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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF	:	
THE DISCIPLINARY PROCEEDINGS	:	
AGAINST	:	
	:	FINAL DECISION AND ORDER
ERIC A. POULIN, M.D.	:	LS-0405202-MED
RESPONDENT	:	

DOE 03 MED 270

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

Eric A. Poulin, M.D.
c/o Attorney David C. Hutchinson
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Medical Examining Board
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PROCEDURAL HISTORY

A hearing in the above-captioned matter was held on November 22, 2004 before Administrative Law Judge Dennis C. Schuh. The Division of Enforcement appeared by Attorney James Polewski. Eric A. Poulin, M.D. appeared in person and by his attorney David Hutchinson.

Based upon the entire record, and the reasons set forth herein, the Wisconsin Medical Examining Board hereby adopts the Findings of Fact, Conclusions of Law and Order set forth in the *Proposed Decision* prepared by the Administrative Law Judge (ALJ), Dennis C. Schuh, with the exception of the recommendation that the costs of the proceeding be assessed against the Division of Enforcement.

FINDINGS OF FACT

1. Eric A. Poulin, M.D., ("Respondent") was born on December 3, 1970, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 41803, first granted November 19, 1999.

2. Shortly before noon on November 10, 2002, Respondent was the physician on duty at the emergency room of River Falls Area Hospital, River Falls, Wisconsin, when Patient E.S. was brought to the emergency room.

3. Patient E.S. was a male, born March 29, 1982, and a student at the University of Wisconsin-River Falls. He

was a resident of a university dormitory.

4. Patient E.S. complained of chills, headache, weakness and fever of several hours' duration, and cold symptoms, fatigue, and sore throat of several days duration. At 11:50 a.m., his blood pressure was recorded as 134/57, heart rate at 109, respirations at 20, and temperature at 101.3˚ F. Blood analysis of a sample drawn at 12:38 p.m. showed a white count of 5,700, 56% bands, 12% lymphocytes. The manual analysis of the patient's blood showed 30% neutrophils.

5. Respondent examined Patient E.S. at 12:15 p.m. and had a throat culture and urine analysis sample collected. A rapid Strep test at approximately 12:30 p.m. was negative. Respondent's record of the examination states that Patient E.S. denied neck pain, but that the Patient said his neck was a little bit stiff. Respondent's record of examination further states that the Patient "does not really have any throat pain" although the patient said he could feel some swollen glands. Respondent's physical examination found the patient's neck to be "supple and non-tender"

6. At 12:55 p.m., Patient E.S. was given 30 mg. of Toradol for headache pain; according to Respondent's emergency room dictation, the Patient reported his headache was almost gone at 2:00 p.m.

7. At 1:00 p.m., Patient E.S. had a blood pressure of 115/50.

8. At 1:30 p.m., one liter of Lactated Ringers solution was administered to Patient E.S. as a flush; at 2:10, the nurse's notes state that the flush was complete, and that the Patient's color was "a little more pink." His systolic blood pressure was recorded as 111, with no diastolic pressure recorded; heart rate at 110, and temperature at 102.2˚ F.

9. Respondent suggested a spinal tap to Patient E.S. The parties disagree on the purpose for the tap. Respondent asserts that he sought the tap to evaluate the possibility of viral meningitis. The complaint suggests the respondent sought the tap on the possibility of bacterial meningitis. The respondent did not prescribe any antibiotics to the patient on the afternoon of November 10, 2002.

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10. Patient E.S. was reluctant to consent to the spinal tap. The patient called his mother, who spoke with Respondent. The patient's mother came to the hospital to discuss the situation with Patient E.S. and Respondent. The respondent and the patient's mother discussed a spinal tap.

11. Respondent admitted Patient E.S. to the hospital, for observation and follow-up care of fever, headache, abdominal pain and vomiting.

12. The initial nurse's note for Patient E.S. at 2:50 p.m. records him saying "I've never felt this bad" and that his headache "is not so bad now" and describes the Patient as very pale. The nursing notes show the patient was feeling nauseous. The patient told the nurse that he had stayed up late the previous night and woke up with the symptoms he was then experiencing.

The nursing notes indicate that the patient was oriented to place.

13. After discussion with the patient and his mother, Respondent performed a lumbar puncture. The puncture was performed at about 3:45 to 4:00 p.m. The spinal fluid obtained was clear and colorless to the eye. The cerebral spinal fluid was reported to contain one white blood cell and one red blood cell, the glucose was 64 mg/dl, the protein was 17 mg/dl and on gram stain analysis no organisms were seen.

14. At approximately 3:00 p.m., the nurse's graphic record for Patient E.S. indicates a pulse of 104, respirations at 16, and blood pressure at 126/65.

15. At 4:00 p.m., the nurse's note states "very pale; weak voice, very soft; lethargic" and records a temperature of 102.3˚ F. The nurse's graphic record indicates a pulse of 119, respirations at 16, blood pressure falling to 105/64. Respondent was performing a spinal tap on the patient at this time and was able to observe the patient's condition.

16. Respondent's assessment of the Patient's condition was that he did not have bacterial meningitis because the spinal fluid was clear and colorless. Respondent did not order antibiotics at the time of the lumbar puncture.

17. At 4:15 p.m., the Patient was given 650 mg. of Tylenol, and the nurse recorded that the initial laboratory result was negative for meningitis.

18. At approximately 6:30 p.m., Respondent assured the Patient's parents that the Patient was comfortable, and needed fluids, but did not need to be transferred to another hospital. The nurse's notes for that time indicate that the Patient had a temperature of 103.2˚, and that cold packs were placed at both axilla and on the forehead. 2 mg. of morphine sulphate was administered for comfort at 7:00 p.m.

19. At approximately 8:30 p.m., the patient vomited, and the nurse noted that his color was still very pale, but that his lips now had a pink tinge.

