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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

MARK K. JENSON, M.D.,
RESPONDENT.

FINAL DECISION AND ORDER
Case No. LS0403293MED
02MED482

PARTIES

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

Mark K. Jenson, M.D.
1745 Dousman Street
Green Bay, WI 54303

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

This proceeding was commenced by the filing of a Notice of Hearing and Complaint on March 29, 2004. The Answer was filed on April 15, 2004. The hearing was held on August 23, 2004. The hearing transcript was filed on September 1, 2004. Closing arguments were filed by October 4, 2004. Attorney James E. Polewski appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Paul H. Grimstad, Nash, Spindler, Grimstad & McCracken, LLP, appeared on behalf of Dr. Jenson.

The Administrative Law Judge Ruby Jefferson-Moore filed her *Proposed Final Decision in the Matter of Disciplinary Proceedings Against Mark K. Jenson, M.D, Respondent* LS403293MED on April 7, 2005. The Complainant filed the *Division of Enforcement Objections to the Proposed Decision and Proposed Additional Findings of Fact and Alternate Conclusions of Law* on April 27, 2005. The Respondent requested and was granted an extension to file their *Brief Opposing the Division's Objections to the Proposed Decision* on May 9, 2005.

Based upon the entire record herein, the Medical Examining Board adopts, in part, and rejects, in part, the Findings of Fact and Conclusions of Law and Order of the Proposed Decision. The supplemental findings of fact are numbered and incorporated as subparagraphs to the original Findings of Fact in the Proposed Decision. These findings are cited to their location in the hearing transcript by the designation "Tr." followed by the transcript page number. The Board has also modified the Conclusions of Law to reflect a finding of unprofessional conduct within the meaning of Wis. Admin. Code s. MED 10.02(2)(h).

Based upon the evidence in the record, the Wisconsin Medical Examining Board adopts as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Mark K. Jenson (d.o.b., 10/11/58), 1745 Dousman Street, Green Bay, WI 54303,
is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license #29927, which was first granted on

December 8, 1988. Dr. Jenson is a family practitioner. He has been certified by the American Board of Family Practice since 1989.

2. On July 8, 1999, patient BG, a female born on November 29, 1985, presented to Bellin Health Hospital Center in Green Bay while Dr. Jenson was on duty in Clinicare, an urgent care facility.

3. Patient BG was five feet tall and weighed 265 pounds. She complained of back pain, right lower quadrant abdominal pain, and had a fever of 101 degrees. The nurse's examination notes state that Patient BG's abdomen was round and firm, and that it was usually soft. Dr. Jenson assessed BG's abdomen as soft with positive bowel sounds and lower right quadrant tenderness. Dr. Jenson noted in the patient's chart that her pulse rate was 120 per minute, and that her respirations were 32 per minute.

4. Dr. Jenson ordered laboratory analysis of a blood sample. In his documentation, Dr. Jenson stated "[w]hite count is bizarre with a 5700 white count, 24 neutrophiles, 32 bands. Reactive lymphs are increased."

5. Dr. Jenson ordered two radiographs, a flat plate and an upright, which he read as "basically unremarkable". Three radiographs were taken of the patient. Dr. Jenson did not learn that the third x-ray film had been taken until sometime after July 8, 1999.

6. The x-ray films taken of Patient BG on July 8, 1999, were read the next day by a radiologist, who noted free air in the abdomen. The radiologist noted the following in his report: "Impression: Findings consistent with free air under both diaphragms with several associated slightly distended loops of small bowel. These findings were called immediately to the Treatment Center and discussed with Dr. Hendricks."

7. Dr. Jenson prescribed Toradol, 60 mg. IM, for pain, and assessed the patient's condition as "Probable Mittelschmerz."

7(a). Mittelschmerz is a condition of pain on ovulation; it lasts approximately six to eight hours, and is not accompanied by any notable fever, or by rapid pulse or respirations, or an increase in immature white blood cells in circulation. [Tr.27:10 – 31:6]

7(b). Patient BG had a fever of 101 F. (Exhibit 2B, pp.3-4.)

