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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
WALTER R. BOISVERT, M.D., RESPONDENT.	:	LS0805201MED

Division of Enforcement Case No. 06 MED 391

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 19th day of August, 2009.

Gene Musser MD
Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST **WALTER R. BOISVERT, M.D.,** RESPONDENT.	:	**PROPOSED DECISION AND ORDER** Case No. LS-0805201-MED

06 MED 391

PARTIES

The parties in this matter under section 227.44 of the Statutes and section RL 2.037 of the Wisconsin Administrative Code, and for purposes of review under sec. 227.53, Stats. are:

Complainant:
Department of Regulation and Licensing
1400 East Washington Ave.
Madison, WI 53708-8935

represented by
Attorney James E. Polewski
Division of Enforcement

Respondent:
Walter R. Boisvert, M.D.
610 E. Taylor Street
Prairie du Chien, WI 53821

represented by
Attorney Thomas H. Taylor
Johns, Flaherty & Collins, SC
600 Exchange Building
205 5th Avenue South
La Crosse, WI 54602-1626

Disciplinary Authority:
Medical Examining Board
1400 East Washington Ave.
Madison, WI 53703

APPLICABLE STATUTE AND ADMINISTRATIVE RULE

Wisconsin Statutes

448.02 Authority
...
(3) Investigation; hearing; action.
(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.
...
(c) Subject to par. (cm), after a disciplinary hearing, the board may, ... when it finds a person guilty of unprofessional conduct or negligence in treatment, do one or more of the following: warn or reprimand that person, or limit, suspend or revoke any license, certificate or limited permit granted by the board to that person. The board may condition the removal of limitations on a license, certificate or limited permit or the restoration of a suspended or revoked license, certificate or limited permit upon obtaining minimum results specified by the board on one or more physical, mental or professional competency examinations if the board believes that obtaining the minimum results is related to correcting one or more of the bases upon which the limitation, suspension or revocation was imposed.
...

Wisconsin Administrative 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.
...

PROCEDURAL HISTORY

A. The Complaint and Notice of Hearing in this matter were filed by Attorney Polewski on May 19, 2008. The case was assig to Administrative Law Judge Jacquelynn Rothstein.

B. A Notice of Prehearing was sent to the parties on May 20, 2008.

C. The Answer in this matter was filed by Attorney Taylor on behalf of the Respondent, Dr. Boisvert, on June 6, 2008.

D. A prehearing conference was held on June 17, 2008 and a memo was filed on the same day.

E. The Complainant's Preliminary Witness List was filed on June 26, 2008.

F. The Respondent's Preliminary Witness List was filed on August 1, 2008.

G. The Complainant's Final Witness List was filed on September 2, 2008.

H. The Respondent's Final Witness List was filed on September 16, 2008.

I. Emails were exchanged on October 21 and 22, 2008 regarding depositions and witnesses.

J. The Respondent filed a Motion to Compel Discovery and a Motion in Limine on October 29, 2008. The Motion to Compel Discovery sought an order compelling Mr. Polewski to respond to interrogatories and document requests. The Motion in Limi sought the following rulings:

1. Dr. Mark Timmerman's testimony should be limited to only those opinions he rendered at his August 14, 2008 discov deposition and he should not be allowed to offer additional opinions not disclosed at or since that time.
2. Attorney Polewski should be precluded from asking any expert witnesses what he or she would have done in a particu situation.
3. Evidence should be prohibited as to whether any witness has previously been named as a defendant in a different case
4. Attorney Polewski should be precluded from offering any testimony from Dr. Timmerman concerning possibilities.
5. Conversely, the Respondent's legal counsel should be permitted to ask possibility questions of the Respondent's expe and the Division of Enforcement experts.
6. The Administrative Law Judge should prohibit any cross-examination of the Respondent's expert witnesses using their testimony in other cases unless such prior testimony is submitted to the Respondent's legal counsel at least one [sic] 96 h prior to the hearing.
7. The Administrative Law Judge should prohibit Attorney Polewski from offering any evidence on issues relating to the lighting conditions in the operating room at Prairie du Chien Memorial Hospital, the date(s) when view boxes were install the operating room, and other issues on which he has failed and refused to respond to the Respondent's discovery pleadi

K. The Complainant filed documents for use in the prehearing conference and motion hearing on November 7, 2008.

L. A prehearing conference and motion hearing were held on November 7, 2008, and a memo was filed the same day. The me stated without elaboration that the issues raised in the Motion in Limine were resolved.

