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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY	:	FINAL DECISION AND ORDER
	:	LS0801251MED
MOHAMAD A. HAKIM, M.D., APPLICANT.	:	

Division of Enforcement Case No. 07MED425

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

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

Dated this 17th day of September, 2008.

Gene Musser MD
Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE APPLICATION
FOR A LICENSE TO PRACTICE **PROPOSED DECISION**
MEDICINE AND SURGERY **Case No. LS-0801251-MED**

MOHAMAD A. HAKIM, M.D.
APPLICANT.

Division of Enforcement Case No. 07MED425

PARTIES

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

Mohamad A. Hakim, M.D.
P.O. Box 28322
Atlanta, Georgia 30358

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

Department of Regulation & Licensing
Division of Enforcement
P.O. Box 8935
Madison, Wisconsin 53708

This matter was commenced by the filing of a Notice of Hearing on January 25, 2008. A hearing was held on April 30, 2008. Atty. James E. Polewski appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Mohamad A. Hakim appeared in person without legal counsel. The hearing transcript was filed on May 12, 2008.

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Mohamad A. Hakim, M.D., applicant, P.O. Box 28322, Atlanta, Georgia 30358, filed an application on January 12, 2006, with the Medical Examining Board (Board) for a license to practice medicine and surgery.

2. In conjunction with his application for licensure to practice medicine and surgery, Dr. Hakim was required to complete an oral examination pursuant to Wis. Adm. Code, § Med 1.06 (1) (a), because he had been subject to adverse formal action during the course of his medical education, postgraduate training, hospital practice or other medical employment. Specifically, Dr. Hakim's history of medical education and postgraduate training showed the following adverse formal actions:

a. Failure of Step 1 of the United States Medical Licensing Examination (USMLE) on three attempts in 1993 and 1994.

b. Failure of Step 2 of the USMLE on four attempts in 1993, 1994 and 2006.

c. Failure of Step 2 of the USMLE on two attempts in 2004 and 2006.

d. Incomplete anesthesia residency training program at the University of Miami/Jackson Medical Center, Miami, Florida, in 2001-2002, due to termination for violating the program personnel rules regarding a false statement in an application for employment. The Associate Program Director further indicated that approximately 2 to 3 months into the residency it became apparent that anesthesia was not an appropriate specialty career and that the applicant resigned from the position as of January 18, 2002.

e. Incomplete surgical residency training program at Hahnemann University Hospital, Philadelphia, Pennsylvania, in 1999-2000 and removal from the clinical arena after 6 months due to poor clinical performance. The information from the Designated Institutional Official stated that according to the Program Director at that time, "His clinical performance was so poor that the faculty demanded that we remove him from the clinical arena." The remainder of the training year was completed in research in the Department of Pathology in a non-training activity. The verification indicates that none of the training year was satisfactorily completed and that no certificate of completion can or will be granted for the time spent at the institution.

3. On October 18, 2006, Dr. Hakim appeared before a two-person panel of the Wisconsin Medical Examining Board for an initial oral examination pursuant to Wis. Admin. Code § MED 1.06 (4). The panel scored Dr. Hakim's initial oral examination as "failed" and recommended that he be examined by the full board which would make the final decision.

4. On December 20, 2006, the Medical Examining Board conducted a full board oral examination. The purpose of the oral examination was to test Dr. Hakim's knowledge of the practical application of medical principles and techniques of diagnosis.

5. On December 22, 2006, the Medical Examining Board issued a final decision on Dr. Hakim's initial oral examination. The Board found, based upon Dr. Hakim's responses to clinical questions, that he did not demonstrate sufficient clinical knowledge of medical principles and techniques of diagnosis and treatment. Dr. Hakim was notified of the Board's decision and the fact that he did not pass the oral examination. Dr. Hakim was also informed that he was not eligible for licensure; that he could challenge the grading of his examination or retake the examination.

6. On January 22, 2007, Dr. Hakim submitted a request for Board review of examination error pursuant to Wis. Adm. Code, § Med 1.10. The Board reviewed the information that Dr. Hakim submitted and did not find any mistake in the content, procedures or scoring of the examination. On March 27, 2007, the Board issued a final decision affirming the determination that Dr. Hakim failed the required oral examination and that he was ineligible for licensure. Dr. Hakim was informed of his right to reapply and retake the examination.

7. On April 15, 2007, Dr. Hakim submitted a request for a second examination in accordance with the Notice of Right to Reexamination, pursuant to Wis. Adm. Code,
§ Med 1.08 (1). On May 16, 2007, a panel of the Board, consisting of two physicians who were not part of the first examination panel, conducted Dr. Hakim's oral retake examination. The panel determined that Dr. Hakim failed the retake examination and was referred for full Board examination, pursuant to Wis. Adm. Code, § Med 1.06 (4).

8. On June 20, 2007, Dr. Hakim appeared before the full Board for an oral examination (second attempt). On July 2, 2007, the Board issued a decision which scored the examination as "failed". The written decision of the Board informed Dr. Hakim that he would note be admitted to any further examination, in accordance with Wis. Adm. Code, § Med 1.08 (1), until he successfully completed an ACGME accredited postgraduate training program of twelve months in a board-approved facility.

9. On July 17, 2007, Dr. Hakim submitted a claim of examination regarding the grading of his second attempt to pass the required examination on the basis that his response included all the essentials steps listed in a respected medical textbook.

10. On August 15, 2007, the Board reviewed the information which Dr. Hakim submitted in support of his claim of

examination error. The Board did not find any mistake in the examination content, procedures or scoring of the oral examination and found that in comparing the excerpt from the medical text book to the transcript of the applicant's responses, that his responses were inadequate and incomplete.

11. On November 17, 2007, the Board denied Dr. Hakim's application for licensure on the basis that he failed to achieve a passing grade on the examinations required under § MED 1.08.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to Wis. Adm. Code, § 448.04 (1) (a), 448.05 (1) and (2), and 448.06 (2), Wis. Stats.