20. The nurse's graphic record for the period shows that the Patient had a pulse of 109, respirations of 16, and blood pressures of 75/30, and 96/39 on another measurement about the same time.

21. At 10:10 p.m., the Patient was found to have "wine stain" blotches over his entire body. He was moved to an isolation room, and Respondent called an infectious disease consultant because Respondent suspected meningococcal disease.

22. At the suggestion of the infectious disease consultant and after consultation of the Sanford Guide, Respondent ordered the administration of Penicillin G, but none could be located in the hospital at the time. Instead, Respondent administered Ceftriaxone, 2 grams, IV, at 11:00 p.m.

23. Patient E.S. was noted to have a blood pressure of 86/56; normal saline was infused as a push to improve the blood pressure.

24. At 11:30 p.m., Patient E.S. was noted to be hypoxic. Respondent ordered oxygen by nasal cannula at 2 liters/minute; the Patient's oxygen saturation was measured at 82% with the oxygen, and his blood pressure was measured at 113/73. Respondent called for helicopter transport to a Minneapolis hospital.

25. At 11:45, the oxygen was increased to 3 liters/minute; the Patient's oxygen saturation increased to 84%, and his blood pressure was measured at 102/71. Patient E.S. complained of "pain all over."

26. At 11:50, the oxygen was increased to 5 liters/minute; the Patient's oxygen saturation decreased to 76%, and his blood pressure was measured at 110/72.

27. At 11:40 p.m., Patient E.S. was given 2 mg. of morphine sulphate, IV.

28. At 12:10 a.m. on November 11, 2002, Patient E.S. began to repeatedly clear his throat. Respondent examined him, and saw "significant hemorrhaging occurring back by the tonsils and posterior pharyngeal area." Respondent called for anesthesia assistance for intubation to protect the Patient's airway.

29. At or about 12:30 a.m. on November 11, 2002, Patient E.S. began to cough and stated that his chest "feels like it is filling up." On auscultation, the Patient's lungs were congested throughout.

29. At 12:30 a.m., Patient E.S. began to cough up frothy pink fluid.

30. At 12:45 a.m., Patient E.S. lay down, became "less responsive" and Respondent began to suction the Patient's airway and attempted intubation.

31. At 12:50 a.m., Code Blue was initiated. Patient E.S. was intubated by Marge Warner, CRNA, and suctioned for large amounts of red frothy fluid.

32. Resuscitation efforts continued until Respondent declared Patient E.S. dead at 1:06 a.m.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. §448.02(3) and Wis. Admin. Code MED §10.02(2) (h).

2. The complainant has not shown that Respondent's conduct as herein described was unprofessional conduct contrary to § 448.02(3), Wis. Stats., and Wis. Admin, Code MED §10.02(2) (h) in that he engaged in conduct that tended to constitute a danger to the health, welfare and safety of the patient. The complainant has not shown that Respondent's care tended to constitute a danger to the health, welfare and safety of his patient or is acts which showed Respondent to be unfit for the practice of medicine and surgery

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the disciplinary action against Respondent ERIC POULIN M.D. be and hereby is dismissed.

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This Order is effective on the date of its signing.

EXPLANATION OF VARIANCE

The Board adopts the proposed Findings of Fact and Conclusions of Law recommended by the Administrative Law Judge. The Board in addition adopts the Order recommended by the Administrative Law Judge, with one exception: The Board declines to assess costs of the proceeding against the Division of Enforcement.

It is the view of the Board that the record in this case does not establish that the Division commenced this action or continued it in bad faith, solely for the purposes of harassing or injuring another or that the claim was without any reasonable basis in law or equity. Wis. Stat. § §227.483.

OPINION

Applicable Law

Wisconsin Statutes §448.02(3) provides in part;

448.02(3) (a)

(a) the board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license, certificate or limited permit granted by the board. …

448.02(3)(b)

(b) After an investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct or negligence in treatment, the board shall hold a hearing on such conduct.

Wis. Admin. Code Med 10.02
Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

…

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct.

State v. Aldrich, 71 Wis. 2d 206, 209 (1976).

Punishment of the licensee is not an appropriate consideration.

State v. McIntyre. 41 Wis. 2d 481, 485 (1969).

The state's purpose in licensing professionals is to protect its citizens.

Strigenz v. Department of Regulation and Licensing 103 Wis.2d at 286, 307 N.W.2d at 667.

License revocation is the ultimate means of protecting the public short of fining or imprisonment.

Strigenz v. Department of Regulation and Licensing, 103 Wis.2d 281, 287, 307 N.W.2d 664 (1981).

SUMMARY

The complaint filed against Respondent asserts the unprofessional conduct occurred at two points in the treatment. The first allegation was the Respondent's failure to administer antibiotics to treat suspected bacterial meningitis at or before the time of hospitalization tended to constitute a danger to the health, welfare and safety of the patient in that such treatment would have been the appropriate treatment for the disease the patient actually had, meningococcemia thus being unprofessional conduct. The second allegation set forth in paragraph 34 of the complaint[1] was apparently abandoned prior to hearing. No testimony was introduced concerning this allegation and the complainant did not address it in his opening or closing statements.

E.S., a 20-year-old college student at a local campus arrived at the emergency department of River Falls Area Hospital at 11:45 am on November 10, 2002. E.S. complained of chills, headache, weakness, fever, cold symptoms, fatigue and sore throat. The Respondent examined E.S. beginning at approximately 12:15 pm. The nature, extent and manner of that examination are admitted by all to be appropriate.

Respondent requested several clinical tests all of which were admitted by all parties to be appropriate. Respondent prescribed Toradol for headache pain, also deemed by all to be appropriate. E.S. was administered one liter of Lactated Ringers solution, also deemed by all to be appropriate.

E.S. was admitted to the hospital at approximately 2:30 pm. Curiously, the complainant's expert witness indicated that hospitalization was not necessary.

