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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST

GWEN D. MARTIN, M.D.,

RESPONDENT.

**FINAL DECISION AND ORDER**

LS9901208MED

97 MED 83

98 MED 236

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The parties to this action for the purposes of § 227.53, Wis. Stats., are:

*Gwen D. Martin, M.D.*
*1020 Lakeshore Dr.*
*Rice Lake, WI 54868*

*Wisconsin Medical Examining Board*
*P.O. Box 8935*
*Madison, WI 53708-8935*

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

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Respondent Gwen D. Martin (dob 9/26/59) is and was at all times relevant to the facts set forth herein a physician and surgeon licensed in the State of Wisconsin pursuant to license #28678, first granted on 7/1/87. Respondent is a surgeon.

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2. On July 31, 1996, at about 12:30 PM, respondent performed a pyloromyotomy upon a neonate, dob 7/6/96, who weighed 4.5 kg. Following the procedure, the patient was transferred to the floor at about 3:25 PM.

3. For postoperative hospital care, respondent prescribed morphine for pain, writing the order as "$MSO_4$ .5-1 mg IV qH @ hr with .2 mg IV q 1 hr PRN."

4. The morphine was administered at the rate of 0.5mg/hr beginning at about 5:00 PM. At approximately 9:00 PM, respondent checked with the attending nurse, and was informed that the patient was sleeping with reduced respirations of 28.

5. At that time, respondent ordered the morphine rate decreased to 0.2mg/hr.

6. At about 1:55 am on August 1, 1996, the patient was discovered by nursing staff to have no respirations or heartbeat. Attempts to resuscitate the patient were unsuccessful. The cause of the patient's death was morphine overdose.

7. Standard reference works state that the appropriate dose for morphine for a neonate is no more than 50 micrograms per kilogram per hour, or 0.05mg/kg/hr, or 0.225 mg/hr for this patient.

8. By writing the amount of morphine as ".5" instead of "0.5" respondent created the possibility of misreading the intended 1/2

milligram dose as 5 milligrams, which would have an even more substantial overdose. There is no benefit to the method of writing a prescription order used by respondent, and the risk created by failing to use a leading zero was therefore without any medical justification.

9. Since the incident described above, respondent has attended a pain conference offered by June Dahl, Ph.D., of the UW Pharmacy School, and a separate pediatric pain conference at the University of Michigan Medical Center. But for this attendance, the Board would have limited respondent's license to require such continuing medical education. Respondent has substantially improved her approach to prescribing morphine for neonates. At the same time, the hospital where this surgery was performed has ceased doing neonatal surgery, and such patients are referred to other facilities.

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10. On 9/23/96, respondent assisted another surgeon in performing a closure of a sigmoid colostomy using an EEA stapler; the patient was a 60 year old woman who weighed about 200 lbs. Respondent’s actions included being responsible for stapling the rectum to the end of the colon.

11. Respondent mistakenly inserted the stapler into the vagina, resulting in the stapling of the intestine to the patient’s vagina.

12. The error was discovered several days later and was corrected with a subsequent surgical procedure. Respondent suggests that the error may not have been detected during the 9/23/96 procedure in part because of the patients’ thinned rectal-vaginal septum and stenotic vagina.

## CONCLUSIONS OF LAW

A. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to §448.02(3), Wis. Stats. and is authorized to enter into the attached Stipulation pursuant to §227.44(5), Wis. Stats.

B. The conduct described in paragraph 3, above, was negligence in treatment within the meaning of § 448.02(3)(b), Wis. Stats., for the reasons set forth in paragraphs 7-8, above. The conduct described in paragraph 5 was negligent in that respondent should have halted all morphine at that time, in response to the decreased respirations, and come in to examine the patient.

C. The conduct described in paragraph 11, above, was negligence in treatment within the meaning of §448.02(3)(b), Wis. Stats.

## ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, that Gwen D. Martin, M.D., is REPRIMANDED for her unprofessional conduct in these matters.

IT IS FURTHER ORDERED, that respondent shall pay the costs of investigating and prosecuting this matter in the amount of $1300, within 30 days of this order.

IT IS FURTHER ORDERED, that pursuant to §448.02(4), Wis. Stats., if the Board determines that there is probable cause to believe that respondent has violated any term of this Final Decision and Order, the Board may order that the license and registration of respondent be summarily suspended pending investigation of the alleged violation.

Dated this 3/29/99, *nunc pro tunc* January 20, 1999.

WISCONSIN MEDICAL EXAMINING BOARD, by:

Ronald Grossman, A Member of the Board