# WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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#### State of Wisconsin

#### Before the Medical Examining Board

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In the Matter of Disciplinary Proceedings Against

Burton J. Friedman, M.D.

Respondent.

LS0203201MED

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#### Final Decision and Order

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

Burton J. Friedman, M.D.

2600 N. Mayfair Road

Milwaukee WI 53226

Medical Examining Board

Department of Regulation and Licensing

P.O. Box 8935

Madison WI 53708

Division of Enforcement

Department of Regulation and Licensing

P.O. Box 8935

Madison WI 53708

The parties having agreed to the attached stipulation, the Medical Examining Board makes the following:

### **Findings of Fact**

1. Burton J. Friedman, M.D., ("Respondent") was born on August 11, 1934, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 13642, first granted on July 1, 1960. Respondent specializes in cardiology.

2. On January 11, 2000, a 67 year old woman presented at St. Mary's Hospital in Milwaukee, Wisconsin, for placement of a cardiac pacemaker at Respondent's recommendation. Respondent assisted the cardiovascular surgeon during the procedure.
3. During the procedure, Respondent saw that the surgeon was working in the patient's arterial tree, instead of the subclavian vein, but he did not immediately advise the surgeon of the error.
4. The patient immediately began to demonstrate unusual distress.
5. The patient went into cardiac and pulmonary arrest, and, despite the efforts of Respondent, the surgeon, and additional medical staff called to the incident by the surgeon, she died.
6. On autopsy, the cause of death was determined to be perforation of the aorta during pacemaker placement.
7. Respondent's opportunity to save this patient was lost very early in the procedure when the surgeon placed a dilator into the small hole made by the guidewire he inserted into the aorta in the mistaken belief that he was operating in the subclavian vein, causing rapid massive blood loss that Respondent had no ability to correct.
Conclusions of Law
1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.03, Stats.
2. Respondent's failure to immediately notify the surgeon he was assisting of the surgeon's error in operating on the wrong structure, and in failing to take immediate and effective steps to reduce the adverse consequences of the error to his patient, constitutes a violation of s. MED 10.02(2)(h), Wis. Admin. Code.
Order
Now, therefore, Respondent is <b>REPRIMANDED</b> .
It is further ordered that the license previously issued to Burton J. Friedman, M.D., is <b>LIMITED</b> by the condition that he may not undertake, assist, or attend the placement of any cardiac stent, coil, pacemaker or implanted defibrillator, or any cardiac catheterization or angioplasty, or any other invasive cardiology procedure.
It is further ordered that Respondent shall return his credentials to the Department immediately, and the Department shall reissue the credentials with the legend "Limited."
It is further ordered that within six months of the date of this Order, Respondent shall pay the costs of this proceeding in the

amount of \$9,500.00, payable in two equal installments.

It is further ordered that pursuant to s. 448.02(4), Stats., if the Board determines that there is probable cause to believe Respondent has violated any term of this Order, the Board may order that the license and registration of Respondent be summarily suspended pending investigation of the proposed violation.

Dated February 19, 2003.

Wisconsin Medical Examining Board

Sidney Johnson

A Member of the Board