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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	**FINAL DECISION AND ORDER**
	LS0302193MED
SHIRLEY YEZDI GODIWALLA, M.D., RESPONDENT.	

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Shirley Yezdi Godiwalla, M.D.
W283 N3671 Yorkshire Trace
Pewaukee, WI 53072

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

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
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This proceeding was commenced by the filing of a Notice of Hearing and Complaint on February 17, 2003. The Answer was filed on February 28, 2003. The hearing was held on August 26, 2003. The hearing transcript was filed on November 17-20, 2003. Closing arguments were filed by the Respondent on November 26, 2003. The Complainant's Closing Arguments were filed on December 2, 2003. Paul J. Gossens appeared on behalf of the Respondent, Dr. Shirley Yedzi Godiwalla. Gilbert C. Lubcke appeared on behalf of the Complainant, Department of Regulation and Licensing, Division of Enforcement.

The Administrative Law Judge Jacquelynn B. Rothstein filed her *Proposed Final Decision in the Matter of Disciplinary Proceedings Against Shirley Yezdi Godiwalla, M.D. Respondent* LS03020193 on February 13, 2004. The Respondent and Complainant filed *Objections to the Proposed Decision* on March 18, 2004. The Respondent filed a *Response to the Complainant's Objections to the Proposed Decision* on April 5, 2004. The Complainant filed a *Response to Respondent's Objections* on April 8, 2004. Oral arguments on the parties' objections and responses were held before the Wisconsin Medical Examining Board on May 19, 2004.

Based upon the entire record herein, the Medical Examining Board adopts, in part, the Findings of Fact and Conclusions of Law and Order of the Proposed Decision. Further, the Board finds substantial evidence in the record to support the adoption of supplemental factual findings. The supplemental findings are numbered and incorporated as subparagraphs to the Findings of Fact in the Proposed Decision. The supplemental findings of fact are based upon the testimony in the hearing record, cited as "Tr." followed by the designated page number. Also, the Board has modified the Conclusions of Law with respect to the Respondent's care of the Patient NL, finding that Dr. Godiwalla's conduct was not below the minimum standard of care. Finally, the Board has modified the Order to provide Dr. Godiwalla with an option to petition for the removal of the limitation upon her license upon successful complete of additional education and training. An explanation of the reasons for the Board's variance from the Proposed Decision is set forth more fully below.

FINDINGS OF FACT

1. Shirley Yezdi Godiwalla, M.D., (dob 10/01/52) is duly licensed to practice medicine and surgery in Wisconsin (License #26973). Her license was first granted on July 2, 1985. Dr. Godiwalla specializes in urology, including pediatric urology.

2. Dr. Godiwalla's most recent address on file with the Medical Examining Board is W283 N3671 Yorkshire Trace, Pewaukee, Wisconsin.

3. MM was born on July 6, 1991. He was diagnosed with an attention deficit disorder and also had a history of primary nocturnal enuresis and diurnal incontinence.

4. On January 12, 2000, MM presented to Dr. Godiwalla for evaluation and treatment of the primary nocturnal enuresis and diurnal incontinence.

5. On January 26, 2000, as part of her diagnostic workup, Dr. Godiwalla performed a video urodynamics study and cystoscopy under general anesthesia on MM. Both the video urodynamics study and cystoscopy were conducted without first attempting a diagnostic and therapeutic trial of behavioral or pharmacological modalities.

6. Dr. Godiwalla diagnosed MM as having posterior urethral valves, detrusor sphincter synergia, trabeculated bladder, and primary nocturnal enuresis.

7. On January 28, 2000, Dr. Godiwalla performed a transurethral resection on MM under general anesthesia of what she believed to be the posterior urethral valves.