M. Emails were exchanged on November 12, 13 and 14, 2008 regarding hospital records.

N. A hearing was held on November 17 and 18, 2008. Testimony was presented by Mark Timmerman, M.D., Harry Farb, M Charles Stanley Greenhouse, M.D., Steven Alan Ringer, M.D., Howard Thalacker, M.D., Kurt Jorgensen, M.D., Dawn Kalie the respondent, Walter Boisvert, M.D.

O. Emails were exchanged on November 17 and 18, 2008 regarding the authentication of records.

P. The Complainant filed a letter and affidavits on November 21, 2008 regarding exhibits 4 and 18, preserving an objection to admissibility.

Q. The Respondent filed his closing argument on January 7, 2009.

R. The Complainant filed his closing argument on January 7, 2009, along with proposed findings of fact and conclusions of law.

S. The Respondent filed proposed findings of fact and conclusions of law on January 8, 2009.

T. The Respondent filed a correction to his closing argument on January 8, 2009.

U. The case was reassigned to Administrative Law Judge Nick Schweitzer and the parties were notified of the change on Marc 2009.

V. On March 17, 2009, the Respondent requested that oral arguments be scheduled before ALJ Schweitzer after he had revie the record.

W. Supplemental oral arguments were heard on April 27, 2009.

FINDINGS OF FACT

1. The respondent, Walter R. Boisvert, M.D., was born on September 12, 1957, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 27563, which was first granted on July 1, 1986.

2. Dr. Boisvert's most recent address on file with the Wisconsin Medical Examining Board is 610 E. Taylor Street, Prairie du Chien, Wisconsin 53821.

3. Since 1988 and at all times relevant to this proceeding, Dr. Boisvert was employed as a family practitioner at Gunderson Lutheran Clinic in Prairie du Chien, Wisconsin. [tr., p. 140]

4. At the time of the incident that led to this proceeding, Dr. Boisvert was certified in advanced life support obstetrics, neonatal resuscitation, and advanced cardiac life support as well as being board certified as a family practitioner. [tr., p. 140-141] Dr. Boisvert has been involved in approximately 20 to 24 neonatal resuscitations, with approximately 12 of those involving endotracheal intubation. [tr., p. 158]

5. Dr. Boisvert was paged at approximately 11:10 P.M. on July 23, 2001 to assist with an emergency resuscitation of a newborn child identified as M.S. Dr. Boisvert arrived at the hospital at approximately 11:25 P.M. and joined the team working on M.S. a few minutes before the nursing note that indicates he placed an umbilical vein catheter at 11:36 P.M. [tr., pp. 144-146]

6. Present in the operating room when Dr. Boisvert arrived were Dr. Bintz, Dr. Grunwald, nurse anesthetist Beinborn, two other nurses and a respiratory therapist. [tr., p. 147]

7. M.S.'s mother had attempted a v-back (vaginal delivery after caesarian), her uterus had ruptured, and an emergency caesarian was performed to deliver M.S., who was found floating free with the placenta in her mother's peritoneum. While part of the team tended to the mother, emergency resuscitation efforts were begun on M.S. [tr., p. 147]

8. Nurse anesthetist Beinborn intubated M.S. with an endotracheal tube, the team performed CPR including bagging, and three doses of epinephrine were administered through the endotracheal tube. [tr., p. 148; ex. 1, p. 10] An endotracheal tube is held in place by tape affixed to the lip. [tr., p.303]

9. The Apgar scores for M.S. at 1, 5, 10 and 15 minutes were 0, 0, 0 and 1. [tr., pp. 151-152]

10. At approximately 11:33 P.M., Dr. Boisvert examined M.S., looking at her, testing her for reflex irritability, and listening to both lungs and the epigastrium. At 11:34 P.M., M.S. was blue, with no respiratory effort, muscle tone or reflex irritability. [tr., p. 151-153]

