talked about just previous to this is also occurring?

A. I think either a change in her cardiac status or a change in her blood volume or, as I say, she could be getting ill and septic for other reasons. Any of these three are possibilities at the time she initially presents.

Q. Would you still take the opinion, Doctor, that a minimally competent physician would have explored the change in blood pressure upon admission to the hospital?

A. Yes. [Tr., pp. 156-158]

The board agrees.

Next, the board has modified the discipline recommended by the ALJ, who proposed that Dr. Eder's license be suspended for 90 days, that the suspension be stayed pending Dr. Eder's completion of 25 hours of continuing medical education satisfactory to the board, and that the suspension be lifted if Dr. Eder completes the ordered continuing medical education within one year. The board instead orders that Dr. Eder's license be suspended for 60 days, but that the suspension not be stayed. A finding that Dr. Eder's treatment of patient II fell below minimum standards of competence established in the profession constitutes serious unprofessional conduct which militates for an actual rather than a merely ostensible interruption of practice. The board therefore considers it necessary that the relatively short period of suspension ordered hereby actually be imposed.

Finally, the board has ordered that Dr. Eder be assessed the costs of this proceeding. The board finds that the ALJ's basis for failing to order that costs be assessed against Dr. Eder in this case merely because Dr. Eder did not fail to cooperate in the board's investigation and did not obstruct or delay the proceedings in any way, to be inconsistent with the purposes of the cost assessment statute. The board considers the clear purpose of Wis. Stats. sec. 440.22(2) to be to permit recovery of costs of prosecuting disciplinary matters regardless of whether the respondent did or did not cooperate with the board's procedures. To assess costs based on some perceived dissatisfaction with the respondent's conduct during the course of the investigation or hearing would indicate an intent to punish the respondent rather than merely to recover the costs of the proceeding. To fail to assess costs because the respondent is perceived to have acted appropriately during the course of the proceedings is therefore also inconsistent with the purposes of the statute.

Dated this 10 day of November, 1992.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by B. Ann Neviaser
B. Ann Neviaser
Secretary

WRA:BDLS2:2419

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

| | | |
|---|---|---|
| IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST<br><br>RICHARD EDER, M.D.,<br>RESPONDENT. | : | AFFIDAVIT OF COSTS OF OFFICE OF BOARD LEGAL SERVICES<br>Case No. LS-9110011-MED |

John N. Schweitzer affirms the following before a notary public for use in this action, subject to the penalties for perjury in sec. 946.31, Wis. Stats.:

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

2. In the course of his employment, he was assigned as the administrative law judge in the above-captioned matter.

3. Set out below are the actual costs of the proceeding for the Office of Board Legal Services in this matter:

a. Administrative Law Judge Expense - John N. Schweitzer

| | |
|---|---|
| Phone conferences and followup | 1 1/2 hours |
| Conduct hearing, March 17th and 18th, 1992 | 9 1/2 hours |
| Reading, writing & research for Proposed Decision, August - September 1992 | 31 1/2 hours |
| | 42 1/2 hours |

Total administrative law judge expense:
42 1/2 hours @ $23.80/hour = $1,011.50

b. Reporter Expense - Magne-Script, 112 Lathrop Street, Madison, WI

| | |
|---|---|
| Record hearings | $ 210.00 |
| Transcribe hearings | $ 755.70 |

Total reporter expense = $965.70

Total costs for Office of Board Legal Services = $1,977.20

John N. Schweitzer
Administrative Law Judge

Sworn to and signed before me this 11th day of ~~September~~ November, 1992.

Lourdes Jurma, Notary Public, State of Wisconsin.

My commission 11-6-94.

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

| | | |
|---|---|---|
| IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST<br><br>RICHARD EDER, M.D.,<br>RESPONDENT. | : | AFFIDAVIT IN SUPPORT OF MOTION FOR COSTS<br>87 MED 126 and 89 MED 310 |

STATE OF WISCONSIN )
) ss.
COUNTY OF DANE )

Pamela M. Stach, being duly sworn, deposes and states as follows:

1. That she is an attorney licensed in the state of Wisconsin and is employed by the Wisconsin Department of Regulation and Licensing, Division of Enforcement:

2. That in the course of those duties she was assigned and served as the prosecutor in the above-captioned matter; and

3. That set out below are the costs of the proceeding accrued to the Division of Enforcement in this matter, based upon Division of Enforcement records compiled in the regular course of agency business in the above-captioned matter. These costs are based upon salary average and benefits of Division of Enforcement attorneys and investigators.