8. MM did not have posterior urethral valves but had mini valves, a normal anatomical variant, that do not require surgical intervention.

a) The minimum standard of treatment by a physician who performs a video urodynamic study and cystoscopy evaluation for a patient who presents with a history of daytime incontinence and voiding dysfunction is the ability to correctly differentiate between posterior urethral valves and mini valves and render appropriate treatment. [Tr. at 206-209]

b) Dr. Godiwalla's treatment deviated from the minimum standard of care because she the patient misdiagnosed the patient as having posterior urethral valves and preformed unnecessary surgery due to her lack of knowledge of the existence of mini valves and the proper course of treatment. [Tr. at 206, 209, 516]

c) Dr. Godiwalla's treatment deviated from the minimum standard of care in that she resected the patient's mini valves, a normal anatomical variant which did not require surgical removal. [Tr. at 217]

d) Dr. Snyder, a highly accomplished pediatric urologist, author, professor of surgery and member of the National Board of Urology, testified that it has been well known in the field of urology since 1987 that mini valves are a normal anatomical variant, which is not the cause for incontinence and which do not warrant surgical intervention. [Tr. at 724, 725.]

e) According to Dr. Snyder, the proper standard of care would be to incise the valves if they were posterior urethral valves. [Tr. at 638.]

f) Dr. Godiwalla's surgical resection of the patient's mini valves created an unacceptable risk by subjecting the patient to possible injury to the sphincter mechanism resulting in worsening degrees of incontinence or formation of stricture, scarring at the point of the surgical injury causing later mechanical obstruction and increased incontinence problems for the child, and possibly necessitating a second surgical procedure to correct the scarring and subsequent obstruction. [Tr. at 217]

g) Dr. Godiwalla's surgical resection of the patient's mini valves also created an unacceptable level of risk associated with general anesthesia and airway problems, including asthmatic attacks, anesthetic agent reactions with allergies, inappropriate placement of endotracheal tubes resulting in aspiration, aspiration pneumonia, middle ear infections from intubations, risk of infection and bleeding. [Tr. at 218]

h) A competent urologic surgeon who is doing pediatric urologic care should be able to recognize the difference

between a true posterior urethral valve and a mini valve and be able to appropriately diagnose and treat or not treat those conditions. [Tr. at 212, 217]

9. LSG was born on October 12, 1996, and was referred to Dr. Godiwalla for bilateral undescended testes.

10. On October 8, 1999, Dr. Godiwalla performed bilateral orchidopexy to treat the undescended testes of LSG. During the course of the surgery, Dr. Godiwalla also made diagnoses of bilateral congenital hernias, a left varicocele, and frenular adhesions.

11. Varicocele is an extremely uncommon condition in males prior to puberty.

12. Dr. Godiwalla misdiagnosed a left varicocele in LSG.

13. Dr. Godiwalla elected, during the course of the orchidopexy on LSG, to dissect out what she believed to be the left varicocele and, in the process of performing this dissection, to sacrifice the testicular artery.

a) The minimum standard of treatment for a physician performing a surgical repair of a varicocele is the ability to correctly diagnose the varicocele through proper physical palpitation and visual examination while the patient is an upright position. [Tr. at 222, 224, 225]

b) Dr. Godiwalla's treatment deviated from the standard of care in that she misdiagnosed the presence of a varicocele during the performance of a bilateral orchidopexy and proceeded to surgically dissect the varicocele resulting in sacrifice of the testicular artery. [Tr. at 222, 226, 517, 520]

c) The original Post –Operative Diagnosis prepared by Dr. Godiwalla does not contain any reference to the presence of a varicocele. [Tr. at 521]

d) The pathology report does not refer to the presence of a varicocele or identification of any the four surgical specimens provided by Godiwalla as a varicocele. [Tr. at 525, 526]

e) Dr. Godiwalla did not indicate to the first surgical assistant during surgery that she identified a varicocele and did not draw anything out on a piece of paper, surgical towel or drape indicating a varicocele. [Tr. at 164, 165]

f) Dr. Godiwalla performed a surgical mass litigation of the vascular structure which created a risk of compromise in the vascularity to the left testicle, possible atrophy or failure of growth of the testicle and decrease in volume, possible infarcation or loss of the testicle, or compromise of the testicular function as it relates to the production of hormones and fertility. [Tr. at 236]

g) A minimally competent physician would have performed a proper examination and made a correct diagnosis of a varicocele before proceeding to a surgical repair which resulted in the sacrifice the testicular artery. [Tr. at 222]