7(c). Patient BG had an elevated band count at 32, approximately 3 times the normal maximum, indicative of an acute infection. [Tr.129-130, Dr. Davis at Tr.28-30; Exhibit 2B, p.6]

7(d). Patient BG had a significantly elevated pulse rate at 120 beats per minute. [Tr.22.35 – 24.12]

7(e). Patient BG had a significantly elevated respiration rate at 32 breaths per minute. [Tr.22:25 – 24:22]

7(f). The minimally competent family practice physician would consider the elevated pulse rate, the elevated respiration rate, the fever and the significantly elevated band count in Patient BG's presentation, and not rely upon a diagnosis of Mittelschmerz, but continue to look harder to find out what is going on with the patient. [Tr.27:10 -28:3, 30:1-25; 30:1-5, 94:23-25.]

7(g). An internal pelvic examination, pelvic ultrasound, or CAT scan was not performed when Patient BG presented at the urgent care. [Tr:76:5-8]

8. Prior to releasing BG to go home, Dr. Jenson consulted with Dr. Peter Falk, a surgeon, regarding BG's symptoms and health status.

8(a). Dr. Jenson did not determine that Patient BG had free air in her abdomen and, therefore, did not inform Dr. Falk of its presence. [Tr.135-136]

8(b). Dr. Jenson did not ask Dr. Falk to come to the hospital to examine Patient BG, or to come to the hospital to examine the radiographs of Patient BG. (Exhibit 2B, p.3)

8(c). A minimally competent family practice physician would call a surgeon to the hospital to examine the patient and keep the patient in the hospital under close observation when free air is observed an abdominal radiograph. [Tr.46:6 - 19; 52:13; 53:9]

9. Dr. Jenson released Patient BG to go home with her mother, with instructions to contact Dr. Peter Falk if her condition got worse overnight; finish taking her Macrobid; to consume "clear liquids tonight only"; to return to the Clinic the following morning to undergo another complete blood count (CBC), and, if not better, to see Dr. Falk the following day. Dr. Jenson also prescribed Naprosyn 500 bid for pain.

9(a). Dr. Jenson's decision to send Patient BG home with a diagnosis of Mittelschmerz exposed her to the grave risk of an untreated surgical emergency, when the minimally competent physician would have begun prompt medical intervention and preparations for surgery. [Tr.52:2 - -53:9.]

10. Dr. Jenson noted the following in the patient's chart [Exhibit 2B]:

SUBJECTIVE: This is a 13-year-old white female, very heavy 265 pounds with temperature 101 today. Seen and put on Microbid and Pyridium Saturday for UTI. Continues to have back pain and fever, right lower quadrant pain today, mucousy stool, usually is soft, a little harder today.

OBJECTIVE: Temperature 101, went down with Tylenol. Pulse 120, respiratory rate 32. Head: Normocephalic, atraumatic Eyes: PERRLA. Tympanic membranes intact. Abdomen is soft. Positive bowel sounds. Right lower quadrant tenderness. She is two weeks post-period. White count is bizarre with a 5700 white count, 24 neutrophiles, 32 bands. Reactive lymphs are increased. Flat plate and upright are basically unremarkable.

ASSESSMENT: Probable mittelschmerz. She got excellent relief with Toradol in the treatment center and was able to hold down some Sprite.

PLAN: Naprosyn 500 bid, finish her Macrobid. Clear liquids tonight only. If any worsening tomorrow, mom is a nurse on 2 South, she will see Dr. Peter Falk in the morning. I discussed the case with him and he said to watch it tonight and he will deal with it tomorrow if there is any increase in pain.

11. While at home, Patient BG vomited throughout the night and she aspirated. She was brought to the urgent care clinic the next morning, with cold and mottled skin, shallow panting respirations, and mental confusion. She required resuscitation in the urgent care, and was taken directly to the operating room. Dr. Falk's impression was: "septic shock, probably due to perforated viscus".