2. By failing to achieve a passing score on the oral examination, as described in Findings of Fact 2-11 herein, Dr. Hakim failed to satisfy the examination requirements under Wis. Adm. Code, § MED 1.06 (1) (a) and 1.08, for a license to practice medicine and surgery in the state of Wisconsin.

ORDER

NOW THEREFORE, IT IS ORDERED, that the decision of the Medical Examining Board to deny the application of Mohamad A. Hakim for a license to practice medicine and surgery be, and hereby is, affirmed.

OPINION

I. Background

On January 12, 2006, Dr. Hakim filed an application with the Medical Examining Board for a license to practice medicine and surgery.

In conjunction with his application for licensure to practice medicine and surgery, Dr. Hakim was required to complete an oral examination pursuant to Wis. Adm. Code, § Med 1.06 (1) (a), because he had been subject to adverse formal action during the course of his medical education, postgraduate training, hospital practice or other medical employment.

On October 18, 2006, Dr. Hakim appeared before a two-person panel of the Wisconsin Medical Examining Board for an initial oral examination pursuant to Wis. Admin. Code § MED 1.06 (4). The panel scored Dr. Hakim's initial oral examination as "failed" and recommended that he be examined by the full board which would make the final decision.

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On December 22, 2006, the Medical Examining Board issued a final decision on Dr. Hakim's initial oral examination. The Board found, based upon Dr. Hakim's responses to clinical questions, that he did not demonstrate sufficient clinical knowledge of medical principles and techniques of diagnosis and treatment. Dr. Hakim was notified of the Board's decision and the fact that he did not pass the oral examination. Dr. Hakim was also informed that he was not eligible for licensure; that he could challenge the grading of his examination or retake the examination.

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On July 17, 2007, Dr. Hakim submitted a claim of examination regarding the grading of his second attempt to pass the required examination on the basis that his response included all the essentials steps listed in a respected medical textbook. On August 15, 2007, the Board reviewed the information which Dr. Hakim submitted in support of his claim of examination error. The Board did not find any mistake in the examination content, procedures or scoring of the oral examination and found that in comparing the excerpt from the medical text book to the transcript of the applicant's responses, that his responses were inadequate and incomplete.

On November 17, 2007, the Board denied Dr. Hakim's application for licensure on the basis that he failed to achieve a passing grade on the examinations required under § MED 1.08.

II. Summary of Evidence

Testimony of Mohamad A. Hakim, M.D.

Dr. Hakim offered into evidence an excerpt from a textbook entitled "Child and Adolescent Neurology", page 214, which was written by Ronald B. David, M.D., 2nd edition (2005) and two additional references. The excerpt includes Table 8.25, which is referenced "Sequence of Steps for Emergency Treatment of Status Epilepticus as found in Child and Adolescent Neurology". The excerpt identifies 13 steps for emergency treatment of Status Epilepticus. Exhibit 5.

Dr. Hakim testified that if you compare what he said or what was written during the oral exam, he mentioned all of the steps in the table during the exam. In reference to the various steps, Dr. Hakim testified as follows [Transcript p. 13-17]:

> DR. HAKIM: Cardiorespiratory function, No. 2, No. 2.
>
> And then I did say I will insert an oral airways. That will cover item No. 3. Item No. 3, insert oral airway and oxygen, granted.
>
> Then I did say I will give diazepam and this will cover item No. 9, give diazepam or diazepam offered. Then I did say I will give phenytoin, and this will cover items No. 10 and 11 because if the status stops or continues, we must give phenytoin. I think that covers these items.
>
> Then I did say I will intubate the child, and this will cover item No. 12, No. 12, the intubations.

And I did say I will alert anesthesia team. And that would cover item No. 13.

No. 13, it was for late stages you should consider general anesthesia, and it should be, the anesthesia team should be notified in that case.

As for items 1, 4, 5 and 8 -- 1, 4, 5 and 8, this will go to Exhibit No. 6. And that's what I found now in a nursing textbook. If you see from the page for Nursing Book, Real-World Nursing Survival Guide: Critical Care & Emergency Nursing by Lori Schumacher and Chernecky, first edition, 2005, published by Elsevier Saunders, page 178.

And it says in the chapter for status epilepticus, and under the heading "What You Do," and it's very, having for a nursing matters like -- I have it over here like showing a little picture like what you do, like obvious to the nurse what you should do

THE ALJ: Now, you're referring to page 2 of the, it's an attachment to Exhibit 6?

DR. HAKIM: Exactly. And you'll see over here, if epilepticus does occur, the nurse must notify the physician immediately and support the airway, breathing, and circulation of the patient.

Immediate interventions include providing oxygen via mask -- or face mask, preparing for intubation, protecting the patient from injury, establishing IV access and infusing an IV of normal saline solution.

In addition, insert nasogastric NG tube and connecting it to gastric suction will assist in preventing the patient from vomiting and possible aspiration.

Cardiac rate and rhythm, along with continuous blood pressure, should also be monitored.

That's for nurse to do prior to the intervention of physician.

And if you go down under the "Medications should be administered as prescribed, usually IV diazepam," and it says as prescribed, doesn't mean the physician should be present. But for the previous steps it didn't say the physician should order, so -- and this complete all the steps listed by that medical textbook. The medical textbook gives you all the details required for this case.

And that's all. And I think I did miss -- I did say I will get ABG, arterial blood gases.

THE ALJ: Now which document are you looking at now? Which exhibit?

DR. HAKIM: Exhibit 5.

THE ALJ: 5, okay.

DR. HAKIM: I did say I will get an ABG, arterial blood gases, and this will cover item No. 6, which is the arterial blood gases. And that should cover the arterial blood oxygen saturation.

Testimony of Mohammad Ousama Tomeh, M.D.