11. Between 11:30 P.M. and 12:43 A.M. on July 24th, M.S.'s condition improved. By 11:36 P.M., M.S.'s oxygen saturation rate was 79 percent, her heart rate was in the 120s, and her blood pressure was 69 over 48. The heart rate remained in excess of 100 and the oxygen saturation rate continued to improve into the 80 percent and 90 percent range. CPR was stopped at 11:38 P.M. Bagging continued until 12:43 A.M. Throughout this period, Dr. Boisvert observed bilateral chest sounds and bilateral chest movement. [tr., p. 153-156] He placed the following in his progress notes: "... ET tube confirmation was obtained with good bilateral breath sounds, symmetric expansion of the chest and no breath sounds auscultated over the stomach, no movement of the stomach with bagging respirations." [ex. 1, p. 8]

12. The nurses' notes record the following changes in M.S.'s heart rate, oxygen saturation level, and blood pressure:

time	heart rate	O2 level	BP
11:08 P.M.	0		
11:26 P.M.	96	50%	
11:33 P.M.		75%	
11:36 P.M.	120s	79%	69/48
11:38 P.M.	130s	86-87%	
11:39 P.M.	140s	91%	
11:41 P.M.		91%	
11:43 P.M.	130s	93%	
11:43 P.M.	130s	94%	
11:44 P.M.	130s	96%	102/56
11:46 P.M.	128	96%	
11:48 P.M.	127	96%	
11:52 P.M.	120s		
11:54 P.M.	125	89%	90/32
11:55 P.M.	120s		

[ex. 1, pp. 10-12] After improving steadily from 11:08 P.M. to 11:44 P.M., all three measures dropped between 11:44 and 11:54 P.M. Around 11:55 P.M., Dr. Boisvert was concerned that M.S. wasn't responding to the resuscitation efforts to his satisfaction and he ordered a chest x-ray "to look for correctable causes to help the baby; could it have been congenital abnormality, could it have been an infection going on, any sort of hyaline membrane disease, pneumothorax, pneumomediastinum or misplacement of the endotracheal tube." [tr., pp. 170-171]

13. An x-ray of M.S., supine in expiration, was taken at midnight. Dry blankets were placed under M.S. at 11:56 P.M. prior to the x-ray being taken, and M.S. was lifted in order to place the x-ray plate under her. [tr., p. 160]

14. The endotracheal tube could have become dislodged from the trachea into the esophagus as M.S. was moved shortly before the x-ray was taken.

15. The developed x-ray was delivered to Dr. Boisvert at 12:25 A.M. At that time, M.S. had a heart rate of 116, but she had an oxygen saturation of 92 % and blood pressure of 107/59 and perhaps most importantly she was making her own respiratory efforts. [tr., pp. 166-167]

16. The placement of the endotracheal tube was not an issue of any medical importance in the treatment of M.S. at 12:25 A.M.

17. There being no view box in the operating room, Dr. Boisvert, Dr. Grunwald, and nurse anesthetist Beinborn looked at the x-ray by holding it up to the light. The endotracheal tube is difficult to see in the x-ray even under optimal circumstances using a viewbox, and none of the three saw that it extended farther down in the chest than would be consistent with placement in the trachea. Dr. Boisvert thought that it was too far down but he interpreted the placement as being in the right main stem bronchus and he ordered it withdrawn one centimeter. [tr., pp. 170-172; ex. 1, p. 9]

18. A radiologist reviewed the x-ray the following day and reported "There is a tube which extends to about the level of the diaphragm which is probably in the esophagus." [ex. 1, p. 6]

CONCLUSIONS OF LAW

I. The Medical Examining Board is the legal authority responsible for issuing and controlling licenses to practice medicine and su in Wisconsin, under sec. 448.02, Stats., and it has jurisdiction over a hearing regarding allegations of unprofessional conduct, u sec. 448.02 (3), Stats.