PROSECUTING ATTORNEY EXPENSE

| Date | Activity | Time Spent |
|---|---|---|
| 12-12-90 | Review of File | 2 hrs. |
| 1-30-92 | Hired Expert | 20 min. |
| 2-11-91 | Preparation of Materials and Letter for Expert Witness- John Beasley, M.D. | 12 hrs. |
| 4-8-91 | Preparation for Meeting with Expert | 6 hrs. |
| 4-9-91 | Meeting with Expert | 2 hrs. |
| 4-9-91 | Preparation of memorandum of meeting with Expert | 2 hrs. |
| 5-30-91 | Letter to Respondent's Counsel-Ward Winton | 10 min. |
| 6-4-91 | Telephone conversation with Winton | 20 min |
| 9-14-91 | Draft Complaint | 6 hrs. |
| 9-26-91 | Draft Notice of Hearing | 15 min. |
| 10-17-91 | Review Answer from Respondent | 20 min. |
| 11-5-91 | Prehearing Conference | 20 min. |
| 11-5-91 | Conversation with Respondent | 20 min. |

| | | |
|---|---|---|
| 11-15-91 | Preparation of Witness List | 20 min. |
| 11-25-91 | Letter to Respondent regarding deposition | 10 min. |
| 12-3-91 | Prehearing Conference | 15 min. |
| 12-18-91 | Letter to Expert | 10 min. |
| 1-9-92 | Letter to Respondent | 20 min. |
| 1-14-92 | Review of Letter from Respondent | 10 min. |
| 1-27-92 | Prehearing Conference | 15 min. |
| 1-27-92 | Telephone Conversation with Respondent | 20 min. |
| 1-30-92 | Letter to Expert | 10 min. |
| 1-30-92 | Letter to Administrative Law Judge | 5 min. |
| 1-30-92 | Letter to Respondent | 5 min. |
| 1-30-92 | Telephone Conversation with Expert | 15 min. |
| 2-10-92 | Review of Respondent's Motion to Dismiss | 30 min. |
| 2-18-92 | Preparation of Subpoena Duces Tecum and Letter | 20 min. |
| 2-24-92 | Hearing on Respondent's Motion to Dismiss | 45 min |
| 2-26-92 | Letter to Expert | 15 min. |
| 2-26-92 | Preparation for Respondent's Deposition | 4 hrs. |
| 2-27-92 | Preparation for RESPONDENT'S Deposition | 8 hrs. |
| 2-27-92 | Travel to Hayward, Wisconsin for Deposition | 5 hrs. |
| 2-28-92 | Preparation for Eder Deposition | 1 hr. |
| 2-28-92 | RESPONDENT'S Deposition | 2 hrs. |
| 2-28-92 | Return to Madison from Hayward, Wisconsin | 5 hrs/30 |
| 3-5-92 | Letter to Expert | 15 min. |
| 3-5-92 | Notice of Motion and Motion to Close Proceedings | 30 min |
| 3-10-92 | Prepared for meeting with Expert | 8 hrs. |
| 3-11-92 | Prepared for meeting with Expert | 4 hrs. |
| 3-12-92 | Meeting with Expert | 2 hrs. |
| 3-13-92 | Hearing on Motion to Close Proceedings | 30 min. |
| 3-15-92 | Preparation for Hearing | 9 hrs/ 45 min. |
| 3-16-92 | Preparation for Hearing | 11 hrs. |
| 3-17-92 | Preparation for Hearing | 4 hrs. |
| 3-17-92 | Participation in Hearing | 6 hrs. |
| 3-18-92 | Participation in Hearing | 2 hrs. |
| 9-15-92 | Received and Reviewed Proposed Decision | 1 hr. |
| 10-5-92 | Research for Objections to Proposed Decision | 3 hrs. |
| 10-6-92 | Drafted Objections To Proposed Decision and Brief in Support of Objections | 6 hrs. |
| 10-7-92 | Drafted Brief in Support of Objections to Proposed Decision | 8 hrs. |
| 10-8-92 | Drafted Brief in Support of Objections to Proposed Decision | 3 hrs. |
| 10-9-92 | Review of Respondent's Objections to the Proposed Decision | 2 hrs. |
| 10-9-92 | Drafted Response to Respondent's Objections to the Proposed Decision | 3 hrs/30 min. |
| | TOTAL HOURS | 136 hours 30 min. |

Total attorney expense for
hours and minutes at $30.00 per hour
(based upon average salary and benefits
for Division of Enforcement attorneys) equals: $4095.00

INVESTIGATOR EXPENSE FOR SUE SCHAUT

| Date | Activity | Time Spent |
|---|---|---|
| 8-10-89 | Phone Call/Memo and Letter | 30 min. |
| 9-8-89 | Letters | 10 min. |
| 10-15-89 | Preparation for Preliminary Review By Advisor | 30 min. |
| 12-18-89 | Phone call and Letter | 20 min. |
| 2-8-90 | Prepare File for Advisor | 1 hr. |
| 5-23-90 | Meeting with Advisor and Memo or Meeting | 1 hr. |
| 6-4-90 | Preparation of PIC Summary | 2 hrs. |

TOTAL HOURS 5 hours 30 min.