Dr. Tomeh testified at Dr. Hakim's request. Dr. Hakim asked Dr. Tomeh the following questions [Transcript, p. 30]:

1) What constitutes emergency treatment of a child who's becoming cyanotic because of prolonged seizures and the child cannot breathe and turning blue, cyanotic?

2) What emergency steps would you take in such a case?

Dr. Tomeh testified that in the case of a 911 call, you take the patient to the emergency room, do resuscitation and give the patient oxygen. Dr. Tomeh further testified as follows:

A The emergency transport the child who is cyanotic, not breathing, you have to establish a few things immediately. You have to take the vital sounds, including the blood pressure and pulse rate and respirations. You have to measure the pulse oxymetry. But immediately you have to establish airway and give the baby oxygen. It depends on

the patient. You can give oxygen by mask or you can intubate the child. It depends about their condition and the response to your mask breathing or intubations and oxygen, and immediately. And then you look -- after the child improve or the patient improve, improve the color back to normal and you check the pulse at that time if somebody else will help you to check the vital sounds, pulse rate, the blood pressure, pulse oximeter, the breathing monitor. After you establish these and you resuscitate, you don't do any blood test first. You go ahead and resuscitate the child, let him go to -- come to normal, normal conditions either by intubation and oxygen or by mask. When the color improve, the breathing is normal, then you can go ahead and look for the reasons for cyanosis like seizure or other things. Then you can run your blood tests and laboratory tests. It depends what you need to do at that point.

So the first emergency treatment, you have to resuscitate, establish airway, give oxygen, and check the vital signs and check the blood pressure. And then after that immediately you need to check the laboratory tests and establish IV for the child, IV for medications.

All right? This is the answer immediately what you do in the next few minutes. Go on and ask more questions.

During cross-examination, when asked if there is anything else that goes into being a minimally competent physician other than graduating from a medical school and having residency training, Dr. Tomeh testified that you have to swear that you will treat the patients to the best of your ability. If you think you cannot treat a patient, refer them to a specialist. So honesty of the doctor is important. Dr. Tomeh also stated that quizzing a physician about various medical conditions and see how the physician answers the questions can also be used to determine the physician's competence. Dr. Tomeh testified that he has never been a member of a Medical Examining Board. Transcript. p. 33-36.

Testimony of Megeen Parker, M.D.

Dr. Parker testified at the request of the Division of Enforcement. Dr. Parker is a clinical physician affiliated with the University of Wisconsin Medical School in the Department of Family Medicine. She graduated from Emory University Medical School in Atlanta, Georgia in 1986. After graduating from medical school, Dr. Parker completed a residency in family medicine at the Medical University of South Carolina in Charleston, South Carolina. She stayed in Charleston for one year to do a fellowship in academic family medicine. Then she spent three years in Tennessee at East Tennessee State University on the faculty of the medical school and teaching in a family medicine residency program. She was as an academic faculty member at the University of Wisconsin from 1993 to 2000. Transcript, p. 37-39.

In reference to her duties as a faculty member at the medical schools, Dr. Parker taught medical students in all four years, both in the clinical or office setting as well as in the hospital setting. She directly supervised the care provided by residents to patients, both in the office and hospital setting, family medicine residents, and actually in some cases pediatric

residents or residents in other specialties that were rotating in on their service at the hospital. Transcript, p. 39.

When asked what a physician is supposed to think first when presented with a patient who is in seizure, Dr. Parker testified that seizures are in general a medical emergency. She said that the two main goals are to treat the seizure safely and effectively because most of the negative consequences are the result of the seizure activity and not necessarily the cause of the seizure. And then the second most important goal of treatment is that the treatment is effective and does not hurt the patient further. Transcript p. 39-40.

In reference to the minimally competent response by a physician to a child presented with seizures, Dr. Parker testified as follows [Transcript p. 50-52]:

> Q Doctor, in your opinion, what is the minimally competent response by a physician to a child presented to him in this condition?
>
> A The first step, because you have an instant clue of lack of oxygen, is to restore oxygen flow. You have to ensure that there's actually a path to the lungs through the airway. And typically in a seizure, often that can be accomplished with positioning and just thrusting the jaw forward, which is the first step in establishing an airway.
>
> It's often very difficult practically to get an airway in a seizing child or adult because the muscles of the jaw are also affected. But you make an effort. Adding oxygen to the air they breathe is the simplest way.
>
> So you administer oxygen would be -- once you make sure that positioning -- that you position the airway in a child who's seizing practically, you would probably go right to trying to put a mask on them and give them extra oxygen by bagging them.
>
> Q You used a term, you said "insert an airway."
>
> A That's right.
>
> Q What do you mean by insert an airway?
>
> A An airway is a little plastic -- it's a C-shaped piece of plastic with a tiny little handle off one end that has grooves in either side that essentially allows you to move the tongue forward from the back of the throat.
>
> Q So --
>
> A It's about, you know, for an adult it would be

about this big.

Q And you're holding your fingers about two and a half inches apart, maybe three?

A About three, four inches, yeah. It's a very small -- it's not a tube. It's simply -- you can do the same thing with your finger, which would be a little dicier literally to put your finger in and pull the tongue forward. It does the same thing, but it has grooves on the side as if your finger were grooved to allow air passage in case there's any swelling in the back of the throat or mouth, throat as well.

Q Is inserting an oral airway the same thing as intubating a child or a patient?

A No.

Q What's the difference?

A An oral airway does not go past the vocal cords. It simply is in the mouth essentially. Intubation implies actually placing a tube into the main airway before it divides down in the lungs and practically is almost impossible in someone with status. It just physically can't be done because you don't have -- you can't really get it through a clinched mouth typically. You can place an airway through the nose, a little trickier. And so when you see most management strategies for status, intubation is done as a last resort, often in connection with intubation -- I mean often done in connection with paralysis and IV sedation, meaning an anesthesiologist or someone who has that same qualification for advanced resuscitation, literally again stops the seizure, and also in doing so stops the breathing and then intubates someone.