II. The Medical Examining Board has personal jurisdiction over the Respondent, Walter R. Boisvert, M.D., based on his holdir license to practice medicine and surgery issued by the Board, and based on notice under sec. 801.04 (2), Stats.

III. The allegation that Dr. Boisvert's treatment of patient M.S. "was conduct that tended to constitute a danger to patient M.S. in that he attempted the resuscitation of patient M.S. with an improperly placed endotracheal tube, creating the unacceptable risk of inefficient or ineffective artificial respiration and prolonged oxygen deprivation or deficiency, and hypoxic injury or death" was not proven by a preponderance of the evidence.

IV. The allegation that Dr. Boisvert's treatment of patient M.S. "was conduct that tended to constitute a danger to patient M.S. in that he failed to correctly apply anatomical fact to the interpretation of the radiograph he ordered, creating the unacceptable risk that he would fail to recognize or correct the improper placement of an endotracheal tube in his patient's esophagus, leading to prolonged oxygen deficiency or deprivation, and hypoxic injury or death" was not proven by a preponderance of the evidence.

ORDER

THEREFORE, IT IS ORDERED that the Complaint in this matter be DISMISSED.

ANALYSIS

This disciplinary case arose from a medical emergency involving the respondent, Walter Boisvert, M.D., on the night of J 23rd and 24th, 2001. The medical emergency is described in the Findings of Fact above, only two of which (14 and 16) are in dispute. In general, the care provided by the medical team including Dr. Boisvert was excellent: an infant that some witnesses described as stillborn was successfully resuscitated.

The only issues are as follow:
1. whether the x-ray taken in this case shows the endotracheal tube in the trachea or in the esophagus. After reviewing all the evidence and testimony, I conclude that the x-ray shows that the endotracheal tube was most likely in the esophagus at the time x-ray was taken.
2. whether it is possible for an endotracheal tube properly inserted into the airway of a newborn to become dislodged. After reviewing all the evidence and testimony, I conclude that it is possible.
3. whether the placement of the endotracheal tube in the x-ray taken at midnight was a material element in the care of the newb 12:25 A.M. when it was delivered and viewed. After reviewing all the evidence and testimony, I conclude that it was not.

The hearing consisted almost entirely of testimony from five expert witnesses in addition to Dr. Boisvert himself: Dr. Mar Timmerman for the prosecution and Drs. Harry Farb, Charles Stanley Greenhouse, Steven Ringer, and Howard Thalacker for t defense. All of the witnesses including Dr. Boisvert and the hospital radiologist agreed that the x-ray shows that the endotrache tube either was or was "probably" in the esophagus. Dr. Timmerman stated that it was in the esophagus. [tr., pp. 43-44, 49, 5 Dr. Boisvert said when he looked at it on a view box for the first time at a deposition 10 days before the hearing, "the endotrac tube is deeper than I thought that it was" [tr., pp. 174-175], and he agreed with the radiologist's report that said "There is a tu which extends to about the level of the diaphragm which is probably in the esophagus" [tr., pp. 185-186], though he said that without a lateral view x-ray he could not state definitively where it was [tr., p. 169]. Dr. Timmerman was the only witness who testified that it is impossible for a properly inserted endotracheal tube to be dislodged. All of the witnesses except Dr. Timmern expressed the opinion that Dr. Boisvert's actions did not constitute a danger or pose unacceptable risks to the patient.

The legal standard to be applied in this case is that described in Gilbert[1] as clarified in Gimenez[2], which says that for e disciplinary allegation, the Medical Examining Board must state the following five elements and explain the evidence that relates each:
(1) what course of treatment the physician provided;
(2) what the minimum standards of treatment required;
(3) how the physician's treatment deviated from the standards;
(4) how the treatment created an unacceptable level of risk; and
(5) what course of treatment a minimally competent physician would have taken.