Total investigator expense for
hours and minutes at $18.00 per hour
(based upon average salary and benefits
for Division of Enforcement investigators) equals: $ 99.00

COSTS OF DEPOSITIONS

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

Deposition of Richard Eder, M.D. $ 412.15

EXPERT WITNESS FEES

1. John Beasley, M.D. $ 675.00

MISCELLANEOUS DISBURSEMENTS

1. Mileage for travel to and from Hayward Wisconsin for Eder deposition. $ 109.89

| | | |
|---|---|---|
| 2. | Lake Hayward Motel expenses for Eder deposition | $ 28.50 |
| 3. | Photocopies of office records of Richard Eder, M.D. | $ 8.60 |
| 4. | Photocopies of hospital records of Hayward Area Memorial Hospital | $ 33.80 |

**TOTAL ASSESSABLE COSTS** **$ 5461.94**

Pamela M. Stach

Pamela M. Stach

Subscribed and sworn to before me this 30th day of November , 1992.

Notary Public
My Commission is permanent.

PMS:ps

# NOTICE OF APPEAL INFORMATION

**(Notice of Rights for Rehearing r 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 f r 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.

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

| | | |
|---|---|---|
| IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST<br><br>RICHARD EDER, M.D.,<br>RESPONDENT. | :<br>:<br>:<br>:<br>: | NOTICE OF FILING<br>PROPOSED DECISION<br>LS9110011MED |

TO: Richard Eder, M.D.
Brooks Building
Hayward, WI 54843
Certified P 992 818 938

Pamela M. Stach, 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, John N. Schweitzer. A copy of the Proposed Decision is attached hereto.

If you have objections to the Proposed Decision, you may file your objections in writing, briefly stating the reasons, authorities, and supporting arguments for each objection. Your objections and argument must be received at the office of the Medical Examining Board, Department of Regulation and Licensing, Room 176, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before October 5, 1992. You must also provide a copy of your objections and argument to all other parties by the same date.

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

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

Dated at Madison, Wisconsin this 14th day of September, 1992.

John N. Schweitzer
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

| | | |
|---|---|---|
| IN THE MATTER OF | : | |
| DISCIPLINARY PROCEEDINGS AGAINST | : | PROPOSED DECISION |
| | : | Case No. LS-9110011-MED |
| RICHARD EDER, M.D., | : | (DOE case numbers |
| RESPONDENT. | : | 87 MED 126 and 89 MED 310) |

## PARTIES

The parties in this matter under sec. 227.44, Wis. Stats. and sec. RL 2.036, Wis. Adm. Code, and for purposes of review under sec. 227.53, Wis. Stats. are:

Richard Eder, M.D.
Brooks Building
Hayward, WI 54843

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

## PROCEDURAL HISTORY

A. This case was initiated by the filing of a complaint with the Medical Examining Board on October 1, 1991. A disciplinary proceeding (hearing) was scheduled for January 20, 1992. Notice of Hearing was prepared by the Division of Enforcement of the Department of Regulation and Licensing and sent by certified mail on October 1, 1991 to Richard Eder, M.D., who received it on October 2, 1991.

B. A prehearing conference was held by telephone on December 3, 1992, and due to difficulties in deposition scheduling, the hearing was rescheduled to April 7, 1992.

C. Another telephone prehearing conference was held on January 27, 1992, at which time the hearing was rescheduled to March 17, 1992.

D. On February 12, 1992 Dr. Eder filed a Motion for Dismissal with supporting documents. A motion hearing was held by telephone on February 24, 1992, and based in part on the extremely high legal standard for dismissal prior to hearing, the motion was denied.

E. Attorney Pamela Stach of the Department's Division of Enforcement filed a Motion to Close Hearing and a Notice of Submission of Hospital Records on March 5. The motion to close hearing was grounded on the fact that some of the medical records for patients whose care is the subject of the complaint were obtained under the authority of sec. 146.82(2)(a)(5), Wis. Stats, and sec. 146.82(2)(b), Wis. Stats. requires that all such information be kept confidential and that no identifying information about the patient be disclosed. A motion hearing and prehearing conference was held by phone on March 13, at which the motion to close hearing was granted and the hospital records were accepted.

F. All time limits and notice and service requirements having been met, the disciplinary proceeding was held as scheduled on March 17th and 18th, 1992. Dr. Eder appeared in person, without legal representation. The Medical Examining Board was represented by Attorney Stach. Ms. Stach moved to dismiss Counts III and V of the complaint, to delete paragraphs 23.C. and 24.C. in Count II, to amend paragraph 39 in Count IV to read "40 cc" rather than "4000", and to correct paragraph 42 to refer to "39, 40, and 41" rather than "3, 4, and 5". The motions were granted. The hearing was recorded, and a transcript of the hearing was prepared and delivered on June 15, 1992. The testimony and exhibits entered into evidence at the hearing on March 17th and 18th form the basis for this Proposed Decision. To comply with the statutory privacy requirement, the patients referred to in this proposed decision are identified as "Patient I" and "Patient II".

## FINDINGS OF FACT

1. Respondent Richard Eder, M.D. is and was at the time of the facts set forth below a physician licensed to practice medicine and surgery in the state of Wisconsin, under license number 16796-5, originally granted on July 9, 1969.