Q That sounds like a particularly risky maneuver on its own.

A It is.

In reference to Dr. Hakim's answer to the examination question that was asked by the Wisconsin Medical Examining Board, Dr. Parker testified as follows [Transcript, p. 40-41]:

Q. Dr. Parker, you were present at this morning's hearing since the beginning?

A Yes.
Q And you heard the examination question that was asked of Dr. Hakim and his answer?

A Yes.

Q. And you've had an opportunity to examine the transcript that was provided to Dr. Hakim, the rough transcript?

A Yes.

Q Have you also had an opportunity to review the article that Dr. Hakim cited as his support for his examination challenge, the Current Management in Child Neurology?

A Yes.

Q I believe that's -- you.

Q In the course of reviewing materials that you've seen, the examination question and the transcript, have you also examined Dr. Hakim's examination challenge?

A Yes.

Q And that's part of Exhibit No. 1?

A Yes.

Q That's the large packet? Actually, you have seen all of Exhibit 1 at one time or another, have you not?

A Yes, I have.

Q. And I would ask you a general question. Have you come to an opinion, to a reasonable degree of medical certainty, as to whether Dr. Hakim gave a minimally competent answer to the question that was asked of him at the oral examination?

A Yes.

Q And what is your opinion?

A My opinion is that the answer that he provided, while it was inclusive of certain elements, because it did not address why you perform those

actions and it did not specify them in the correct order or imply why you might do certain things at certain times, was not sufficient to reflect a minimally competent physician's emergency treatment of a child with prolonged seizures.

Dr. Parker further testified as follows regarding the Medical Examining Board's examination question and Dr. Hakim's response [Transcript p. 43-47]:

Q Doctor, you've read the question that was asked of Dr. Hakim in the oral examination.

A Yes.

Q In your opinion, was that a fair question?

A Yes.

Q Why?

A I think it gets at an understanding of basic knowledge that a physician needs to have beyond simply knowing the steps on a particular treatment protocol. So it's a fairly subtle question that asks about a very common emergency and gives enough detail to allow for drawing on an expected knowledge of medicine to be able to explain why you're choosing to do the things that you do.

Q Doctor, I'm handing you a copy of the transcript of the examination, and I'd like you to refer to that as we go through.

A Sure.

Q You can refer to your notes if you'd like.

A Okay, great.

Q Doctor, you said that it was a common situation.

A Uh-huh.

Q Can you tell me how common the situation is.

A I can't quote you numbers, but -- but essentially children are the most common, as compared to adults, to show up in an emergency room with a prolonged seizure.

Q Why is that?

A Because prolonged seizures are often due to fevers, high fevers, and in children that's a very common scenario.

Q What does the question tell the doctor about the condition of the patient in the scenario?

A Well, when you specify a child, you can immediately eliminate, with reasonable certainty, a number of causes of seizure that an adult might have; for example, a seizure could be a complication of a stroke. That would be highly unlikely in a child, not impossible but highly unlikely. So it already starts your brain thinking about what are the likely causes, which is not the first thing you want to think of in emergency treatment.

The implication that the child is becoming cyanotic implies that the seizure has been prolonged enough to interrupt normal breathing patterns. Seizures are uncoordinated activity, electrical activity in the brain which results in uncoordinated electrical activity in the muscles, particularly the diaphragm. So anyone who's having a seizure starts to have difficulty getting oxygen to their brain because, one, their brain is using it at a faster rate because it's out of control and it's firing off at a far faster rate than normal, and No. 2, the diaphragm is not working in a coordinated fashion, so it might be contracting to cause you to breathe out before you've even taken a full breath in.

So the fact that that has been going on long enough to cause cyanosis or evidence that the body is not getting sufficient oxygen tells you that it's a prolonged seizure and falls into the category of status epilepticus in terms of when you start to look at treatment protocols and implications.

Q Is it fair to say that the question tells the minimally competent physician what the diagnosis probably is?

A Yes. People quibble about the actual duration of time that constitutes a status epilepticus, and this gets around that by not giving a specific duration but rather saying a seizure that's been going on long enough to interrupt normal breathing

patterns to cause lack of oxygen, sufficient oxygen is close enough. I mean, it's really the underlying -- it's one of the underlying -- it's what makes status epilepticus an emergency.

In reference to the Dr. Hakim's response on the question on the oral examination relating to status epilepticus, in comparison to the guidelines for treatment contained in Table 78-1, Dr. Parker testified as follows [Transcript p. 58-63; Exhibit 4]:

Q Dr. Parker, you've also read the Medical Examining Board's explanation of why Dr. Hakim failed on his examination challenge. This would be page 11 of Exhibit No. 1.

A Yes.

Q And I'd like to ask you if you recall Dr. Hakim talking about Table 78-1 in Exhibit No. 3 I believe it is.

A No. 4, yes.

Q No. 4, thank you. The article from Current Management in Child Neurology.

A Yes.

Q Do you have any criticisms of Dr. Hakim's reliance on Table 78-1 in that text in relation to what he said in the examination?

A Say that again.

Q Incoherent question. Let me try again.

A Okay.

Q When you compared Table 78-1 with Dr. Hakim's answer --

A Yes.

Q -- you came to a different conclusion than Dr. Hakim did?

A That's correct.

Q Dr. Hakim concluded that he answered the question correctly according to Table 78-1?

A That's correct.

Q And you concluded that he did not?

A That's correct.

Q Correct? What was the reason for your conclusion that he did not meet the elements listed in Table 78-1?

A I would give a two-part answer. One is specifically in reference to this table, in a child the most common cause of status epilepticus is a high fever. So a key element in treatment on this table is to check a temperature and to give antipyretics or medications that lower fever, Tylenol, rectal Tylenol is typical or practical solution in most cases.