Testimony supporting the allegations was presented by Mark Timmerman, M.D. Dr. Timmerman is a clinical assistant professor of sports medicine at the U.W. Medical School. [tr., p. 109] He is qualified in the medical specialty of family medici and he practiced obstetrics as a family practice physician for 14 years at St. Mary's Hospital, during which time he took a cour and obtained certification in neonatal resuscitation. [tr., p. 40] He is also qualified in the medical specialty of sports medicine. p. 38] Between 1993 and 2007, he practiced at the Dean clinic, where 50% of his practice was sports medicine, and at most was obstetrics. [tr., p. 99] Since February of 2007, he has done no obstetrical work other than prenatal care until the third trimester. [tr., pp. 103-4] He has never intubated a newborn [tr., p. 104]. Since his residency he has never had an occasion t order and view a chest x-ray of a newborn in order to assess the proper placement of an endotracheal tube. [tr., p. 105] Sinc residency he has never worked in an emergency room or provided emergency services. [tr. p. 105] He is board certified in fa practice but not in neonatology, anesthesiology, or radiology. [tr., p. 105] He testified once before as an expert witness in a c

involving prolotherapy (the injection of a sugar-water solution into joints). [tr., pp. 110-111]

Dr. Timmerman expressed the opinion that the endotracheal tube was inserted into the patient M.S.'s esophagus from th beginning [tr., 111-114]. One basis for this opinion was that there was some air in the stomach and small intestine [tr., p. 44], e though he agreed that the x-ray also shows that the lungs are expanded. [tr., p. 120] He also stated that M.S.'s oxygen satura improved because she was in an oxygen-rich environment, because infants are better able to use oxygen than adults are, and because "I assume that she was breathing on her own". [tr., p. 80] This latter assumption was inconsistent with the nursing not [ex. 1, p. 10] which record "Ø Resp effort spontaneously" until 2336, 26 minutes after the tube was inserted and bagging bega Dr. Timmerman appeared to have worked backward in his analysis and to have based his opinion on the radiologist's report wh says the tube is "probably in the esophagus". [tr., pp. 47, 119 ff] Dr. Timmerman confirmed this by his own reading of the x-r Indeed, in hindsight and on a viewbox, the x-ray shows the endotracheal tube to most likely be in the esophagus. This is becau one of the supposedly radiopaque lines on the tube is just barely visible down the midline of the body, which would be consiste with placement in either the trachea or the esophagus, but the fact that it extends down to the level of the diaphragm makes placement in the trachea very unlikely. Dr. Timmerman concluded that Dr. Boisvert should have known from the beginning that endotracheal tube was inserted in the esophagus, and that he created "the unacceptable risk of inefficient or ineffective artificial respiration and prolonged oxygen deprivation or deficiency, and hypoxic injury or death" by not removing and inserting it properly. Dr. Timmerman did not explain h Dr. Boisvert should have known that it was inserted improperly prior to 12:25 A.M. when the ray arrived. Nothing in the testimony or in the medical records would lead a physician to th conclusion: all of the objective clinical information -- the lung sounds, the lack of stomach sounds or distention, and the improvements in O2 level, respiration, pulse, blood pressure, and color -- indicated that the tube was properly placed.

Dr. Timmerman rejected the possibility that the endotracheal tube might have become dislodged from the trachea into esophagus shortly before the x-ray was taken when M.S. was picked up in order to place dry blankets under her, and picked u again to position the x-ray plate under her. In rejecting such a possibility he expressed the opinion that it is impossible for a pro placed endotracheal tube to be dislodged from the trachea into the esophagus. [tr., pp. 110-114] This opinion was disputed b Boisvert [tr., pp. 160-161], Dr. Greenhouse [tr., pp. 274-275], and Dr. Ringer [tr., pp. 301-304]. Dr. Ringer said

> "If that tube for some reason -- now, at the other end, the tube is, is either held at the lip or secured at the lip with some t but particularly in the context of a resuscitation -- the fixation of that tube is often tenuous, because the baby is wet, there secretions, and it, it's sort of the best that any of us can do. And even if it were well affixed to the lip, the tissues of the b are easily distensible, moved. So with all that as background, if the endotracheal tube is placed into the trachea and it's something like that distance [gesturing] down into the trachea and it's for some reason moved backwards by just that tiny amount -- one to two centimeters, I guess I should specify it since it's hard for you to type that -- if it's then pushed back down, even if it's pushed back down, it's not going to go into the trachea. Anatomically it will go into the esophagus eve time. So it's a, unfortunately it's a common event for endotracheal tubes to become dislodged during the conduct of resuscitation, and it's something that we teach people to worry about in their resuscitation and to consider, but it happens unfortunately, rather easily under these situations.
>
> Q: And Doctor, during your twenty-plus years of practice as a neonatologist, have you had that happen to you, specifical dislodging the endotracheal tube?
>
> A: Yes."