2. Dr. Eder practices what he characterizes as adult general medicine, by which he means general practice minus pediatrics, obstetrics and surgery. Dr. Eder also practices ophthalmology to the extent of doing refractions.

3. Dr. Eder has hospital privileges at Hayward Area Memorial Hospital, and had hospital privileges there at the time of the facts set forth below.

With regard to Patient I

4. Beginning in approximately September 1973 Dr. Eder provided medical care and treatment for Patient I, d.o.b. 8/20/1898.

5. Hemoglobin levels and hematocrits for Patient I in Dr. Eder's office records from 1985 on are as follow:

| Date | Hemoglobin | Hematocrit |
|---|---|---|
| 3-19-85 | 12.3 | 34 |
| 4-16-85 | (not reported) | 35 |
| 6-14-85 | 12.5 | 37 |
| 9-9-85 | 12.1 | 34 |
| 12-4-85 | 11.6 | 32 |
| 10-2-86 | 11.4 | 32 |
| 3-24-87 | 11.6 | 30 |
| 12-11-87 | 11.2 | 25 |
| 4-11-88 | 8.7 | (not reported) |

6. On 12-11-87, the day on which Patient I's hematocrit was reported as 25, the following notation appears in Dr. Eder's office records: "Routine. Check cholesterol, potassium, hemoglobin, hematocrit. 120/60. Not feeling as good as normal. Heart OK. 106 pounds. Lab OK. Needs iron. Will use multiple vitamins and iron. May use Fero B." Dr. Eder did not perform tests to make a diagnosis of the patient's anemia, but concluded that she had an iron deficiency anemia based on her report to him that while on vacation in Florida she had been hospitalized following a nosebleed, and that a hematologist there had given her a prescription, which Dr. Eder saw, for supplemental iron.

7. On March 7, 1988 Dr. Eder gave Patient I an injection of Fero B, an iron supplement.

8. On March 21, 1988 Dr. Eder ordered a urinalysis on Patient I, noted that she had a urinary tract infection, and ordered a ten-day supply of Azo-Gantanol, an antibiotic.

9. On April 11, 1988, the day on which Patient I's hemoglobin level was reported as 8.7, Dr. Eder gave Patient I another injection of Fero B, and a urinalysis indicated a continuing infection.

10. On April 14, 1998 Patient I was admitted to Hayward Area Memorial Hospital via the emergency room, complaining of edema in both legs and feet, and feeling a need to urinate but being unable to do so. At the time of admission, her blood urea nitrogen level (BUN) was 90 (high), her hemoglobin level was 6.9 grams (low), and her hematocrit was 26.5 (low).

11. At the time of admission, Dr. Eder performed a history and physical exam on Patient I, summarizing it with the following: "Impressions: 1. Acute and chronic heart failure secondary to severe rheumatic valvular disease. 2. Anemia, etiology undetermined."

12. On 4/14/88 Dr. Eder ordered that Patient I's stool be checked for blood and he offered her a transfusion, which she refused. He did not order a serum iron test during her hospitalization.

13. At the time of Patient I's admission, Dr. Eder did not perform a urinalysis and did not provide any treatment for her urinary tract infection until April 16th, when he ordered Macrodantin as an antibiotic.

14. Upon admission, Dr. Eder ordered a test of the digoxin level in her blood. When informed later that day that her digoxin level was 2.9 (high), he discontinued an order for Lanoxin.

With regard to Patient II

15. Dr. Eder provided medical care and treatment for Patient II, d.o.b. 6-11-13, beginning in approximately February 1979.

16. On November 4, 1988 Patient II visited Dr. Eder complaining of nausea. Dr. Eder diagnosed influenza and prescribed Ceclor.

17. At 12:50 P.M. on November 5, 1988 Patient II was admitted to Hayward Area Memorial Hospital via the emergency room, complaining of vomiting and diarrhea. At the time she entered the emergency room, her blood pressure was 82/50 (low) and her white blood count was 14,600 (high).

18. An x-ray taken at the time of admission showed right upper lobe pneumonia. The emergency room physician had ordered tetracycline, and Dr. Eder changed the order to Cefobid. Dr. Eder also ordered a sputum culture to verify the appropriate antibiotic for the pneumonia.

19. Patient II's blood pressure following admission was as follows:

| | |
|---|---|
| 11-5 at 1250 | 82/50 |
| 1325 | 60/52 |
| 1600 | 68/50 |
| 1730 | 90/50 |
| 2000 | 84/50 |
| 11-6 at 0000 | 66/48 |
| 0600 | 58/50 |
| 0800 | 70/52 |
| 1000 | 80/60 |
| 1015 | 88/55 |
| 1200 | 90/52 |
| 1400 | 94/62 |
| 1600 | 88/50 |

20. Patient II's urine output during the first 1 1/2 days of her hospitalization was as follows:

| | |
|---|---|
| from 1250 on 11-5 to 1500 | 0 cc |
| from 1500 to 2300 | 80 cc |
| from 2300 to 0700 on 11-6 | 50 cc |
| from 0700 to 1500 | 400 cc |
| from 1500 to 2300 | 1250 cc |

21. At 1345 on the date of admission Dr. Eder ordered that Patient II be given fluids intravenously, and he directed the nurses to recheck her blood pressure and notify him. Dr. Eder was notified that her blood pressure at 1700 was 68/50, and he was notified that at 1730 it was 90/50.