14. AD was born on May 8, 1987, and was referred to Dr. Godiwalla because the patient had noted that on occasion his right testis was down in his scrotum but his left testis was never present in his scrotum.

15. On January 19, 2000, Dr. Godiwalla examined AD and noted that at the time of the examination both testes were in the inguinal canal but could be brought down into the scrotum. When the testes were released, they returned to the inguinal area. Dr. Godiwalla diagnosed bilateral retractile testes.

16. Dr. Godiwalla advised AD and his parents that AD could either initiate no treatment and continue to watch the condition, or he could undergo surgical intervention by a bilateral orchidopexy to correct the condition.

17. Bilateral retractile testes as diagnosed in AD were normal findings that did not represent any condition that required surgical intervention to correct.

18. Dr. Godiwalla performed a bilateral orchidopexy of AD on January 21, 2000.

a) The minimum standard of treatment for a physician is the ability to differentiate between and diagnose retractile versus undescended testicles and to reassure the patient and family and continue to observe the patient without proceeding to surgical intervention. [Tr. at 254, 258]

b) Dr. Godiwalla's treatment deviated from the minimum standard because she failed to correctly diagnose retractile versus undescended testicles and, as a result, subjected the patient to an unnecessary surgical procedure. [Tr. at 258]

c) Dr. Godiwalla recorded a diagnosis of bilateral retractile testicles in the post-operative report, although she recorded the patient's testicles as undescended in the pre-operative report. [Tr. at 77, 78.]

d) Dr. Godiwalla prepared the discharge diagnosis and procedures form and wrote that the patient had retractile testes. [Tr. at 79.]

e) Dr. Godiwalla described her diagnosis and surgical procedure in a letter to the patient's referring physician as *"a 12-year-old male child with left undescended testicle. He was initially found to have bilateral retractile testes under anesthesia. Both testes came down, however, I did on both sides bilateral orchiopexy and pexed both sides of his testes."* [Tr. at 80, Exhibit 7]

f) Dr.Oldham, a board certified pediatric surgeon, who is the Surgeon in Chief and Chief of the Division of Pediatric Surgery at Children's Hospital in Milwaukee, testified that he had significant experience in the differential diagnosis of undescended testes versus retractile testes and based upon his observations of the patient at the time of the surgery, the patient did not have undescended testes. [Tr.at 578-590.}

g) Dr. Godiwalla's treatment created an unacceptable level of risk of complications due to general anesthesia and possible injury or vascular compromise due to surgical errors. [Tr. at 258, 259]

h) A minimally competent physician would have correctly diagnosed retractile testicles, assured the family, observed the patient and not proceeded with an unnecessary surgery. [Tr. at 258, 259]

19. NL was born on December 9, 1985, with bladder exstrophy. Reconstructive surgery was performed shortly after her birth and a sigmoid neobladder was constructed for her. In the years that followed the reconstructive surgery, NL had two ruptures of the neobladder with peritonitis.

20. On or about October 24, 1998, NL was admitted to a hospital in Iron Mountain, Michigan, with abdominal pain, nausea, a high fever, and anergia. The physician caring for the patient diagnosed a urinary tract infection and commenced IV antibiotic therapy. The physician also obtained a CT scan that was read as negative for perforation or abscess formation. When the patient did not respond to the antibiotic therapy and had gradual worsening of her abdominal pain, the physician contacted Children's Hospital in Milwaukee to request transfer of the patient to that facility.