[tr., pp. 302-304] and Dr. Greenhouse said

> "My experience is that definitely does occur and, of course, I go to many conferences, many combined conferences with neonatologists and obstetricians, and all the time you hear about displacement of the endotracheal tube going from the tra to the esophagus. The esophagus is just behind the trachea, and if the tube comes out, it can easily slip into the esophagu which is right behind it, and there are numerous articles that I have read over the years and my experience in talking with people that this is not uncommon to have."

[tr., pp. 274-275]

Dr. Farb [tr., pp. 190-240] practices medicine in Minnesota. He is board certified in obstetrics, gynecology and maternal fetal medicine. He has practiced for 39 years and during that time has delivered thousands of babies and been involved in many situations involving neonatal resuscitation, including ones that required endotracheal intubation, though he has not personally inserted an endotracheal tube in over 30 years. He provides consulting services regarding obstetrical complaints to the Minnesota Board of Medical Practice. He stated that the term used in reviewing a physician's work in Minnesota is "standard of care" rather than "minimum competence". Dr. Farb agreed that when viewed carefully, the x-ray taken at midnight shows that "the ET tube clearly appears to be too low" [tr., p, 225] and that one of the three supposedly radiopaque lines on the tube "extends down to the diaphragm" [tr., p. 236], but that even on viewbox, the lines can't be clearly seen. [tr., p. 239] Dr. Farb expressed the opinion that M.S.'s positive response to the resuscitation efforts meant that it was not possible that the endotracheal tube was inserted in the esophagus from the beginning. [tr., p. 204] He stated that there is no way to have proper oxygenation with an esophageal intubation, unless the baby is breathing on its own, which it was not doing initially. [tr., p. 223]. Dr. Farb expressed the opinion that Dr. Boisvert did not deviate from the standard of care, that he provided a minimal level of competence, and that he did not subject M.S. to an unacceptable risk of harm in his review of the x-ray because of the totality of the circumstances when he received it. [tr., pp. 213-214]

Dr. Greenhouse [tr., pp. 250-289] is on the academic staff at Holy Cross Hospital in Maryland, an affiliate teaching

hospital of the George Washington University Medical School, where he teaches obstetrics and gynecology. Dr. Greenhouse stated that the diaphragm will be higher up upon expiration than at other times, so the x-ray can give a false picture of where the tube is in relation to the diaphragm [tr., p. 282] but that upon careful review, he thinks the radiologist was correct [tr., p. 285]. Dr. Greenhouse expressed the opinion that "it would have been impossible for this baby to have progressed the way it was and get to 2346 if this baby was intubated in the esophagus as opposed to the trachea." [tr., p. 266] He said that "it wasn't important where the endotracheal tube was at that particular time, at 0025" [tr., p. 287], that he would have glanced at the tube, but that it would have been secondary [tr., p. 272-273] and that there was no need to know where it was. [tr., p. 288-289] Dr. Greenhouse expressed the opinion that the care provided by Dr. Boisvert was well above the normal standard of care and that he did not expose M.S. to an unacceptable risk of harm or danger. [tr., p. 275]