The other element, the other two elements that I think are key off of this table in terms of emergency treatment are administering oxygen, administering oxygen. And in this case, this particular table refers to giving it nasally and administering -- checking the blood sugar to know immediately whether administering glucose is a priority.

Q Was that one part or two parts?

A That was the one part.
The second part is that as a physician you are compelled to know more than how to follow a table. You are compelled to know how to apply that table to a particular situation and why.

That's what constitutes being a medical doctor as opposed to another professional health provider.

Q Thank you. Dr. Parker, Dr. Hakim has repeatedly said that he would do intubation or oxygen or airways, so he's really met the business of we need to make sure that the child is getting oxygen; correct?

A Right.

Q He didn't mention glucose, did he?

A Not that I noted, no.

Q Did you note any mention of temperature or bringing a fever down?

A No.

Q Did you notice anything about his selection of medications after he was prompted?

A Diazepam would not be the best choice unless you did not have an IV established. Diazepam causes more problems with breathing and it's less effective in stopping a seizure quickly. And you would never use Dilantin as a first drug of choice for status in a child or an adult. It takes too long to take effect, up to 30 minutes actually.

Q All right. Now, looking specifically at the first paragraph on page 11 of Exhibit 1, the Medical Examining Board concluded that Dr. Hakim did not include all of the appropriate medications or appropriate dosages. Do you believe that that is a fair criticism of Dr. Hakim's answer?

A I do.

Q And that's because he didn't mention Lorazepam?

A That's correct.

Q Is that sufficient in your opinion to say that he really didn't hit all of the appropriate bases?

A In and of itself, missing that one point would not constitute a problem because he did mention diazepam. However, that was only one of their two points.

Q And the other point was?

A That did not include all of the required elements listed for stabilization, vital signs, including temperature, monitoring of heart rhythm, frequent suctioning, nasal oxygen, medications, antipyretics, which are medications that would lower fever, obtaining IV access; although I would say that that's implied in his answer, although it's not specifically stated. In an exam setting like this it is reasonable to ask that people actually specifically state it.

Pulse oxymetry is a way to very simply

measuring the oxygen levels by putting a clip on your finger. Again getting a blood gas requires quite a bit of technical skill, particularly in a seizing patient. So practically it's a great thing to shoot for, but pulse oximeter would give you much more important information about oxygen status more quickly and help you help the patient faster and more effectively.

And then drawing blood for laboratory tests was included on Table 78-1 but was not mentioned.

Again, that would be something you would do as part of the process, but it would be -- it would determine what you did for emergency treatment after the first 10 or 15 minutes. So in and of itself, it's not a major omission in terms of the first five to ten minutes in emergency treatment.

Q Doctor, you mentioned the appropriateness of an answer on an examination, or something to that general effect.

A Uh-huh.

Q In your experience as a faculty member at medical schools, when you're giving examinations to medical students, what are you looking for in the answer?

A I'm looking for specifics that indicate an understanding of what you need to -- what needs to happen regardless of who ends up doing it, that you have an understanding.

A good example is every two years I have to recertify to resuscitate newborns, and this is recertification. So it's the same certification process a nurse goes through, an EMT would go through, an OB/GYN would go through, to say that I have the appropriate basic skills to resuscitate an infant if the need arose. And I am required to go through every single step in detail. Even if I'm working in the exam with a team, it is still my responsibility to demonstrate that I know every single step, and that if the need arose, I could tell people what to do if they didn't know what to do.

So as a physician, I'm compelled to know what to do even if other people know. I'm always in charge is the bottom line. If I'm physically there, I'm in charge. That's what being a physician implies.

In reference to Dr. Hakim's answer to the examination question relating to doing arterial blood gases (ABGs), Dr. Parker testified as follows [Transcript p. 52-58]:

Q Dr. Hakim's answer talks about doing ABCs, trying to resuscitate the child. Is there anything wrong with the first part of Dr. Hakim's answer?

A No. Certainly the first paragraph about doing the ABCs, secure an airway by mouth, that's certainly an appropriate, reasonable step.
What's missing is then to administrator oxygen.

Q Why is that important?

A Because that may be the -- that may stop the seizure.

Q Tell me about using oxygen as means of stopping a seizure.

A Seizures can start for any reason. And in this case the reason isn't particularly important to the initial treatment. As in most cases, at least that's the question they asked. But they often become prolonged because your brain is not getting either oxygen or glucose, sugar, so it has abnormal activity as a result.

So the first two things that you can do simply in treating a prolonged seizure are to see if supplying oxygen and, if it's needed, sugar will stop the prolonged seizure, regardless of how it first got started.

Q How do you check to see whether the child needs sugar or glucose?

A You can do a finger stick blood sugar, either from blood that you've gotten from starting an IV or just with a finger stick, as people would do in their own homes.

Q Diabetic patients?

A That's right.

Q Do it all the time?

A That's right.

Q Did Dr. Hakim mention checking blood sugar levels?

A No.

Q Should he have?

A Yes. Particularly in a prolonged seizure.

Q Why is prolonged seizure more important to check glucose than a short seizure? What is it about seizure activity that deals with glucose?

A Again, your brain is going haywire essentially in working overtime, so it's consuming more oxygen and more sugar. And initially your body will put out more sugar to compensate, but then that supply gets exhausted, and then you actually become -- you develop low blood sugar, and that can actually perpetuate the seizure. Either low oxygen or low sugar can perpetuate the seizure.

Q It sounds like you're describing a vicious circle.

A That's correct.

Q Would a minimally competent physician know that it is important to interrupt that circle?

A Yes.

Q Is that something that the minimally competent physician would have learned in medical school?

A Yes and no. That particular scenario would probably have come up again and again in terms of a commonly used scenario to talk about basic emergency treatments. But answering this specific question would not be a universal requirement for getting an M.D. degree.

Q Fair to say that the minimally competent physician would know that seizures use up glucose and oxygen at a fast rate?

A That's correct.