12. The operation, that Patient BG had, disclosed a tubo-ovarian abscess with large quantities of pus in the intraperitoneal cavity. The patient suffered two cardiac arrests during the operation, from which she was resuscitated, and two episodes of bradycardia, with resuscitation. She was taken to the intensive care unit with adult respiratory distress syndrome, renal failure, hemodynamic instability, and died early the next morning from cardiac arrest with ventricular fibrillation that could not be corrected.

13. The Patient's Discharge Summary Report dictated after the operation states the following regarding BG's diagnosis: Preoperative diagnosis: ABD Pain. Final Diagnosis: 1) marked chronic salpingitis with fibrosis; 2) ovarian abscesses with acute fibrinopurulent peritonitis change.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 (3) Wis. Stats.

2. The evidence presented, as described in Findings of Fact paragraphs #2-13 herein, establishes that Dr. Jenson failed to appreciate the significance of Patient BG's condition on July 8, 1999, and that his care and treatment of the patient

constituted a danger to the health and safety of the patient within the meaning of s. MED 10.02 (2) (h), Wis. Admin. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the respondent, Mark K. Jenson, M.D. is REPRIMANDED and his medical license shall be LIMITED to require that he complete twenty-four (24) credit hours in abdominal diagnosis, evaluation and management, including pediatric or adolescent patients, within six (6) months from the date of this order. The education required under this order shall not be used to satisfy Dr. Jenson's continuing medical education requirement for licensure renewal.

IT IS FURTHER ORDERED that pursuant to s. 440.22 Wis. Stats., Dr. Jenson shall pay the full costs of this proceeding.

The Respondent may petition the Board for modification of limitation upon his license after he has satisfied the requirements of this order.

All petitions, requests, notifications and payments shall be mailed, faxed or delivered to: Department Monitor, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Ave., P.O. Box 8935, Madison, WI 53708-8935, Fax (608) 266-2264, Telephone (608) 267-3817.

This Order is effective on the date on which it is signed on behalf of the Medical Examining Board.

VARIANCE OPINION

Based upon the entire record, and the reasons set forth herein, the Wisconsin Medical Examining Board hereby issues this variance to the *Proposed Decision* prepared by Ruby Jefferson-Moore, the Administrative Law Judge (ALJ). This variance supplements the Findings of Fact and reverses the Conclusions of Law with respect to the allegation of unprofessional conduct and imposes professional discipline on the respondent. Specifically, the Board finds that substantial evidence exists in the record to establish that Dr. Jenson did not meet the standards of minimally competent practice when he discharged the Patient BG with a working diagnosis of "Mittelschmerz." Rather, the Board finds that a minimally competent family practice physician would not have made such a diagnosis given the patient's symptoms and presentation. The Board further finds that Dr. Jenson's failure to appreciate the significance of Patient BG's medical condition on July 8, 1999, and to render a plausible diagnosis and to treat her appropriately at that time, tended to constitute a danger to her health, welfare and safety and constituted unprofessional conduct within the meaning of Wis. Admin. s. Med 10.02(2)(h).

Prior to adopting this variance, the Board consulted with the ALJ as to the credibility and weight which she gave to the evidence, particularly as to the testimony of the expert witnesses. The ALJ informed the Board that she gave more weight to Dr. Nichols' testimony because he was a surgeon, although she found both experts to be well qualified. After careful review of the testimony by both experts, the Board has determined that the testimony of Dr. Davis was entitled to greater weight and that based upon his expert testimony and other substantial evidence in the record, the allegations of unprofessional conduct were established.

Dr. Davis is board certified in the field of family practice medicine and the former chief resident at the University of Wisconsin Medical School since 1980. Dr. Davis has also been continuously employed as a practicing family practice physician. [Tr.14, 15] Dr. Davis teaches and supervises residents and medical students who provide family practice medical care to actual patients in the teaching clinic.