21. Dr. Godiwalla was the physician on call at Children's Hospital on October 25, 1998, when the patient's physician in Iron Mountain, Michigan, contacted Children's Hospital to request the transfer of the patient. Dr. Godiwalla agreed that the patient should be transferred to Children's Hospital. The physician in Iron Mountain, Michigan, advised Dr. Godiwalla that the patient had abdominal pain, nausea, high fever, and a negative CT scan. He also advised her that the patient was stable without evidence of perforation, peritonitis, or septic shock.

22. NL arrived at Children's Hospital in Milwaukee on October 25, 1998. Upon arrival, Dr. Godiwalla examined NL and determined that she was tachycardic with a pulse of 140, a respiratory rate of 32, a blood pressure of 100/45, a temperature of 39° C, and a pulse oximetry of 95%. The patient's abdomen was distended, firm with rebound tenderness, and no bowel sounds. Dr. Godiwalla also reviewed the CT scan that had been sent with the patient and read the CT scan as demonstrating a probable perforation of the neobladder with free peritoneal fluid. Dr. Godiwalla was of the opinion that the patient was in septic shock with urosepsis.

23. Dr. Godiwalla believed that NL was not sufficiently stable to undergo abdominal surgery to treat the peritonitis and abscess formation. Dr. Godiwalla elected to take NL to the radiology suite for ultrasonic-guided catheter placement into the neobladder and placement of a peritoneal catheter to drain the peritoneal fluid collection. These procedures were performed under sedation utilizing morphine sulfate, Nembutal, and Versed. The sedation was commenced at 2025 on October 25, 1998. The patient was transported from the radiology suite to the pediatric intensive care unit (PICU) at approximately 2200. At 2200, the NL's blood pressure was 120/60, her respiratory rate was 38, and her pulse was 155.

24. When NL arrived in the PICU, her pulse rate was in the 140s with a diastolic blood pressure by noninvasive measurements in the 30s. She was started on dopamine without significant response. Thereafter, a phenylephrine drip was initiated and gradually increased over the evening to maintain a diastolic pressure above 45.

25. NL's sepsis resolved on or about October 28, 1998, and she was discharged from the hospital under Dr. Godiwalla's continuing care on November 6, 1998.

26. NL was discharged from the hospital without any cystoscopic examination or radiographic studies to determine if the perforation of her neobladder had closed resolving the condition that had initially been responsible for her hospitalization.

a) The minimum standard of treatment of a patient presenting with perforated neobladder would include the placement of catheters while the patient was under IV sedation without the presence of a medical doctor anesthesiologist. [Tr. at 670.].

b) Dr. Godiwalla's decision to drain the sepsis with a less aggressive surgical approach did not deviate from the minimum standard of treatment because the patient may have decompensated or possibly died under general anesthesia due her acute infectious condition. [Tr. at 672].

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 (3) Wis. Stats., and s. MED 10.02 (2) Wis. Adm. Code.

2. Respondent's conduct, as described in the Findings of Fact herein, constitutes negligence in treatment under s. 448.02 (3) (b), Stats.

3. The Medical Examining Board has jurisdiction in this matter pursuant to §448.02, Wis. Stats.

4. By having engaged in the conduct with respect to Patient MM as set forth in Findings of Fact 4-8, Shirley Yezdi Godiwalla engaged in unprofessional conduct contrary to §448.02 (3), Wis. Stats., and § MED 10.02 (2) (h), Wis. Admin. Code.

5. By having engaged in the conduct with respect to Patient LSG as set forth in Findings of Fact 9-13, Shirley Yezdi Godiwalla engaged in unprofessional conduct contrary to §448.02 (3), Wis. Stats., and § MED 10.02 (2) (h), Wis. Admin. Code.

6. By having engaged in the conduct with respect to Patient AD as set forth in Findings of Fact 14-18, Shirley Yezdi Godiwalla engaged in unprofessional conduct contrary to §448.02 (3), Wis. Stats., and § MED 10.02 (2) (h), Wis. Admin. Code.