E.S. contacted his mother, referred to here as C.S. by telephone and advised her of his situation. C.S. and her spouse went to the hospital arriving at approximately 2:55 pm.

A lumbar puncture was performed by Respondent at approximately 3:45 to 4:00 pm. The fluid collected was clear and colorless. The test results were returned at 4:15 pm indicating that E.S. had neither viral nor bacterial meningitis.

E.S.'s parents left the hospital at approximately 5:30 pm to eat, returning around 6:30 pm. C.S. testified that they sat with E.S. while he slept for an undisclosed time before leaving to return to their home 27 miles distant at approximately 9:00 pm.

At approximately 10:00 pm E.S. rose to go to the bathroom and noted that he had a rash all over his body. The respondent determined that E.S. was suffering from meningococcemia. The patient, E.S. deteriorated and died at approximately 1:06 am on Nov. 11, 2002. No issues are raised over the nature or quality of the care and treatment provided by the Respondent from approximately 4:15 pm or after.

TESTIMONY

The complainant produced two witnesses, both by videotape. C.S., the mother of E.S., testified to having two telephone conversations with the Respondent on Nov. 10, 2002. The first occurred after E.S. informed her that he was being hospitalized. The conversation occurred at approximately 2:45 while C.S. was traveling from her home to the hospital. The conversation included reference to meningitis and the possibility of performing a spinal tap/lumbar puncture for diagnostic purposes. The second telephone conversation occurred at approximately 10:55 pm when the Respondent informed them that E.S.'s condition had changed.

C.S. further testified that she and her husband spoke with the Respondent a number of times at the hospital. The first

in-person contact occurred approximately 10 minutes after their arrival. (3:05 pm) They spoke immediately before the Respondent performed a lumbar puncture on E.S. They also spoke immediately after the lumbar puncture and C.S. confirmed that the fluid was clear and colorless.

C.S. also spoke with the Respondent upon their return to the hospital at approximately 11:30 pm after E.S. had broken out in a rash.

Complainant produced the transcript testimony of John Pershing M.D. as an expert witness. Dr. Pershing is the chair of the Department of Emergency Medicine at Gundersen Lutheran Hospital at LaCrosse, Wisconsin. He earned his medical degree at the University of Wisconsin and has been practicing medicine for 21 years. Dr. Pershing is Board certified in emergency medicine and is a member of the American College of Emergency Physicians.

Dr. Pershing reviewed the hospital records for the dates of Nov.10-11, 2002 concerning E.S. Dr. Pershing opined that the respondent breached the standard of care by; "(W)ith the index of suspicion of a serious illness, meningitis being one of those, with the delay that he was experiencing in doing the rest of the diagnostic testing, he should have administered antibiotics early rather than late, and failed to do that…"

Dr. Pershing noted that E.S. actually had meningococcemia. This was described as a disease caused by bacteria that produces a toxin which has a profound effect on multiple organ systems of the body, and there is an extremely high mortality rate. *Dr. Pershing testified that he did not fault the Respondent for not including meningococcemia in the differential diagnosis.*

Dr. Pershing's opinion can be summarized as follows;

> E.S. presented with symptoms for which the differential diagnosis should have included viral meningitis, sepsis, *and bacterial meningitis*.
> A lumbar puncture was a reasonable diagnostic tool to either diagnose or refute the existence of bacterial meningitis or viral meningitis.
> The delay in pursuing the lumbar puncture to allow consultation with E.S.'s parents was reasonable.
> The decision to hospitalize E.S. was reasonable; however, it would also have been reasonable to send E.S. home.
> The administration of Toradol, the fluid IV, and observation of E.S. were all appropriate.

Dr. Pershing's criticism focuses on what he describes as a significant delay in the obtaining the lumbar puncture. Dr. Pershing opined:

> I think after he had gotten all of his lab back, after he had been with the patient for a while, I think he administered some IV fluids and some Toradol, and when he got all done with that part of the evaluation, it was prior to when he admitted the patient to the hospital…so sometime before that is probably when I feel that he probably should have administered the anti… before he left the emergency department.

Dr. Pershing refined his comments: "But the time that I feel that he should have gotten the antibiotics is when he (the Respondent) came to the conclusion that he was not going to be allowed to tap, do the spinal tap on E., and it was going to be significantly delayed." Dr. Pershing was unable to define what constitutes a significant delay.[2] However he clearly states that a delay for several hours would be significant.[3]

Dr. Pershing also recognized that the results of the lumber puncture indicated that antibiotics were not necessary.

Complainant summarized Dr. Pershing's opinion as follows:

> Q Is it fair to say, Doctor, that (E.) (S.) just plain looked sick enough to justify the administration of antibiotics?
> A It's the impression that I get.

Complainant introduced several articles concerning the treatment of bacterial meningitis.[4] Complainant's premise expressed in his closing argument is that Respondent should have included bacterial meningitis as a differential diagnosis for E.S., based upon his symptoms upon presentation at the emergency room at 11:45 a.m. on November 10, 2002, and that bacterial meningitis should have remained on the differential diagnosis until a spinal tap could be performed. Complainant asserted that when presented with the likelihood of a "significant period of time" between E.S.'s presentation at the emergency department and the spinal tap, a minimally competent physician would have administered antibiotics empirically. Because the administration of antibiotics would have had a beneficial effect on the disease that E.S. actually suffered from, the failure to administer this treatment based upon a differential diagnosis of bacterial meningitis (which complainant asserts should have been included by respondent) constituted a danger to the health, welfare and safety of E.S.

The Respondent testified on his own behalf and presented three expert witnesses, one of whom was presented by videotape.