Q And that the minimally competent physician would know that you want to replace oxygen and certainly check glucose?

A That's correct.

Q When you looked at Dr. Hakim's answer, and listened to Dr. Hakim's answer, what did you hear

Dr. Hakim emphasizing in his answer?

A The ABCs, the basics of resuscitation.

Q Is there anything wrong with emphasizing ABCs?

A No.

Q Is it sufficient?

A No.

Q Why not?

A Because restoring oxygen alone may not stop the seizure. So you can't assume that just giving oxygen, establishing an airway and giving oxygen will stop the seizure.

Q What do you have to do to stop the seizure, assuming that oxygen and glucose don't do it?

A Don't do it.

Q What do you do?

A Then you have to administrator a medication that is fast acting and that is effective and that has a minimal chance of causing further harm.

Q When you listened to and read Dr. Hakim's answer, did you form an opinion as to whether he recognized that medication was required in the answer?

A I was uncertain because he had to be prompted by the Medical Examining Board for addressing emergency -- that piece of emergency treatment.

Q What does being prompted mean to you?

A Being prompted means that Dr. Osborn from the Medical Examining Board said, "I may not have heard this. Are you doing anything for the seizure?"

Q Did you draw any conclusions about Dr. Hakim's knowledge base from the prompt?

A I did. He asked about prior medications. Most children who present to the emergency room in status don't have a prior history of epilepsy.

There are certainly some drugs that you would take for epilepsy that if you had taken an insufficient amount or had taken too much could cause you to have a seizure that was prolonged. However, most children who present in status epilepticus do not have a history of a seizure disorder, and it does not inform or change what drug you administrator to them. You administer a short acting benzodiazepine.

Diazepam is in that drug category. It causes more respiratory depression, and it tends to be less effective than Lorazepam, which is a shorter-acting benzodiazepine.
So in this particular setting, whether it's a child or an adult, actually, the drug of choice typically is Lorazepam because it causes less -- it's less likely to cause depressed breathing.

Q And depressed breathing is already a problem in a patient who is cyanotic?

A That's correct.

In reference to a physician's reliance on the knowledge of a nurse, Dr. Parker testified as follows [Transcript p. 64-65]:

Q You heard Dr. Hakim read his Exhibits 5 and 6, Evidence No. 1 and Evidence No. 2.

A Yes.

Q In your opinion, is it appropriate for any physician to rely on the knowledge of the nurse that may or may not be helping him?

A It's practically acceptable, but it's done with -- it's done knowing that the physician also knows the information. It's not a substitute for knowing what to do if you were the only one there, or if the nurses that are working with you in the emergency room are occupied elsewhere or they just got out of nursing school or they're an LPN and they actually don't have the skills that are required. So it is acceptable to say that other people would be doing pieces of that and would be supplying information to you, but it's still your job to take all of that information in and make sure that the care they're providing is appropriate.

Q In your opinion, may a minimally competent physician say I didn't mention that, but the nurses would know to do that in answering an exam?

A No, because it implies that you're assuming that the nurse knows to do that and will, and that's not a fair assumption.

Q Why not?

A Because ultimately nurses practice under the supervision of physicians. Their license actually limits them to -- they cannot function independently. So ultimately -- ultimately it always comes back to you. Even if there's a written protocol in place in an emergency room for how to handle status, it had to be authored and signed off on by a physician. And all of the physicians are compelled to know it in and out in case someone else forgets. That doesn't mean we're not human and can't make a mistake, but it is our responsibility as physicians.

When asked about Dr. Tomeh's testimony regarding referral of a patient for treatment, Dr. Parker testified as follows [Transcript p. 47-49]:

Q I want to take a short side trip off.

A Sure.

Q We heard the testimony of Dr. Tomeh just now.

A Uh-huh.

Q And Dr. Tomeh said that if you can't treat a patient, you need to refer him or her to a specialist. Did you hear that?

A Yes.

Q Is this situation described in the oral examination question the sort of thing that a minimally competent physician would need to refer to a specialist?

A That wouldn't be an option.

Q Why not?

A Because it asks about what constitutes emergency treatment.

Q Is this emergency treatment of a type that is rarefied or requires specialized knowledge?

A No.

Q Why not?

A In part because the treatment steps you would take for a child to treat a child as well as an adult are similar to those you would use for an adult.

Children present commonly, more commonly than adults in status epilepticus, and it's one of the most common childhood emergencies. So in any kind of emergency setting this might be seen.

Q What would the minimally competent physician know was the immediately expected reaction here from the physician?

That was a really difficult question and I'm not at all surprised that you're giving me the look of that was incoherent. Let me try again.

Q. Would a minimally competent physician know what the treatment goals were in this situation?

A Yes. Stop the seizure, safely.

Q I'm sorry?

A Stop the seizure safely.

Q And what else -- is there anything else that goes with that other than stopping the seizure safely?

A Making sure that how you do it doesn't hurt the patient further or injure the patient further.

Finally, in reference to the risks of harm to a patient, Dr. Parker testified as follows [Transcript p. 49-50]:

Q What are the risks of hurting the patient further in this situation? How would you do that?

A The --

Q Was that another incoherent question?

A No, no. No, it's very coherent. I was going to say the way to hurt the patient further, which is kind of a strange thing, but effectively the longer you let the seizure continue, the more you're hurting the patient.

Q Why is that?

A Because most of the consequences in terms of brain damage, for a generic term, are the result of prolonged seizures.

Q You talked a little bit about uncoordinated movement of the diaphragm. Can we liken this to hiccups?

A Yeah, in a way.

Q In what way is it not like hiccups?

A Hiccups still allows for normal respirations in between. The interval between the hiccups is much longer than it would be in seizure activity. And it varies depending on the degree of seizure activity and the type. But in this case you're talking about a type of seizure activity that has led to ineffective breathing for a period of time, sufficient to lead to lack of oxygen.