With regard to Count IV

22. On August 19, 1983, Dr. Eder ordered three schedule II controlled substances: 200 25 mg tablets of Preludin; 400 5 mg tablets of Dexedrine; and 2 20 ml vials of injectable Demerol, 100 mg/ml. Dr. Eder received the Preludin and the Demerol; he did not receive the Dexedrine.

23. On January 11, 1984, Dr. Eder ordered 500 25 mg tablets of Preludin and 200 75 mg tablets of Preludin. Dr. Eder received the Preludin as ordered.

24. On March 27, 1986, Dr. Eder ordered 100 75 mg tablets of Preludin; 200 5mg tablets of Dexedrine; and 50 15 mg tablets of Dexedrine. Dr. Eder received the Preludin and the Dexedrine as ordered.

25. At the time Dr. Eder ordered and dispensed all the schedule II controlled substances listed above he did not maintain a separate controlled substances log.

## CONCLUSIONS OF LAW

I. The Medical Examining Board has personal jurisdiction over the Respondent, based on fact #1 above and paragraph A under "Procedural History".

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

III. With regard to Patient I, Dr. Eder's decision not to order a serum iron test when Patient I was admitted to Hayward Area Memorial Hospital on April 14, 1988 did not fall below minimum standards of competence established in the profession. Dr. Eder's decision not to order a urinalysis for Patient I did not fall below minimum standards of competence established in the profession. Dr. Eder's failure to treat Patient I's urinary tract infection in a timely manner fell below minimum standards of competence established in the profession, and constituted unprofessional conduct under sec. MED 10.02(2)(h), Wis. Admin. Code.

IV. With regard to Patient II, Dr. Eder's lack of inquiry into the cause of Patient II's low blood pressure when she was admitted to Hayward Area Memorial Hospital on November 5, 1988 did not fall below minimum standards of competence established in the profession. Dr. Eder's lack of inquiry to determine whether Patient II was septic did not fall below minimum standards of competence established in the profession .

V. With regard to Count IV of the complaint, Dr. Eder's actions in failing to maintain a separate controlled substances log constituted unprofessional conduct under sec. MED 10.02(2)(a), Wis Admin. Code.

## ORDER

**THEREFORE, IT IS ORDERED** that Dr. Eder be reprimanded for his failure to comply with sec. MED 10.02(2)(a), Wis. Admin. Code.

**IT IS FURTHER ORDERED**, for Dr. Eder's unprofessional conduct under sec. MED 10.02(2)(h), Wis. Admin. Code with regard to Patient I, that his license to practice medicine and surgery in the state of Wisconsin be suspended for a period of 90 days, effective 10 days after this order is signed on behalf of the Board.

**IT IS FURTHER ORDERED** that the suspension of Dr. Eder's license shall be stayed for one year, pending his successful completion of 25 hours of continuing medical education in addition to all requirements for continuing medical education under ch. MED 13, Wis. Admin. Code.

**IT IS FURTHER ORDERED** that the suspension of Dr. Eder's license shall terminate upon successful completion of the above condition.

## OPINION

The complaint in this case originally contained five counts of unprofessional conduct against the Respondent, Dr. Richard Eder. Counts III and V were dismissed at the beginning of the hearing, leaving counts I, II, and IV. Dr. Eder was credible as a witness when he recounted facts or described events which are not reflected in his office records, and I generally accept his testimony as truthful. In fact, on at least one occasion, involving his offer of a transfusion to Patient I, he testified on the first day of the hearing to a fact which did not appear to be in the record, and on the second day he was able to locate documentary evidence of it. At times however, he was a bit irascible.

### Patient I
### (exhibits 5, 6, 11, 12; transcript, pp. 29-63, 83-90, 104-127, 139-147, 158-160, 165, 179-187, 193-201, 204-205)

Count I charged Dr. Eder with (A) failing to order a serum iron test or otherwise to make adequate inquiry into the cause of Patient I's anemia when she was admitted to Hayward Area Memorial Hospital on April 14, 1988 with a hemoglobin level of 6.9 grams, pain and swelling in her legs, and an inability to urinate; (B) failing to order a urinalysis to determine if Patient I had a urinary tract infection; and (C) failing to treat Patient I's urinary tract infection in a timely manner. Only the third charge was proven.