In addition, Dr. Davis has authored a number of publications, articles and continuing education materials on issues related to the quality of care of family practice physicians. He is extensively familiar with the evaluating patients with common presenting problems in family practice settings. [Tr.17:15] Dr. Davis' teaching specialization includes clinical decision-making, analysis and patient diagnosis. [Tr. 18-25, 19:1-9]. Dr. Davis has been recognized for his contributions to the development of the medical school's clinical medicine and practice courses, specifically, how to do an appropriate history, physical examination and differential diagnosis. [Tr. 19:1-9]

In comparison, Dr. Nichols, the expert who testified for the respondent, is a surgeon and professor of microbiology and

immunology. He described his medical expertise as dealing with infections in surgical patients. However, the issue in this case does not involve surgical techniques, microbiology or immunology. The primary issue in this case is whether Dr. Jenson appreciated the significance of the patient's condition and rendered an adequate differential diagnosis as required under the standards of minimally competent practice for a family practice physician.

In his own testimony, Dr. Nichols admitted that he was not familiar with Mittelschmerz, the medical condition that had been diagnosed by Dr. Jenson and that he did not treat patients with such conditions. He even testified that he would not have included Mittelschmerz on his differential diagnosis for the Patient BG. Specifically, when asked why Dr. Jenson would have ordered a repeat blood count if he thought that the Patient BG had Mittelschmerz, Dr. Nichols testified as follows:

> A: I really don't know why he ordered. I didn't –I already said that Mittelschmerz is not on my differential, because I never put that on my differential, okay? I really don't know about it. So I really don't know enough about it. So I really don't answer questions about the little ruptures of the ovaries that occur at mid-cycle, because I don't see, you know, patients like that frequently. [Nichols Tr.98:5-15].

It is the view of this Board that the testimony of Dr. Nichols, a general surgeon, is less convincing than the testimony given by Dr. Davis, who is a board certified specialist in family practice medicine, with many years of academic and professional expertise relevant to the standard of care at issue in these proceedings.

Gilbert/Gimenez Analysis

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.

As to the first requirement; which is the course of treatment the physician provided, the Board has adopted additional Findings of Fact relevant to the course of treatment provided by Dr. Jenson in this case. These findings are enumerated below and were incorporated in the Findings of Fact herein:

7(a) Mittelschmerz is a condition of pain on ovulation; it lasts approximately six to eight hours, and is not accompanied by any notable fever, or by rapid pulse or respirations, or an increase in immature white blood cells in circulation. [Tr.27:10 – 31:6]

7(b) Patient BG had a fever of 101 F. (Exhibit 2B, pp.3-4.)

7(c) Patient BG had an elevated band count at 32, approximately 3 times the normal maximum, indicative of an acute infection. [Tr.129-130, Dr. Davis at Tr.28-30; Exhibit 2B, p.6]

7(d) Patient BG had a significantly elevated pulse rate at 120 beats per minute. [Tr.22.35 – 24.12]

7(e) Patient BG had a significantly elevated respiration rate at 32 breaths per minute. [Tr.22:25 – 24:22]

7(g) An internal pelvic examination, pelvic ultrasound, or CAT scan was not performed when Patient BG presented at the urgent care. [Tr:76:5-8]

8(a) Dr. Jenson did not recognize that Patient BG had free air in her abdomen and Dr. Falk was not informed of it. [Tr.135-136, 138:14-24]

8(b) Dr. Jenson did not ask Dr. Falk to come to the hospital to examine Patient BG, or to come to the hospital to

examine the radiographs of Patient BG. (Exhibit 2B, p.3)

As to the second requirement under the Gilbert and Gimenez decisions; which is the minimum standard of treatment required, the Board has adopted supplemental findings relevant to that requirement based upon substantial evidence in the record. These findings are enumerated below and were also incorporated in the Findings of Fact herein:

7(f) The minimally competent family practice physician would consider the elevated pulse rate, the elevated respiration rate, the fever and the significantly elevated band count in Patient BG's presentation, and not rely upon a diagnosis of Mittelschmerz, but continue to look harder to find out what is going on with the patient. [Tr.27:10 -28:3, 30:1-25; 30:1-5, 94:23-25.]

8(c) A minimally competent family practice physician would call a surgeon to the hospital to examine the patient and keep the patient in the hospital under close observation when free air is observed an abdominal radiograph. [Tr.46:6 -19; 52:13-21; 53:1-9, 54:2-14]

9(a) Dr. Jenson's decision to send Patient BG home with a diagnosis of Mittelschmerz exposed her to the grave risk of an untreated surgical emergency, when the minimally competent physician would have begun prompt medical intervention and preparations for surgery. [Tr.52:25; 53:1-9.]