III Analysis

Dr. Hakim filed an application on January 12, 2006, with the Medical Examining Board for a license to practice medicine and surgery. Because Dr. Hakim had been subject to adverse formal action during the course of his medical education, postgraduate training, hospital practice or other medical employment, he was required to complete an oral examination pursuant to Wis. Adm. Code, § Med 1.06 (1) (a). Exhibit 1.

Between October 2006 and April 2007, Dr. Hakim took and failed the oral examination four times. That includes two oral examinations administered by a two-member panel of the Board and two examinations administered by the full Board. Ex. 1.

On July 2, 2007, the Board issued a decision which scored the examination as "failed". The written decision of the Board informed Dr. Hakim that he would not be admitted to any further examination, in accordance with Wis. Adm. Code, § Med 1.08 (1), until he successfully completed an ACGME accredited postgraduate training program of twelve months in a board-approved facility. Exhibit 1, p. 1.

On November 17, 2007, the Board denied Dr. Hakim's application for licensure on the basis that he failed to achieve a passing grade on the examinations required under
§ MED 1.08.

Dr. Hakim's position is that, in his response to the question posed by the Board regarding a child with a Status Epilepticus, he identified all of the essential steps listed in a respected textbook in reference to such a case. Exhibit 1, page 3; Exhibits 2 and 3.

Dr. Hakim relies upon the following references:

1. Table 78-1 in the Guidelines for Treatment of Pediatric Generalized Convulsive Status Epilepticus (GCSE), as found in *Current Management in Child Neurology*, by Bernard L. Maria, M.D., 3rd edition (2005), page 504. [Exhibit 4]

2. Table 8.28 in the Sequence of Steps for Emergency Treatment of Status Epilepticus, as found in *Child and Adolescent Neurology*, by Ronald B. David, M.D., 2nd edition (2005), p. 214. [Exhibit 5]

3. A passage from *Real-World Nursing Survival Guide: Critical Care & Emergency Nursing* by Lori Schumacher, PhD, RN, CCRN and Cynthia Chernecky, PhD, RN, CNS, AOCN, 1st edition (2005), page 178. [Exhibit 6]

Table 78-1 contains the guidelines for stabilization and treatment of pediatric generalized convulsive status epilepticus. Table 8.28 contains 13 steps for emergency treatment of status epilepticus. The passage from the Real World Nursing Survival Guide defines what constitutes status epilepticus; indicates what a nurse is required to do if it occurs, and list the first-line and initial treatments for the condition.

Based upon a review of the hearing record in this case, of the three references that Dr. Hakim identified during the hearing, only one reference, Table 78-1, was identified as a reference source during Dr. Hakim's examination challenges before the Board. The other two references, Table 8.28 and the passage from the nursing book, were identified as reference sources during this proceeding.

According to Dr. Hakim, of the 13 steps listed in Table 8.28, he referenced steps, 2, 3, 6, 9, 10, 11, 12 and 13 during the oral examination. In reference to steps 1, 4, 5, and 8, Dr. Hakim said that, based upon the passage taken from the Real World Nursing Survival Guide, those steps should be taken by a nurse. There is no evidence in the record that Dr. Hakim's response to steps 1, 4, 5 and 8 during the oral examinations indicated that these steps should be taken by a nurse. It appears that Dr. Hakim is asserting this position for the first time during this proceeding. Dr. Hakim did not indicate whether he referred to step 7 during the examination. Transcript, p. 13-17. Exhibits 5, 6.

Dr. Megeen Parker testified at the request of the Division of Enforcement. When asked if she had come to an opinion as to whether Dr. Hakim gave a minimally competent answer to the question that was asked of him at the oral examination, Dr. Parker said that his response was not sufficient to reflect a minimally competent physician's emergency treatment of a child with prolonged seizures. She said that the answer that he provided, while it was inclusive of certain elements, "did not address why you perform those actions and it did not specify them in the correct order or imply why you might do certain things at certain times". Transcript p. 40-41.

In reference to Dr. Hakim's response to steps 1, 4, 5 and 8 in Table 8.28, indicating that those steps should be taken by a nurse, Dr. Parker said that it is acceptable but that it is done knowing that the physician also knows the information. She said that it is still the physician's job to take all of that information in and make sure that the care provided is appropriate. In answering an examination question, a minimally competent physician could not say that "he did not mention that, but the nurses would know to do that". It assumes that the nurse knows to do that and will, but that is not a fair assumption.

In reference to Dr. Hakim's failure to give a response to step 7 relating to providing a 50% glucose solution, Dr. Parker said that the first two things that you can do simply in treating a prolonged seizure are to see if supplying oxygen and, if it's needed, sugar will stop the prolonged seizure, regardless of how it first got started. She said that you can do a finger stick blood sugar, either from blood that you've gotten from starting an IV or just with a finger stick, as people would do in their own homes.

Dr. Parker said that Dr. Hakim should have mentioned checking blood sugar levels during the oral examination, particularly in a prolonged seizure, because the brain is working overtime, so it's consuming more oxygen and more sugar. She said that "initially your body will put out more sugar to compensate, but then that supply gets exhausted, and then you actually develop low blood sugar, and that can actually perpetuate the seizure. Either low oxygen or low sugar can perpetuate

the seizure". Transcript p. 53-54.

In reference to Dr. Hakim's response to step 9, which indicated that Diazepam or Dilantin should be administered, Dr. Parker said that the drug of choice typically is Lorazepam because it is less likely to cause depressed breathing. She said that Diazepam causes more respiratory depression and tends to be less effective than Lorazepam. Diazepam would not be the best choice unless you did not have an IV established. It causes problems with breathing and it is less effective in stopping a seizure quickly. You would never use Dilantin as a first drug of choice for status in a child or an adult because it takes up to 30 minutes to take effect. Transcript p. 57-61.