Respondent is a 1997 graduate of Washington University Medical School at St. Louis. He is licensed to practice medicine and surgery in Wisconsin and practices in the Ellsworth/River Falls area. He was the emergency department physician for River Falls Hospital on November 10, 2002. He treated E.S. on that day. E.S. died approximately 13 hours after his arrival. The cause of death was later determined to be fulminant meningococcemia.

Respondent reported that ES arrived at 11:45 am. Respondent began his examination at approximately 12:15 pm. His examination consisted of taking a history, performing a physical examination and ordering tests, a process that took approximately 15 to 30 minutes. Respondent testified that he had no final diagnosis at that time. He prescribed Toradol for the headache and Lactated Ringers solution to avoid dehydration because (by history) E.S. had vomited several times before arrival.

The medical records reflect that a rapid Strep test was taken at 12:30 pm and a urine sample was taken about the same time. A Hemotology sample was taken at 12:38 pm. The Toradol was administered at 12:55 pm. E.S. was seen at 1:15 when he stated that the Toradol had helped relieve the headache. At 1:30 pm the fluid IV was commenced and was completed at 2:10 pm. E.S. was reevaluated at 2:34 pm after the flush and lab reports were received.

Respondent testified that his differential diagnosis included enteroviral syndrome, appendicitis, and viral meningitis. He did not place bacterial meningitis high on his differential diagnosis.

Respondent testified that he discussed options with E.S. including hospitalization, return to his dorm room or to his parents' home. E.S. was not resistant to hospitalization. Respondent testified that ES indicated that the headache had been relieved indicating the lack of a serious illness causing the headaches. Respondent testified that E.S.'s mental status was normal but he appeared fatigued. Respondent noted that altered mental status is a classic symptom of meningitis or intercranial bleeding.

Respondent testified that he never suspected bacterial meningitis due to the absence of classic symptoms; no stiff neck, no altered mental status, and no focal problems. Respondent testified that he never suspected meningococcemia until the rash appeared at 10:00 pm. Respondent testified that he spoke to E.S. about viral meningitis and the fact that a spinal tap would be useful to diagnosis or refute that possibility.

E.S. was admitted to the hospital at approximately 2:34 pm. Respondent spoke to C.S. by telephone at approximately 2:40 pm about the hospitalization and suggested that a spinal tap would be useful.

At approximately 3:00 pm respondent ordered blood cultures which were drawn around 3:20 to 3:25 pm. Respondent reexamined E.S. approximately 3:15 to 3:30 pm. He noted that E.S. was no longer alert, appeared more sleepy and had difficulty following commands. Respondent testified that this altered mental status caused him to alter his differential diagnosis. He noted that altered mental status increased the possibility of bacterial meningitis or a brain issue.

Respondent spoke to the patient's parents around 3:30 and urged a spinal tap. Consent was obtained and Respondent indicates that he performed the tap completing it at approximately 3:50 pm. He indicated that the lab results took

15 to 30 minutes and were received at 4:15 pm. Both the lab results and visual observation of the clear and colorless nature of the fluid eliminated both viral and bacterial meningitis as a cause of E.S.'s condition.

Respondent testified that enteroviral syndrome remained his number one suspect. His treatment plan was IV fluids for hydration, analgesics and observation.

Respondent agreed that IF:

> There is a suspicion of bacterial meningitis, *and*
> There will be a delay in obtaining a spinal tap, *then*
> The standard of care would require empirical antibiotics *plus*
> A blood culture of blood drawn before the administration of antibiotics.

Respondent further opined that it is *inappropriate* to administer antibiotics for just fever and headache, to avoid unnecessary use, to avoid possible allergic reaction and to avoid contributing to development of resistant bacteria.

Dr. Jeffrey Dunham testified on behalf of the Respondent. Dr. Dunham is a 1987 graduate of the University of Minnesota Medical School. He is licensed in Wisconsin and is Board certified in Family Practice. He currently practices medicine and surgery in Shell Lake, Wisconsin. Dr. Dunham has never served as an expert witness before and is not acquainted with the Respondent.

Dr. Dunham reviewed the medical records of the hospitalization of E.S. on November 10, 2002. He testified that in his opinion the Respondent's acts did not fall below minimal competence for a physician in the Respondent's circumstance. Dr. Dunham opined that nuchal rigidity and mental status changes are key indicators of bacterial meningitis. Dr. Dunham noted that there was no evidence of nuchal rigidity in E.S. during his hospitalization. Dr. Dunham noted that E.S. did not demonstrate mental status changes until after 3:00 pm on that date.

Dr. Dunham opined that viral meningitis as a working diagnosis of E.S. was very reasonable. He further stated that there is no need for administration of antibiotics if the working diagnosis is viral. Dr. Dunham agreed that the results of the spinal tap did not indicate meningitis in any way.

Dr. Karen Quaday, an emergency room physician at Regions (Minnesota) Hospital also testified on behalf of the Respondent. Dr. Quaday graduated from Wayne State University Medical School in 1984. She is board certified in Emergency Medicine and Internal Medicine. Dr. Quaday is an Assistant Professor at the Medical School of the University of Minnesota.

Dr. Quaday testified that the classic symptoms of meningitis are fever, nuchal rigidity, altered mental status and headache. Dr. Quaday reviewed the medical records of the treatment of E.S. on November 10, 2002.

Dr. Quaday opined that she saw very little reason for the Respondent to suspect meningitis. She noted the lack of nuchal rigidity, no altered mental status and the abatement of the headache in response to the Toradol. Dr. Quaday indicated that it truly was a judgment call whether ES should have been admitted or released. She stated that no specific symptom said "hospitalize".

Dr. Quaday opined that antibiotics should not be indiscriminately administered due to the possibility of allergic reaction. She further stated that when administered the antibiotic should be chosen wisely depending on the organism the treatment is for.

Dr. Quaday agreed that IF:

> There is a suspicion of bacterial meningitis, *and*
> A delay in the ability to obtain a spinal tap, *then*
> Antibiotics should be administered.