7. By having engaged in the conduct with respect to Patient NL as set forth in Findings of Fact 14-18, Shirley Yezdi Godiwalla did not engage in unprofessional conduct contrary to §448.02 (3), Wis. Stats., and § MED 10.02 (2) (h), Wis. Admin. Code.

ORDER

NOW THEREFORE IT IS HEREBY ORDERED that the license of Shirley Yezdi Godiwalla to practice medicine and surgery in the State of Wisconsin shall be **LIMITED** and she shall be prohibited from practicing pediatric urology, including pediatric urological surgery. This limitation shall apply to any and all patients aged eighteen (18) and younger. This limitation shall begin the date on which this Order is signed and shall remain in effect for an indefinite period.

IT IS FURTHER ORDERED that Shirley Yezdi Godiwalla may petition the Board for removal of the limitation upon her license, provided that she has successfully completed a one (1) year ABMS accredited fellowship in pediatric urology. Prior to commencing such fellowship, the respondent shall submit a description of the training program to the Board for pre-approval. Upon completion of the approved training program, the respondent shall submit a complete report and evaluation of her performance to the Board for consideration at the time that she submits her petition for removal of the limitation upon her license. Respondent's license shall remain limited until such time as she completes the required continuing education.

EXPLANATION OF VARIANCE

In adopting this variance, the Board has supplemented the Findings of Fact in the Proposed Decision to support the elements necessary to establish a violation of the Wis. Admin. Code sec. med. 10.02(2)(h) and to satisfy the requirements of Gilbert v. Medical Examining Board, 119 Wis. 2d. 168, 349 N.W.2d. 68 (1984) and Gimenez v. Medical Examining Board, 203 Wis. 2d. 349, 552 N.W.2d. 863 (App. 1996). Gilbert and Gimenez require findings as to: (1) the course of treatment the physician provided; (2) the minimum standard of treatment required; (3) how the physicians' treatment deviated from the minimum standards; (4) how the treatment created an unacceptable level of risk; and (5) what course of treatment a minimally competent physician would have utilized. The Board finds that the record contains substantial evidence sufficient to establish these elements.

Prior to adopting this variance and supplemental findings, the Board inquired of Jacquelynn B. Rothstein, the Administrative Law Judge (ALJ) who conducted the hearing and prepared the proposed decision, as to her opinion on the credibility of the witnesses, particularly as it related to the additional findings and the testimony of the medical experts. The ALJ indicated that there was credible evidence in the record to support the additional findings. The ALJ also indicated that while both experts were well qualified and credible, she found the testimony of Dr. Kennedy to be more informative and, thus, she gave his testimony greater weight. She also indicated that she understood how the Board may have arrived at its variance with respect to the care of Patient NL as the evidence suggested that the deficiencies were not as serious with respect to that patient as compared to the care of the other patients.

At the onset, the Board recognized that the medical experts who testified in this case, Dr. Kennedy and Dr. Synder, disagreed as to what constitutes the minimum standard of care for each patient and whether Dr. Godiwalla's care of the patients fell below that standard. For example, with Patient MM, the experts disagreed as to whether the standard of care requires drug therapy or behavioral modification prior to invasive diagnostic procedures, such as a video urodynamic study or cystoscopy. However, even if invasive diagnostic procedures could be warranted prior to other use of other therapies, the Board does not accept Dr. Snyder's opinion[1] that after Dr. Godiwalla performed such diagnostic tests, including direct observations during surgery, she was practicing competently when she misdiagnosed Patient MM as having posterior urethral valves as opposed to mini valves. The Board rejects the explanation given by Dr. Snyder that since other physicians often mistake mini-valves for posterior urethral valves; it was within the minimum standard of care for Dr. Godiwalla to misdiagnosis this basic anatomical feature in light of the other evidence in the record. There is substantial evidence from both experts that mini-valves have been recognized in the urological field since the early to mid-1980's as a normal feature which do not require surgical excision for the treatment of incontinence. There is also evidence that Dr. Godiwalla admitted that she had never even heard of mini-valves until questions were raised after the surgery.