In reference to comparing the guidelines in Table 78-1 to Dr. Hakim's response on the oral examination to the question relating to status epilepticus, Dr. Parker said that Dr. Hakim's response did not meet the elements listed in the Table. Dr. Parker testified as follows:

> Q Correct? What was the reason for your conclusion that he did not meet the elements listed in Table 78-1?
>
> A I would give a two-part answer. One is specifically in reference to this table, in a child the most common cause of status epilepticus is a high fever. So a key element in treatment on this table is to check a temperature and to give antipyretics or medications that lower fever, Tylenol, rectal Tylenol is typical or practical solution in most cases.
>
> The other element, the other two elements that I think are key off of this table in terms of emergency treatment are administering oxygen, administering oxygen. And in this case, this particular table refers to giving it nasally and administering -- checking the blood sugar to know immediately whether administering glucose is a priority.
>
> Q Was that one part or two parts?
>
> A That was the one part.
> The second part is that as a physician you are compelled to know more than how to follow a table. You are compelled to know how to apply that table to a particular situation and why.
>
> That's what constitutes being a medical doctor as opposed to another professional health provider.
>
> Q Thank you. Dr. Parker, Dr. Hakim has repeatedly said that he would do intubation or oxygen or airways, so he's really met the business of we need to make sure that the child is getting oxygen; correct?
>
> A Right.

Q He didn't mention glucose, did he?

A Not that I noted, no.

Q Did you note any mention of temperature or bringing a fever down?

A No.

Q Did you notice anything about his selection of medications after he was prompted?

A Diazepam would not be the best choice unless you did not have an IV established. Diazepam causes more problems with breathing and it's less effective in stopping a seizure quickly. And you would never use Dilantin as a first drug of choice for status in a child or an adult. It takes too long to take effect, up to 30 minutes actually.

Q All right. Now, looking specifically at the first paragraph on page 11 of Exhibit 1, the Medical Examining Board concluded that Dr. Hakim did not include all of the appropriate medications or appropriate dosages. Do you believe that that is a fair criticism of Dr. Hakim's answer?

A I do.

Q And that's because he didn't mention Lorazepam?

A That's correct.

Q Is that sufficient in your opinion to say that he really didn't hit all of the appropriate bases?

A In and of itself, missing that one point would not constitute a problem because he did mention diazepam. However, that was only one of their two points.

Q And the other point was?

A That did not include all of the required elements listed for stabilization, vital signs, including temperature, monitoring of heart rhythm, frequent suctioning, nasal oxygen, medications, antipyretics, which are medications that would lower fever, obtaining IV access; although I would say that that's implied in his answer, although it's not specifically stated. In an exam setting like this it is reasonable to ask that people actually specifically state it.

Pulse oxymetry is a way to very simply measuring the oxygen levels by putting a clip on your finger. Again getting a blood gas requires quite a bit of technical skill, particularly in a seizing patient. So practically it's a great thing to shoot for, but pulse oximeter would give you much more important information about oxygen status more quickly and help you help the patient faster and more effectively.

And then drawing blood for laboratory tests was included on Table 78-1 but was not mentioned.

Again, that would be something you would do as part of the process, but it would be -- it would determine what you did for emergency treatment after the first 10 or 15 minutes. So in and of itself, it's not a major omission in terms of the first five to ten minutes in emergency treatment.

In reference to risks of harm to patients, when asked if it was fair to say that the treatment Dr. Hakim talked about in his answer is insufficient and would create an unacceptable risk of harm to the patient in that situation, if he stopped where he stopped and did no more, Dr. Parker said that for her what is missing is an understanding of what's missing. She did not have a problem with what Dr. Hakim included in his response. She had a problem with a couple of the key elements that are missing and a lack of understanding of why those are missing. She said that as a physician you are compelled to recognize that you are making a mistake and to address it. So not recognizing that administering oxygen is a key step to state or checking blood sugar is a key step to state or within the first few minutes establish IV access is a key step to state because it has to happen. If no one else is doing it, you need to be. Those are the errors of omission that the Medical Examining Board also referred to specifically that are most concerning to me. Omitting those steps would likely result in harm to a patient.

Finally, in reference to the qualifications of Dr. Tomeh and Dr. Parker to offer expert opinions regarding whether Dr. Hakim provided appropriate responses to the oral examination questions, in my opinion, Dr. Parker is more qualified to render an opinion.

First, other than the fact that Dr. Tomeh has a medical degree, there is no other evidence in the record relating to his qualifications. Dr. Hakim stated on his witness list that "M.O. Tomeh, M.D., P.C." would testify as an expert witness and, at the hearing, Dr. Hakim referred to him as "Dr. Tomeh". However, there was no testimony or documentation offered, in the form of a curriculum vitae or otherwise, relating to Dr. Tomeh's qualifications. As a result, Dr. Tomeh has not been qualified as an expert witness.

Second, in contrast to Dr. Tomeh, Dr. Parker is a clinical physician affiliated with the University of Wisconsin Medical School in the Department of Family Medicine. She graduated from Emory University Medical School in Atlanta, Georgia in 1986. After graduating from medical school, Dr. Parker completed a residency in family medicine at the Medical University of South Carolina in Charleston, South Carolina. She stayed in Charleston for one year to do a fellowship in academic family medicine. Then she spent three years in Tennessee at East Tennessee State University on the faculty of the medical school and teaching in a family medicine residency program. She was as an academic faculty member at the University of Wisconsin from 1993 to 2000. Transcript, p. 37-39.

Finally, as a faculty member at two medical schools, Dr. Parker taught medical students in all four years, both in the clinical or office setting as well as in the hospital setting. She directly supervised the care provided by residents to patients, both in the office and hospital setting, family medicine residents, and in some cases pediatric residents or residents in other specialties that were rotating in on their service at the hospital. Transcript, p. 39.

IV <u>Recommendations</u>

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 14th day of August 2008.

Respectfully submitted,

_____

Ruby Jefferson-Moore
Administrative Law Judge