Dr. Quaday, however, opined that in this instance there was no legitimate suspicion of meningitis.

Respondent produced the videotaped testimony of Gary R. Kravitz, M.D. Dr. Kravitz is a physician specializing in internal medicine and subspecializing in infectious diseases. He is a 1977 graduate of Northwestern University Medical School. He is board certified in internal medicine and in the subspecialty of infectious disease. He practices in St. Paul, Minnesota.

Dr. Kravitz also reviewed the relevant medical records concerning E.S.

Dr. Kravitz testified that the classic signs of bacterial meningitis are fever, an excruciatingly severe headache, stiff neck and a decline in sensorium from lethargy to stupor to coma. Dr. Kravitz related that in his experience the headache is so severe that it cannot be relieved by a non-narcotic pain medication such as Toradol. He also clarified that the stiff neck he referred to is nuchal rigidity, a condition in which the neck cannot be flexed to the chest and generally not flexed at all.

Dr. Kravitz testified that the respondent's evaluation, care and treatment of E.S. on Nov. 10, 2002 did meet the standard of care expected of a minimally competent, similarly qualified physician. Dr. Kravitz agreed that the lack of a stiff neck and the response of the headache to Toradol indicated that bacterial meningitis was not a possibility.

Dr. Kravitz specifically stated the failure of the Respondent to administer antibiotics prior to the lumbar puncture did not violate the standard of care. He formed this opinion because based on the history and physical examination, an appropriate assessment was that the patient did not have bacterial meningitis. Dr. Kravitz also agreed that the appearance of the CSF fluid and the lab results were both inconsistent with a diagnosis of bacterial meningitis.

Wisconsin law allows the use of learned treatises to prove the truth of a matter asserted.[5] Complainant introduced several such treatises. They are listed in full in footnote 4, *supra*. They are all related to the proper care and treatment of bacterial meningitis, a disease the patient did not have. The complainant proffers these treatises for the proposition that "when a spinal tap will be significantly delayed, the standard of care requires the empirical administration of antibiotics". *Readings of these texts however do not support the complainant's position.*

Exhibit 14 is a 1998 article from the *Annals of Internal Medicine*. This article reports on a retrospective study of patients who had bacterial meningitis proven by a lumbar puncture done within 24 hours of presentation in the emergency department. The study's objective was to determine whether antibiotic timing influences clinical outcome. The patients were classified into one of three stages depending on whether they presented with 0, 1 or at least 2 of three independently predictive baseline symptoms. These symptoms were hypotension, altered mental status and seizures. E.S. would have been classified in Stage 1 as he presented without any of those three symptoms. The testimony suggests that E.S. had progressed to Stage 2 shortly before the spinal tap was performed, as an altered mental state was noted. The study found no correlation between a delay in antibiotic therapy in patients advancing from Stage 1 to Stage 2 and adverse clinical outcomes. The authors conclude;

> We used this opportunity to analyze the effect of delayed administration of antibiotics on clinical outcome in our cohort of patients with bacterial meningitis. Standard reference sources (omitted) have recommended that patients with bacterial meningitis be given antibiotics within 30 minutes of arrival in the emergency department. Although this is a laudable goal, it can rarely be achieved in the reality of clinical practice, (citations omitted) is unsubstantiated in published literature, and oversimplifies the effect of antibiotic timing on a disease with heterogeneous presentations. Surrogates of antibiotic delay (for example, duration of symptoms before presentation and time to sterilization of cerebrospinal fluid) have been associated with adverse outcome in some studies, but no study has identified delay in initiation of antibiotic therapy as an independent risk factor after adjustment for other variables that affect clinical outcome.
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> Page 868 (Emphasis added)

Thus, the authors of this study suggest that even if E.S. had bacterial meningitis, which he did not, the delay alleged would not have been related to adverse clinical outcome. It is therefore difficult to conclude that the delay endangered the health, safety or welfare of a patient that did not have the disease.

Exhibit 15 is an excerpt from *Emergency Medicine, A Comprehensive Study Guide, 4th Edition.* Complainant cited the work for the following proposition;

> Patients in whom the leading diagnostic concern is bacterial meningitis should have antibiotics started before they leave the emergency department.
>
> Page 1052

However, this proposition is only relevant if the factual assumption is accurate, i.e. that the leading diagnostic concern was bacterial meningitis. The authors also note that;

> Antibiotics may be withheld in patients whose clinical presentation suggests viral meningitis if close observation is possible, pending results of CSF examination.
>
> Page 1052

This passage is significant in another manner as well. Complainant's allegation rests heavily on the assumption that it is difficult or impossible to differentiate between a patient presenting with viral meningitis symptoms from one who presents with bacterial meningitis symptoms. These authors suggest that such a distinction is possible and leads to different treatment standards. This concept is not recognized by the complainant. *The treatment plan suggested by this author is exactly what the Respondent followed, i.e., close observation in a hospital setting pending CSF analysis.*

Exhibit 17 is a 1997 article from *The New England Journal of Medicine.* The authors sought to provide practical guidelines for deciding controversial questions about the treatment of patients with bacterial meningitis. The authors noted;

> The intuitive assumption is that a delay in (antibiotic) therapy of even a few hours affects the prognosis adversely, but the clinical data are inconclusive.
>
> Page 710

These treatises establish that there is no clinical connection between a delay in implementing antibiotic therapy in patients with bacterial meningitis (Exhibit 14) in patients where the leading concern is bacterial meningitis (Exhibit 15) and when acute meningitis is suspected (Exhibit 17) and an adverse clinical outcome. These treatises militate against finding that the Respondent's conduct tended to constitute a danger to the health, welfare, or safety of patient or public.