Dr. Davis articulated the minimum standard of treatment in the following testimony:

> A: . . . It's expected of the minimally competent physician that they can interpret the tests they order and that they can synthesize the data from the history, the physical, the lab and x-ray and come up with a plausible diagnosis. In this case the doctor doesn't need to know the bacteria count that causes it. He doesn't even need to really know where the gas is coming from. He needs to know that this woman is sick, she is probably on the verge of being gravely ill, and the ruptured viscus, if it's there or the fact that there's gas there and it is not a ruptured viscus doesn't matter. She is in grave need of the hospital and most likely surgical intervention and fluid, and once they figure out where this source is, antibiotics in large dosages and broad spectrum.
> [Tr.95:19; 96:1-11.]

Dr. Davis further described the minimum standard of care in this case as follows:

> A: … the standard of care would have been to have the patient be what's called NPO, nothing by mouth. She would have been given IV fluids. The surgeon should have been consulted, asked to come in and see the patient, and they could discuss on the phone what tests the surgeon would like while they're coming in, most likely a CAT scan or pelvic ultrasound, depending on what was available in the urgent care setting, and worked on taking care of stabilizing this woman. [Tr.52:25, 53:1-9]

In Dr. Davis's opinion, a minimally competent family practice physician would be expected to do far more than Dr. Jenson did for this patient, given her symptoms and presentation. According to Dr. Davis, a minimally competent family practice physician must perform an adequate examination, order appropriate tests, analyze the information obtained from the examinations and tests, and arrive at a plausible diagnosis. The opinion of Dr. Davis was based on fundamental medical concepts which he testified are taught to all medical school graduates in the field of family practice medicine.

> A: . . . It's expected of someone who graduates from medical school that you would have some idea about the tests that might be ordered when one's concerned about abdominal pain. And among those tests would be a blood count, potentially a urinalysis and potentially abdominal and upright x-rays.
> [Tr.95:10-24.]

Dr. Davis acknowledged that while some of the required tests were ordered by Dr. Jenson, his overall care did not satisfy the minimum standard because Dr. Jenson failed to effectively analyze and interpret the information from the tests to arrive at a plausible diagnosis.

> Q: In your education, training and experience, would a minimally competent family practice physician decide that a

temperature of 101 was attributable to a Mittelschmerz ovulation increase?

A: I think it would be very unlikely that a minimally competent physician would diagnose Mittelschmerz in the presence of a temperature of 101. [Tr.94:23]

In comparison, Dr. Nichols, the respondent's expert witness, expressed his opinion as to the standard of care in an equivocal manner and appeared to draw upon his own practice or expectations instead of objective criteria. He testified as follows:

A: Well, I think his care was within the standard. I would have expected, with what the patient presented with, that his approach and his discussion with the specialists and with the mother, who was a registered nurse, and the course of the patient would have be fine to have the patient come back when further symptoms occurred from the period of about eleven o'clock at night until the next morning when the patient was to come back for a CBC, if having any symptoms to see Doctor Falk. [Nichols Tr. 24:16-25, 25:1-3].

Dr. Nichols' opinion that Dr. Jenson met the standard of care was clearly not as convincing as the opinion of Dr. Davis, which was based upon solid medical fundamentals and objective standards in family practice medicine.

As to the third requirement; how the physicians' treatment deviated from the minimum standards; Dr. Davis testified that the diagnosis of "probable Mittelschmerz" was not a minimally competent differential diagnosis given the patient's symptoms, abdominal pain, elevated respiration and pulse rate, temperature of 101, and elevated white blood cell bands. [Tr. 27:10-20]. The diagnosis of Mittelschmerz, according to Dr. Davis is a diagnosis of exclusion and does not explain the patient's presenting condition. Mittelschmerz only accounts for one aspect of the patient's symptoms, her abdominal pain; it does not address the patient's fever, rapid pulse and respirations, abdominal free air and bandemia. Also, Mittelschmerz is a condition, according to Dr. Davis, which rarely last longer than six to eight hours, and is not associated with fever, increased pulse, respiration and elevated platelet count. In other words, Mittelschmerz; is a non-surgical benign condition that passes with time.