There is also substantial evidence in the record showing that Dr. Godiwalla failed to render accurate diagnoses for Patients LSG and AD. As an example, the evidence shows that Dr. Godiwalla diagnosed the presence of a varicocele for Patient LSG and performed surgery to remove it which resulted in the loss of the patient's testicular artery, the most stable blood supply to that organ. The evidence casts considerable doubt on whether Patient LSG had a varicocele: the pathology report does not mention a varicocele specimen; and Lisa Scheel, the surgical assistant, who was present during the surgery, saw no indication of a varicocele. Furthermore, there is evidence that Dr. Godiwalla may have altered her post surgical reports after-the-fact to suggest the presence of a varicocele and thereby justify her diagnosis. Similarly, in the case of Patient

AD, the Board finds credible evidence in the record again showing that Dr. Godiwalla misdiagnosed the patient as having undescended testes and she performed an unnecessary surgery to correct a non-existent condition. Dr. Oldham, a highly experienced pediatric surgeon, indicated that when he observed the patient at the time of surgery, he believed that the patient had retractile testes and not undescended testes.

Dr. Godiwalla's diagnostic mistakes have caused her to proceed with unnecessary and unwarranted surgical procedures, which placed her patients at risk of harm. The type and frequency of Dr. Godiwalla's diagnostic errors strongly suggests to the Board that she requires extensive education and re-training in order to practice competently and safely. For this reason, the Board has determined that Dr. Godiwalla must successfully complete a full urological training program to ensure that her diagnostic skills are refreshed and improved. The Board finds it necessary for public protection that Dr. Godiwalla be restricted from pediatric urological care until such time as she has successfully undertaken the additional remedial education ordered and approved by the Board.

However, with respect to the care of Patient NL, the Board does not find that Dr. Godiwalla's conduct was below the minimum standard of care. The Board accepts the opinion of Dr. Synder that the decision to proceed with NL's catheterization under conscious sedation as opposed to general anesthesia by an anesthesiologist met the minimum standard. The Board finds that Dr. Godiwalla's decision was appropriate, given the patient's acute condition. The Board notes that evidence in the record shows that Dr. Godiwalla's prompt treatment may have prevented further deterioration in the patient's condition and resulted in her immediate improvement. The Board also rejects the opinion of Dr. Kennedy as to whether Dr. Godiwalla performed sufficient tests to determine if the perforation had actually resolved before discharging the patient. Dr. Kennedy admitted that at the time he reviewed the complaint and rendered his opinion, he was not aware that a CAT scan and sinogram had been performed prior to the patient's release. For these reasons, the Board found that the more credible evidence shows that Dr. Godiwalla acted competently when she discharged the patient.

Finally, since the Board did not find that Dr. Godiwalla's conduct was below the minimal standard of care with respect to Patient NL, it has determined that it would be appropriate to reduce the amount of costs in the ALJ's recommended decision by twenty-five percent (25%). Therefore, the costs assessed against Dr. Godiwalla shall be seventy-five percent (75%) of the total costs of the proceeding.

Dated this 27th day of July, 2004.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

Bhupinder S. Saini, Vice Chair
Board Member

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[1] Dr. Synder, one of the medical experts who testified at the hearing, has impressive credentials and is highly accomplished in the field of urology. However, the Board finds that with respect to three out of the four patients in this case, the minimum standard of care was articulated more persuasively by Dr. Kennedy, who is also a board certified urologist. Also, the Board finds that Dr. Kennedy's opinions are more persuasive as to the crux of the problem with Dr. Godiwalla's patient care – misdiagnoses which resulted in unnecessary and deleterious surgical procedures.