ANALYSIS

Complainant's allegation is constructed of several steps in the logical progression leading to their requested conclusion. The complainant has the burden of proof to establish each and every element of those steps by a preponderance of the evidence.[6] This burden has been described as the requirement to satisfy the trier of fact (the Board or the ALJ) to a reasonable certainty by the greater weight of the credible evidence that the Respondent violated the minimally competent standard of care and thereby created a danger to the health, safety and welfare of the patient. The greater weight of the evidence means evidence which when weighed against evidence opposed to it has more convincing power. Credible evidence is evidence which in the light of reason and common sense is worthy of belief.[7]

The determination must be made based upon the record presented by the parties. "[T]here must be testimony to the effect that a minimally competent physician would have avoided or minimized the unacceptable risks which" the respondents treatment posed. *Gilbert v. Medical Examining Board* 119 Wis.2d 168, 349 N.W.2d 68 (1984). Such evidence must also be unequivocal. It is not the evidence that other physicians might have utilized a different treatment or procedure that proves negligence, but that reasonable care and skill usually possessed by physicians of the same school was not exercised. This issue cannot be decided just by the number of witnesses testifying for one side or the other. In determining which opinion, among conflicting opinions to accept, it is appropriate to consider the qualifications and credibility of the expert and whether reasons for the opinion are based on facts in the case.[8] The opinions expressed by authors of learned treatises should be considered as any other expert witness' opinion.[9]

The patient E.S. presented at the emergency department at approximately 11:45 am on November 10, 2002. He had

meningococcemia. All the evidence indicates that it was not possible to diagnosis that disease until approximately 10:00 pm. The respondent performed an appropriate exam beginning at 12:15 pm. The respondent ordered appropriate tests. The respondent reexamined E.S. after receiving the results of some tests and hospitalized him for close observation at approximately 2:30.

The complainant asserts that at this point the respondent created a danger to the health of E.S. by failing to treat him for bacterial meningitis. Complainant asserts no other deficiencies in the course of treatment provided by respondent. The respondent again examined E.S. around 3:30 pm and found a mental status change. He performed a spinal tap, which was completed around 3:50 p.m. The visual results and lab results confirmed that it was not bacterial meningitis. If antibiotic had been commenced earlier, it could have legitimately been terminated upon laboratory confirmation ruling out bacterial meningitis.

Complainant's logic is set forth below in a step by step sequence.

1. E.S. did not have bacterial meningitis.
2. Based upon presenting symptoms, Respondent suspected viral meningitis before E.S. was hospitalized at approx. 2:35 p.m.
3. Based upon E.S.'s presenting symptoms, Respondent *should have* included bacterial meningitis as a differential diagnosis.
4. If bacterial meningitis is included as a differential diagnosis, a spinal tap (lumbar puncture) is necessary to accurately diagnose it.
5. *If* a) bacterial meningitis is either the leading diagnosis, is strongly suspected, or is acute *and* b) there will be a significant delay in the performance of the spinal tap *then* antibiotics should be administered, based upon empirical evidence.
6. If the treatment for bacterial meningitis had been administered to E.S., the treatment would have been beneficial to E.S., who actually had meningococcemia.[10]

The parties dispute the validity of the third premise of complainant's argument, i.e., whether a suspicion of viral meningitis mandates an equal suspicion of bacterial meningitis. In his closing argument the complainant cites the Tintinalli article (Exhibit 15).[11] However his representation of the Tintinalli article is not accurate. The Tintinalli article states that the procedure asserted by complainant should be followed where "the *leading* diagnostic concern is bacterial meningitis." Tintinalli recommends another treatment process where viral meningitis is suggested. The complainant's assertion that the two are indistinguishable is not supported by that author. The complainant also cited Harrison's for this proposition, as well. Harrison's article (Exhibit 16) notes that "A variety of infectious and noninfectious processes can produce an *acute* meningitis syndrome and may be confused with *acute* bacterial meningitis." In the list is viral meningitis or encephalitis. There was no evidence that prior to time of the performance of the spinal tap that E.S. showed *acute* or severe symptoms of bacterial meningitis. Additionally, Harrison's recommendation for empirical antibiotics is couched in terms of "if meningitis is a strong possibility…" something more than a suspicion, or a question.

The complainant also relies upon the testimony of Dr. Pershing. As noted above, Dr. Pershing possesses adequate credentials and appropriate experience to provide an expert opinion. However, the testimony presented significant issues that indicate that the opinions expressed are not entitled to substantial weight. The first concern is that the prosecutor never elicited testimony that the opinions Dr. Pershing expressed were held to a reasonable degree of medical certainty. This is a technical error which can be overlooked if the totality of the circumstances indicates that the witness understood the significance of the testimony.

The crux of Dr. Pershing's testimony was in the following exchange:

Q In your opinion, is it the action of a minimally competent emergency room physician to delay the administration of antibiotics to (E.S.) waiting for a lumbar puncture several hours hence?
A No. I would have given them right at that point.[12]

This testimony fails to meet the standards required to be accepted for several reasons. First, the facts presented in the hypothetical question are not the facts proved. As a result, the opinion given in the answer is not entitled to any weight.[13] The factual scenario in the hypothetical speaks of a delay of several hours. Based upon Dr. Pershing's testimony the maximum

delay he can attribute to the respondent is approximately one hour and twenty minutes (from 2:30 p.m. until 3:50 p.m.) not the several hours presented in the hypothetical question upon which the opinion is based.

Secondly, the response from Dr. Pershing is expressed in terms of his personal practice standard (I would…). Evidence that another physician might have utilized a different treatment or procedure is not sufficient to prove unprofessional conduct. The testimony must unequivocally indicate that a minimally competent physician would have chosen a different course of treatment and that the different course would have avoided or minimized the unacceptable risk. *Gilbert v. Medical Examining Board*, *supra.*

The prosecutor did not elicit any further clarification that the opinion expressed was anything other than Dr. Pershing's personal standard. Additionally Dr. Pershing never explained how the administration of antibiotics for approximately one hour and twenty minutes would have avoided or minimized the risk to E.S. of not treating him for a disease he did not have. For that matter, neither Dr. Pershing nor any other witness opined that administration of antibiotics for 80 minutes would have benefited E.S. in the treatment of meningococcemia. Therefore the complainant has failed to establish by the greater weight of the credible evidence that whenever viral meningitis is suspected that a minimally competent emergency department physician will suspect bacterial meningitis as strongly or more strongly.