The diagnosis of "probable Mittelschmerz," is also inconsistent with Dr. Jenson's thoughts and actions which indicate that he seriously contemplated the necessity of abdominal surgery. Dr. Jenson testified that he thought something acute was going on in the patient's abdomen that might need surgery; yet, he discharged the patient with a diagnosis of Mittelschmerz, a condition which does not justify surgery and is contradictory to Dr. Jenson's view that something acute was going on with the patient.

The Board gave greater weight to Dr. Davis's opinions in regard to the inadequacy of the diagnosis rendered by Dr. Jenson because his reasons were well articulated and logical in view of the totality of the patient's symptoms. Dr. Davis testified as follows:

A: Usually Mittelschmerz will cause some abdominal discomfort. It can be quite uncomfortable. It is virtually unassociated with fever. It is usually a diagnosis of exclusion. You look for other causes first, assume the Mittelschmerz at the end. I would think it unlikely to see a respiratory rate of 32, pulse rate of 120 or a fever of 101 in that setting. It is also a pain that tends to about six to eight hours in duration. It is rarely longer than that, and this patient's symptomatic time course makes that seem unlikely. [Tr. 27:10-20]

A: Mittelschmerz is a diagnosis of exclusion for one, tends to be short, limited pain, shouldn't cause air under the diaphragm. There has to be something major that doing that, and the fact that this woman had been sick for five days also precludes that being on my list. I think that it would be on my list before I saw her. After I saw her, it would be on the bottom. [Tr.50:15-22]

Even Dr. Nichols admitted under cross-examination that he would not have included Mittelschmerz on his differential diagnosis of the patient.

A: Well, I don't know how much you'd know what my differential, but I don't know much about Mittelschmerz. I've heard about it, so that it wouldn't have been on my differential. That's correct. [Nichols Tr. 95:6-10]

Dr. Davis further testified that when a 13 year old patient presents with abdominal pain, there would be a long differential,

including appendicitis, bowel obstruction and gastroenteritis. He also indicated that persistent abdominal and back pain suggests the possibility that the patient had a partial treated pyelonephritis. [Tr.32:13-25]. When asked what a minimally competent family practitioner would do when presented with the blood count present in Patient BG, Dr. Davis testified that his suspicions would be raised and he would be looking harder to determine if something more is going on; that it was very unusual that the patient had been sick for five days and was not getting better and continued to have a fever. [Tr.30-8-16]

Dr. Davis testimony illustrates how Dr. Jenson's care deviated from the minimal standard of care with the kind of specificity that is probative to the issues in this case. Dr. Davis stressed the importance of taking "a very careful history, a very careful physical examination and looking for an occult infection, ranging from an ordinary 'run-of-the-mill' infection to something very important." [Tr.25:2-5]. In contrast, the evidence in the record shows that Dr. Jenson did not even perform a basic pelvic examination although he diagnosed a condition involving the patient's internal reproductive organs. In fact, the only pelvic examination that was done occurred the following day when Dr. Falk performed an external examination of the labia. As a result, Dr. Jenson did not obtain any information about the patient's pelvis, uterus or ovaries prior to making his diagnosis of Mittelschmerz and then discharging her to home, although he admitted that he had a suspicion that something "acute" was going on. [Tr.76:14-18].

Dr. Davis also testified that a minimally competent physician would have ordered an upright x-ray that included the diaphragms to rule out free air under the diaphragm. He explained that is something not to be missed, and the way not to miss it is to make sure that the area of the abdomen adjacent to the lung field is visible. [Tr. 93:20-25; 94:1-4] The record evidence indicates that Dr. Jenson relied upon x-rays of insufficient quality which did not clearly depict the possibility of free air under the diaphragm.