Patient I was admitted to the hospital only secondarily because she was ill. Her admission was primarily because the person who had been caring for her was unable to continue, and her daughter could not come up from Florida right away, so Dr. Eder suggested the hospital (transcript, pp. 196-197). "The people that were supervising her at home were uncomfortable with it and she had no relatives, so her daughter was going to be unable to come right away to take care of her. The point of the hospitalization was more to have a place to put her than anything else. Now, it's fortunate that we did, because we also found out that she had this digitalis intoxication and so we were able to get rid of it." (transcript, pp. 84-85). The fact that Patient I's hospital stay was "domiciliary" would not excuse any laxness by Dr. Eder, but it explains why he did not treat this patient as presenting a condition which needed emergency care. Also, the fact that he was aware of both her anemia and her urinary tract infection (UTI) before she entered the hospital explains in part why he did not treat those conditions as others might have expected him to.

Dr. John Beasley was called as a witness for the Board and he gave his opinion, to a reasonable degree of medical probability, that Dr. Eder's treatment of Patient I fell below minimum standards of competence because (1) he did not run tests to determine the cause of the patient's anemia even though her blood counts dropped significantly between the time Dr. Eder checked them in his office and the time she was admitted, and (2) Dr. Eder did not adequately diagnose or treat the patient's urinary tract infection.

Dr. Eder's treatment of Patient I's anemia at the time of admission.

Dr. Beasley's opinion with respect to the patient's anemia, when her hemoglobin level upon admission was reported as 6.9[1], was that Dr. Eder should have run tests to determine the cause of the anemia, including a test to determine the patient's serum iron as well as a test for blood loss into the gastrointestinal system. I accept Dr. Beasley's opinion, but I find that (1) Dr. Eder did order a test of the patient's stool for blood loss into the GI system on April 14, 1988, (2) Dr. Eder's decision not to order a test of the patient's serum iron was based on a valid premise, that the iron supplements the patient had been taking would likely have rendered such a test undiagnostic, and (3) Dr. Eder offered the patient a transfusion, although she refused it. For these reasons, I find that Dr. Eder's actions did not fall below minimum standards of professional competence in diagnosing and treating the patient's anemia.

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[1]Dr. Eder testified that he had noticed the drop in Patient I's blood levels in December 1988 and that he had essentially seen no change after that time. It is understandable that a peer review panel, the Division attorney, the expert hired by the Board, or the Board itself, would consider the drop in hemoglobin level from 4-11-88 to 4-13-88 at least as dramatic as the drop from 12-11-87 to 4-11-88. Dr. Eder explained that he had considered the 11.2 level on 12-11-87 to be an error on the high side, relying more on the hematocrit level of 25, which showed a marked drop from the level of 30 on 3-24-87, and that he attributed this to the reported nosebleed. He stated that the reported hemoglobin level of 6.9 upon admission to the hospital was simply consistent with the hematocrits he had been seeing since 12-11-87, and he attributed the difference between the levels on 4-11 and 4-14 to the fact that different labs had done the analyses. It was for this reason that he did not order a second test (transcript, p. 59).

This explanation troubles me, because Dr. Eder was presented with a test which could have been interpreted as a significant change in a chronic condition (the patient's hemoglobin level fell in three days from 8.7 to 6.9), yet Dr. Eder disregarded this result, explaining it as a difference in labs. In so doing, he made an important assumption about the patient's hemoglobin level which conflicted with an objective test. Nevertheless, I find that Dr. Eder responded appropriately to the patient's condition. He in effect acknowledged that his earlier diagnosis of iron deficiency anemia was inadequate when he wrote "anemia, etiology undetermined" on the patient's admission record, and more importantly, he did begin to investigate the possibility of GI bleeding. Although his discounting of the hemoglobin test result appears cavalier, he did act, and his actions cannot be said to fall below the minimum standards of the profession.

Dr. Eder's treatment of Patient I's UTI at the time of admission.

Dr. Beasley's first opinion with regard to Patient I's UTI was that Dr. Eder should have ordered a urinalysis, because a chronic infection can be a contributing factor to anemia, and a UTI can cause a person to be episodically confused. Dr. Eder did not order a urinalysis because one done just three days earlier had confirmed the presence of a UTI, and his decision not to run another analysis was sound.

However, Dr. Eder's reason for not administering an antibiotic until April 16, 1988 was less justified. He stated that late on the date of admission he received a lab report showing that the patient had a toxic level of digoxin in her system. He therefore waited until her digoxin level subsided before ordering the antibiotic of his choice, oral Macrodantin, which would have further upset a G-I system already upset by Lanoxin, and he did not consider the UTI serious enough to justify that risk. Dr. Beasley agreed that digitalis toxicity was more dangerous than the bladder infection, but he stated that other antibiotics, especially if administered intravenously, would not cause nausea.