Complainant's fifth premise is also disputed. The prosecutor was not consistent in his statement of this premise. I have worded it in a manner most consistent with authors of the learned treatises. The prosecutor at one point suggests that empirical antibiotics should be administered "when you cannot tell, when you don't know, when there is a question…"[14] He also asserts at page 186, line 6 of the trial transcript "if you suspect meningitis and you cannot disprove it, then you cover with antibiotics." However neither of these is consistent with the expert witnesses' testimony nor the learned treatises. As noted, Tintinalli states that antibiotics should be used empirically where bacterial meningitis is the "leading diagnostic concern…" and recommends no antibiotics and close observation when viral meningitis is suggested. Harrison suggests empirical antibiotics where meningitis is a "strong possibility". The New England Journal of Medicine article suggests this protocol when "acute meningitis" is suspected. Thus I have adopted the language used by the experts rather than the prosecutor in framing the minimal standard of competence.

The parties dispute whether this threshold concern was reached. The complainant proffered the testimony of Dr. Pershing to support the conclusion that bacterial meningitis should have been higher on the respondent's differential diagnosis. However Dr. Pershing's testimony is not that clear. Dr. Pershing testified;

> Um, the patient had a constellation of symptoms that certainly could have brought bacterial meningitis into the differential diagnosis. More importantly, even if he did not have bacterial meningitis, he could have had what we consider a septic condition, bacteria in his blood.
>
> Transcript page 11 lines 16 – 22

Thus Dr. Pershing does not place bacterial meningitis as a leading diagnosis, a strong possibility or describe E.S.'s condition as consistent with "acute" meningitis. The doctor's testimony in this regard was summarized on page 22 as follows;

> Q Is it fair to say, Doctor, that (E.S.) just plain looked sick enough to justify the administration of antibiotics?
> A It's the impression that I get.

The complainant has failed to prove by the greater weight of the credible evidence that a minimally competent emergency department physician would have placed bacterial meningitis as a leading diagnostic concern prior to the hospitalization of E.S. at approximately 2:35 pm on November 10, 2002.

Assuming for the sake of argument that bacterial meningitis was a leading diagnostic concern, the protocol suggested by the complainant hinges on there being a significant delay in obtaining the results of a spinal tap, which could mandate treatment for bacterial meningitis. Again the prosecutor is inconsistent in his argument. In his rebuttal argument, the prosecutor suggests that the delay was as long as three and a half hours.[15] He argued, "he (Respondent) had a suspicion of viral meningitis around 12:15, maybe 1:00 that afternoon."[16] The records show that the respondent first saw E.S. at 12:15 pm on that date. To argue that he instantaneously suspected bacterial meningitis is incredible. This argument should be

disregarded as it is unsupported by the evidence and is not consistent with the opinion expressed by his expert, Dr. Pershing.

Dr. Pershing puts the time at which administration of antibiotics should have begun substantially later than the prosecutor.

> I think after he had gotten all of his lab back, after he had been with the patient for a while, I think he administered some IV fluids and some Toradol, and when he got all done with that part of the evaluation, it was prior to when he admitted the patient to the hospital, which was at 1430-something, admitted room 206 via cart, so sometime before that is probably when I feel that he probably should have administered the anti—before he left the emergency department.[17]

Dr. Pershing further defined the critical time as "when he (respondent) came to the conclusion that he was not going to be allowed to tap, do the spinal tap on (E), and it was going to be significantly delayed."[18] Unfortunately, Dr. Pershing was unable to describe what length of time constitutes a significant delay.

> Q And how much of a delay in doing the spinal tap is significant in your opinion?
> A Is significant? You know, I don't know –
> …
> What's a significant delay? I don't know if you can actually put, you know, 29.5 minutes, that's a significant delay. I don't know that you could say that.
> …
> What I would say is what's reasonable. If I decide to do a lumbar puncture on a particular patient, and I have a conversation with them about risk/benefits of doing the procedure, my expectation would be that I would be able to do that procedure in a relative expeditious manner, 10, 15, 20 minutes. And if I was going to be significantly delayed, and in this case you knew it was going to be hours, to me that's a known significant delay.[19]

His final conclusion that it was known that the spinal tap would be delayed for hours is not consistent with the evidence. The spinal tap was performed within approximately 80 minutes of hospitalization.

Dr. Pershing's analysis is contradicted by the treatise written by Aronin (Exhibit 14).
This treatise contains the following passage;

> Standard reference sources have recommended that patients with bacterial meningitis be given antibiotics within 30 minutes of arrival in the emergency department. Although this is a laudable goal, it can rarely be achieved in the reality of clinical practice, is unsubstantiated in published literature, and oversimplifies the effect of antibiotic timing on a disease with heterogeneous presentations. Surrogates of antibiotic delay (for example, duration of symptoms before presentation and time to sterilization of cerebrospinal fluid) have been associated with adverse outcome in some studies, but no study has identified delay in initiation of antibiotic therapy as an independent risk factor after adjustment for other variables that affect clinical outcome.[20]

The complainant has failed to establish to a reasonable certainty by the greater weight of the credible evidence that both preconditions to the mandated use of empirical antibiotics (that bacterial meningitis was a leading diagnostic concern *and* there would be a significant delay in obtaining the results of a spinal tap) existed in this circumstance.