As to the fourth and fifth requirements of the required analysis; how the physician's treatment created an unacceptable level of risk; and what course of treatment a minimally competent physician would have utilized, the evidence shows that Dr. Jenson's diagnosis in this case was the most critical aspect of his below minimal standard care. The diagnosis was critical because it formed the basis for Dr. Jenson's subsequent decisions and action with respect to the patient. Dr. Jenson's diagnosis was the basis upon which he discharged the patient to home late at night, in the care of her mother, rather than admitting the patient to the hospital for further evaluation, close monitoring and rapid surgical intervention.

Dr. Nichols' testimony further explains why Dr. Jenson's decision created an unacceptable level of risk to the patient:

> A: . . . this young woman was at grave risk of having something serious. She needed to be hospitalized. She needed fluid resuscitation. She needed lots of fluid resuscitation, and she needed a surgeon. [Tr.52:6-12]

Dr. Nichols confirmed that a minimally competent family practitioner would have recognized that the Patient BG needed to be in the hospital under close observation. [Tr.52:13-18]. Dr. Jenson's diagnosis of Mittelschmerz actually increased the level of risk which ultimately manifested the next morning when the patient returned to the clinic in a state of acute sepsis. Had a proper diagnosis been rendered, it is likely that the patient would have received appropriate treatment, including the timely administration of antibiotics to combat her mounting infection.

This Board gives little, if any weight, to the opinion of Dr. Nichols that Dr. Jenson's care did not contribute to the level of risk to the patient. Dr. Nichols essentially testified that nothing could have been done to save the Patient BG; that "the die was cast, probably a day before she saw Dr. Jenson. There was nothing he could have done." [Tr.57:6-10]. The Board considers this testimony as speculative. Dr. Davis testified that a minimally competent family practice physician should have recognized that Patient BG needed more than to be discharged to home with instructions to return to the clinic in the morning if the symptoms grew worse. He testified that she needed to be in the hospital under close observation. [Tr.52:13-18] Dr. Davis further explained why the risk of harm was increased by Dr. Jenson's conduct:

> A: Once you have free air, there is nothing anyone, no matter how qualified they are, can do for this patient at home. You can't give the person fluids. They are in dire need of large amounts of fluids. Watching the person isn't appropriate. You've already done that. You've seen them on the 3rd, you've seen them again on the 8th, there's a problem that's not getting better. There are now signs that patient is ill based on the vital signs, what's described as a bizarre white count and air under the diaphragm, suggesting that this person has something catastrophic and significant going on in their belly. The other thing that confirms that opinion is that when this young woman went home, she began

vomiting. . . . This young woman began vomiting late in the course. That's much more associated with surgical kinds of conditions. [Tr. 54:2-14]

The inherent risk of serious harm or death caused by Dr. Jenson's decision to send Patient BG home with a diagnosis of Mittelschmerz is plainly obvious. A minimally competent family practice physician should not send a patient home with a probable diagnosis of a non-surgical condition such as Mittelschmerz, when the patient's symptoms and presentation suggested an imminent probable surgical condition. Dr. Jenson's failure to reach a minimally competent diagnosis on the evening of July 8, 1999, put his patient in grave risk of harm from the abdominal emergency that ultimately proved to be fatal to her.

Costs of the Proceeding

The assessment of costs against a disciplined professional is authorized by sec. 440.22(2), Wis. Stats. and sec. RL 2.18, Wis. Admin. Code, but neither the statute nor the rule clearly indicates the circumstances in which costs are to be imposed. The Medical Examining Board has the discretion to impose all, some, or none of the costs of the proceeding.

Section 440.22 (2), Stats., provides in relevant part as follows: "In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department."

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the respondent is a discretionary decision on the part of the board and that the discretion extends to the decision whether to assess the full costs or only a portion of the costs. This recommendation that the full costs of the proceeding be assessed is based on two factors. First, the Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Second, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the other licensees who were not involved in this proceeding. Since the Respondent is found to have engaged in unprofessional conduct, he shall be held responsible for the full costs of this proceeding.

The rights of the a party aggrieved by this Decision to petition the Board for a rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal" information.

Dated this 9th day of August, 2005.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

Alfred L. Franger, M.D.