More importantly, it was Dr. Beasley's opinion that even if Dr. Eder decided not to order a urinalysis because he knew the patient had a UTI, he should have obtained a culture to determine what organism was causing the infection and what antibiotic would be most effective, and he remained firm in his conviction that Dr. Eder had no excuse for failing to order a culture (transcript, p. 159). According to Dr. Beasley, the risks of a delay in treating the patient's UTI were not dramatically high, but they included possible stress on her heart, possible decrease in kidney function, possible increased difficulty in treating her anemia, a missed opportunity to improve her mental status, and possible sepsis. On this point, a preponderance of the evidence showed that Dr. Eder should have cultured the patient's urine in order to treat her UTI effectively, especially since he was withholding a particular antibiotic to avoid a side-effect, and this failure was an action which fell below minimum standards of competence established in the profession.[2]

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[2]In my opinion, the point at which Dr. Eder's treatment of Patient I fell even farther below minimum standards was during her last office visit to him on April 11, 1988, three days prior to her hospitalization, but I do not base my finding on that.

When Patient I was hospitalized, Dr. Eder immediately ordered a stool test to diagnose her anemia, and after two days he endeavored to treat her UTI with Macrodantin, but during her last office visit, when he had the same information, he did nothing. Dr. Eder had originally relied on the diagnosis of a hematologist in Florida that Patient I had iron deficiency anemia, but he never talked to the hematologist, never received anything in writing, and did not request Patient I's records from Florida. By April 11, 1988 he should have realized that oral and injectable iron supplements were having no effect on her anemia, and he should have looked for other causes. He even admitted that he continued the injections because she felt better after them and thought

Finally, I feel obliged to comment on the printed obituary for this patient which appeared in the certified hospital records. Dr. Eder was concerned that this may have influenced anyone reviewing the case, including the Board's expert witness, Dr. Beasley. I agree that Dr. Eder had cause for concern and that his objections were appropriate. The obituary was something which could have infected Dr. Beasley's review of the records, even subconsciously, and it could have made his opinion unreliable. However, the obituary was placed in the records by the hospital, not by the Board or the Department, and Ms. Stach could not be expected to have excised it from the certified record; more importantly, Dr. Eder was given the opportunity to cross-examine Dr. Beasley regarding the effect of the obituary on his review. Dr. Beasley testified credibly at some length on this point (transcript, pp. 140-144), and I accept his statements that the obituary did not influence his opinion regarding the care and treatment of Patient I by Dr. Eder.

Patient II
(exhibits 7-8; transcript, pp. 63-77, 90-91, 128-139, 147-158, 160-174, 187-192, 201-204)

Count II charged Dr. Eder with (A) failing to make adequate inquiry into the cause of Patient II's low blood pressure when she was admitted to Hayward Area Memorial Hospital

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([2] continued) they helped her, but that they didn't appear to affect her blood composition (transcript, p. 47).) He also stated that when Patient I was in the hospital he offered her a transfusion, because "she had been on iron replacement for several months at the time of this hospitalization, and under normal circumstances this should have been getting some results" (transcript, p. 88). On 4-11-88, her dangerously low hemoglobin level (8.7) confirmed what Dr. Eder says he had seen on 12-11-87 in her hematocrit (25), yet he did nothing but give Patient I another injection of the Fero B which he knew was ineffective. To all appearances, Dr. Eder should have begun searching for an alternative explanation for her anemia by 4-11-88.

Similarly, the urinalysis done on 4-11-88 showed that her UTI had not responded to the Azo-Gantanol which he had prescribed three weeks earlier, and which had run out by that time. It appears that he should have taken some further step to treat her UTI on 4-11-88, yet he prescribed no antibiotic and ran no further tests.

By declining to make a finding that Dr. Eder's actions on April 11th fell below minimum standards, I am not ruling that a disciplinary action cannot be successful if the complaint alleges incompetent actions on April 14th when those actions really occurred on April 11th. The reason I decline to base a ruling in this case on whether Dr. Eder adequately treated Patient I on April 11, 1988 is that his actions during the office visit on that date were not investigated at the hearing, and he had no opportunity to explain any other circumstances that may have prevented him from taking steps which now appear appropriate and even necessary. From my point of view, however, and with the information available to me, his treatment of Patient I on April 11th fell even farther below minimum standards of professional behavior than it did on April 14th.

on November 5, 1988 with right upper quadrant pain, vomiting, diarrhea, and a blood pressure of 82/50; and (B) failing to make adequate inquiry to determine whether Patient II was septic. Neither of these charges was proven.

Patient II was admitted to the hospital with influenza and pneumonia and an elevated white blood count, but the most serious concern was her blood pressure. Dr. Beasley thought that Patient II's blood pressure at the time of admission (82/50), and even more so half an hour later (60/52), was so low that there was the danger of a CVA or an MCI or tissue damage or "simply failing to survive". Dr. Beasley pointed out that the dangerously low blood pressure was confirmed by the patient's low urine output, which was only 130 ccs during the first 18 hours of hospitalization.