The final aspect of the complainant's allegation need not be addressed, as there was not a requirement to provide antibiotics. Again, I will address the issue assuming that there was a duty to so provide. This premise requires a nexus between the provision of antibiotics and a benefit to the patient or alternatively, a nexus between the failure to provide and some identifiable danger to the health, safety or welfare of the patient. The complainant must establish to a reasonable certainty by the greater weight of the credible evidence that there was a danger to the health, safety or welfare of E.S.

Reviewing the evidence in the light most favorable to the complainant, the assertion is that the patient should have been administered antibiotics under a treatment plan for bacterial meningitis for a short period of time, between approximately 2:30 and 4:00 p.m. on November 10, 2002. The prosecutor refers to the treatises as establishing that the antibiotic most

commonly used to address bacterial meningitis (Ceftriaxone) is the same antibiotic that the respondent used to treat the meningococcemia later in the day. However there was no testimony as to the regimen of treatment. Based upon this record it is not reasonably certain that the amount of antibiotics that would have been administered for the treatment of suspected bacterial meningitis between 2:30 pm and 4:00 p.m. would have had any beneficial effect to E.S.

As noted above, the complainant originally asserted two separate violations but apparently abandoned one prior to hearing. No expert testimony was elicited about the second allegation. While the prosecutor did not move to dismiss this allegation, neither did he assert it during the hearing. The remaining allegation presented was not supported by the evidence, as discussed above. The argument presented by the prosecutor was not supported by or consistent with expert opinion. The prosecutor's statement of the standard of care was contradicted by his own expert, the expert witnesses presented by the respondent and by the learned treatises complainant himself introduced into evidence.

The opinion elicited by complainant from Dr. Pershing was based upon an incorrect assumption of fact, and was presented as a personal standard, not a standard of minimal competence. Additionally, the complainant failed to establish a standard for determining a "significant delay." Dr. Pershing indicated that had the patient been released rather than hospitalized there would have been no violation, an inherently contradictory statement.

In adopting this decision, the Board concurs with the statement that the loss of any life creates trauma and the loss of a young life, full of promise is often a tragedy wholly incomprehensible those who knew and loved him. However, the law does not measure the standard of minimal competence based upon the degree of loss; only when there is an actual showing of a violation of the standards of the profession can discipline be imposed.

Dated this 29th day of August, 2005.

STATE OF WISCONSIN MEDICAL EXAMINING BOARD

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Alfred L. Franger, M.D.

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[1] 34. Respondent's failure to recognize that Patient E.S.'s low blood pressure readings at approximately 8:30 p.m. on November 10, 2002, were cause for serious concern and immediate action tended to constitute a danger to the health, welfare and safety of Patient E.S. in that it delayed evaluation and treatment of a potentially fatal condition, and was unprofessional conduct within the meaning of s. MED 10.02(2) (h), Wis. Admin. Code.

[2] Q And how much of a delay in doing the spinal tap is significant in your opinion? A Is significant? You know, I don't know"

[3] Q In your opinion, is it the action of a minimally competent emergency room physician to delay the administration of antibiotics to E.S. waiting for the lumbar puncture several hours hence? A No. I would have given them right at that point.

[4] Chadwick DR, Lever AML, THE IMPACT OF NEW DIAGNOSTIC METHODOLOGIES IN THE MANAGEMENT OF MENINGITIS IN ADULTS AT A TEACHING HOSPITAL, *Q J Med* 2002; **95**:663-670
Aronin SI, Peduzzi, P, Quagliarello VJ, COMMUNITY-ACQUIRED BACTERIAL MENINGITIS: RISK STRATIFICATION FOR ADVERSE CLINICAL OUTCOME AND EFFECT OF ANTIBIOTIC TIMING, *Ann Intern Med.* 1998;129:862-869
Anderson DC, Kozak AJ, MENINGITIS, ENCEPHALITIS, AND BRAIN ABCESS, *Emergency Medicine, A Comprehensive Study Guide 4th Edition,* 1996
Scheld WM, BACTERIAL MENINGITIS, BRAIN ABCESS, AND OTHER SUPPURATIVE INTRACRANIAL INFECTIONS, *Harrison's Principles of Internal Medicine 14th Edition,* 1998
Quagliarello VJ, Scheld WM, TREATMENT OF BACTERIAL MENINGITIS, *N Engl J Med* 1997; **336**:708-716

[5] Wis. Stat. 908.03 (18)

[6] Wis. Stats. 440.20 (3)

[7] Wisconsin Jury Instructions – Civil 200

[8] Wisconsin Jury Instructions – Civil 260

[9] Wisconsin Jury Instructions – Civil 261

[10] Logically, the converse of complainant's argument: "The failure to provide antibiotics constituted a danger to the health, welfare and safety of E.S.

[11] "The evidence in the case is from Dr. Pershing, from Tintinalli, from Harrison's from QJM when you have a case where you suspect meningitis, you can't tell whether it is viral or bacterial without the CSF without that cerebral spinal fluid from a lumbar tap. When you cannot tell, when you don't know, when there is a question, you do the antibiotics to cover." Transcript p. 184, lines 2-10.

[12] Transcript p 23, line 23 to p 24 line3

[13] Wisconsin Jury Instructions – Civil 265
[14] Transcript page 184, lines 7 -9
[15] Transcript p 197 line 24
[16] Transcript p 198 lines 10 - 11
[17] Transcript p 27 line 21 to page 28 line 6
[18] Transcript p 29 lines 6 - 8
[19] Transcript p 29 line 12 to page 30 line 9
[20] Aronin SI, Peduzzi, P, Quagliarello VJ, COMMUNITY-ACQUIRED BACTERIAL MENINGITIS: RISK STRATIFICATION FOR ADVERSE CLINICAL OUTCOME AND EFFECT OF ANTIBIOTIC TIMING, *Ann Intern Med.* 1998;129:862-869, page 868