However, Dr. Beasley admitted that this case was "a little confusing", and on cross-examination, when Dr. Eder put together the facts that Patient II had aortic stenosis and aortic insufficiency, mitral stenosis and mitral insufficiency, that there was evidence that she might have sustained an MCI, that she had been vomiting and resting in bed (pp. 153-154), and that she had pneumonia (p. 161), Dr. Beasley admitted that all these could have been contributing factors to low blood pressure. Still, he maintained that the marked change in blood pressure could have been the result of a change in cardiac status or a change in blood volume or "that she could be getting ill or septic from other reasons", and Dr. Beasley felt that a minimally competent response would have been to obtain a blood culture and to give a fluid challenge. He did not suggest that Dr. Eder should have intervened in any other ways. Once again, I accept Dr. Beasley's opinion as to what a physician should do, but I find that Dr. Eder had a valid reason for not ordering a blood culture, and I find that he did give the patient a fluid challenge, although it was not as great as recommended by Dr. Beasley, and therefore I find insufficient proof that his actions fell below minimum standards of professional competence.

Dr. Eder testified that he did not order a blood culture because antibiotics had been prescribed for the patient upon entry to the hospital, and Ceclor had been prescribed for her the day before, and that an antibiotic in her bloodstream would make a blood culture unreliable. Dr. Beasley pointed out that laboratories have techniques to absorb an antibiotic from a blood sample, but he recognized the increased difficulty of getting a good culture under such circumstances (transcript, pp. 166-167). Both Dr. Eder and Dr. Beasley stated that septic shock can be diagnosed clinically (just by looking at a person), and aside from her hypotension and her low urine output, there was no evidence that the patient was in shock. Dr. Eder cannot be faulted for not ordering a blood culture when the patient was already taking antibiotics for her flu and pneumonia, which would have made a culture much more difficult, and when she did not appear to be in septic shock.

Although Dr. Beasley felt that one liter of fluid over eight hours was inadequate as a fluid challenge, Dr. Eder did order an IV fluid, and he monitored the patient's progress closely. At 1345 on the date of admission he directed the nurses to recheck her blood pressure and notify him after she received some IV fluids. At 1700 her blood pressure was 68/50, and Dr. Eder was notified of this. At 1730 it was 90/50, and Dr. Eder was notified again. Since this reading was higher than it was at her time of admission, Dr. Eder was not unjustified in feeling that her hypotension was not an imminent threat. I find that the difference between the fluid Dr. Eder ordered for the patient and Dr. Beasley's opinion that he would have ordered a larger fluid challenge is insufficient for a finding that Dr. Eder's actions fell below minimum standards.

Count IV
(exhibits 1-4, 9; transcript, pp. 20-29, 78-83, 192, 203)

Count IV charges Dr. Eder with failing to maintain adequate records for three controlled substances, Preludin, Dexedrine, and Demerol, which he ordered between 1983 and 1986 and dispensed to patients. Dr. Eder admits the charge, saying that at the time he did not know of the requirement to keep a log separate from the patients' charts. Since being informed of the requirement he has maintained a log as required.

Discipline.

With respect to Count IV, a reprimand is appropriate, as recommended by the state. This is not for the protection of the public, and only partly for Dr. Eder's rehabilitation in impressing on him the need to be familiar with all the rules regulating the medical profession. It is primarily for the purpose of informing and deterring other medical professionals.[3]

With respect to Dr. Eder's failure to order a culture to diagnose and treat Patient I's UTI, when he was withholding a particular oral antibiotic because of its potential effect on the patient's GI system, an appropriate discipline would be an order for additional education or training. The purpose of this discipline would be primarily Dr. Eder's rehabilitation, and secondarily the protection of the public; it would have no appreciable deterrence value for other professionals. Dr. Eder's actions were not so deficient as to justify the discipline recommended by Ms. Stach, which was that he submit to an assessment through the University of Wisconsin

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[3]The purposes of professional discipline have been set forth by the Wisconsin Supreme Court in four attorney discipline cases: State v. Kelly, 39 Wis.2d 171, 158 N.W.2d 554 (1968), State v. MacIntyre, 41 Wis.2d 481, 164 N.W.2d 235 (1969), State v. Corry, 51 Wis.2d 124, 186 N.W.2d 325 (1970), and State v. Aldrich, 71 Wis.2d 206, 237 N.W.2d 689 (1976). Those purposes are (1) to protect the public, by assuring the moral fitness and professional competency of those privileged to hold licenses, (2) to rehabilitate the offender, and (3) to deter others in the profession from similar unprofessional conduct.

Continuing Education Program and to undertake a retraining program based on that assessment. However, as an administrative law judge, I am not in a position to determine the specific subject area(s) which would most benefit Dr. Eder, and I invite the Board to modify the Order as written above, to specify education or training that would most benefit Dr. Eder.

In general, an assessment of costs is appropriate where a respondent has failed to cooperate in some way with the Board's investigation, thus increasing the cost of the disciplinary action unnecessarily; if that is not true, however, the burden of disciplining an individual is part of the profession's responsibility, and need not be borne entirely by the disciplined party. In this case, although Dr. Eder was not pleased with the process, he did not obstruct or delay it in any way. Costs are not assessed against Dr. Eder.

Dated September 14, 1991.

John N. Schweitzer
Administrative Law Judge
Department of Regulation and Licensing

BDLS2-1960