Dr. Ringer [tr., pp. 290-350] is the Chief of the Division of Newborn Medicine at Brigham and Women's Hospital in Boston, and he has an academic appointment at Harvard Medical School. He is board certified by the American Board of Pediatrics in neonatal, perinatal medicine. Dr. Ringer stated that upon careful review of the x-ray on a viewbox he agreed with the radiologist's opinion that the tube is probably in the esophagus. [tr., pp. 318-319] He expressed the opinion that it was "inconceivable" to him that M.S. was not properly intubated initially [tr., pp. 300-301, 308] and that lifting the baby to place dry blankets underneath and then lifting the baby to position the x-ray film could have dislodged the endotracheal tube. [tr., pp. 3099-310] Dr. Ringer expressed the opinion that Dr. Boisvert's actions and specifically his review of the x-ray were within the standard of care of a minimally competent physician and that he did not create an unacceptable risk of harm to M.S. [tr., pp. 319-322]

Dr. Thalacker [tr., pp. 351-377] is licensed in Wisconsin and employed at The Midelfort Clinic in Chetek, which is part of the Mayo Health Systems. He has been board certified in family practice for over 30 years. He has delivered hundreds of babies and been involved in approximately five neonatal resuscitations, three of which involved placement of an endotracheal tube. He stated that the purpose of neonatal resuscitation is "to get the infant back breathing, heartbeat up to standards and oxygenate the infant, and allow his or her cardiovascular and neurologic systems to recover to a standard level of life." [tr., p. 355] Dr. Thalacker testified that there was no indication that would cause a reasonably prudent physician to be concerned about an endotracheal intubation in the esophagus [tr., p. 362] and he expressed the opinion that Dr. Boisvert met the standard of care of a minimally competent physician [tr., p. 359], that he did not deviate from the standard of care [tr., p. 368], and that he did not create any undue risk or harm to the infant [tr., p. 372].

Kurt Jorgensen, M.D. [tr., pp. 377-386] presented character testimony for Dr. Boisvert.

When experts present conflicting testimony, the number on each side is not determinative -- one side is not more persuasive simply because five doctors are lined up against one -- what matters are the experts' qualifications and experience, and the logic and consistency of their testimony. In this case the expert witnesses supporting Dr. Boisvert are more specialized and qualified in obstetrics, gynecology and neonatology than Dr. Timmerman. They have more experience in neonatal resuscitation than Dr. Timmerman. Their testimony was logical and consistent both with the medical records and among themselves. As a consequence, I find the two opinions expressed by Dr. Timmerman -- first, that it would be impossible for the tube to become dislodged and second, that the child was therefore improperly intubated from the beginning -- to be less persuasive than the opposite opinions expressed by the witnesses for Dr. Boisvert.

I find that the greater weight of the credible evidence favors the conclusion that it is possible for a properly placed endotracheal tube to be dislodged from the trachea to the esophagus. I also find that the greater weight of the credible evidence favors the conclusion that the endotracheal tube was not placed in the esophagus from the beginning.

The most likely explanation for the events of July 23-24, 2001 is as follows:
- that the endotracheal tube was properly placed initially in M.S.'s trachea, since all the clinical signs confirm that,
- that Dr. Boisvert ordered an x-ray at 11:55 P.M. because M.S.'s vital signs were reversing and going down,
- that the tube was dislodged from the trachea to the esophagus either when M.S. was moved to place dry blankets under her or when she was moved again to place the x-ray film under her just before the x-ray was taken,
- that by 12:25 A.M. when the developed x-ray arrived, M.S. was making her own respiratory efforts, the vital signs were going back up, the reason for taking the x-ray was gone, and the team was no longer concerned with possible impediments to effective respiration, and
- that the team took a look at the x-ray but saw nothing to be concerned about.

It is true that looking at the x-ray under suboptimum lighting conditions Dr. Boisvert and two other professionals failed to notice a very hard-to-see detail, and if the baby had been in respiratory distress at that point, a more careful reading of the x-ray would have been in order, but given the fact that all objective clinical signs at 12:25 A.M. showed that the baby was being successfully resuscitated, the location of the endotracheal tube was of no medical significance and the failure to take a closer look at the location of the tube was unimportant to the treatment of the patient. Under such circumstances, Dr. Boisvert's treatment did not deviate from acceptable medical standards or fall below minimum standards of treatment, and his treatment did not create an unacceptable level of risk or constitute a danger to the health, welfare or safety of the patient.

The first charge was that Dr. Boisvert's treatment of patient M.S. "was conduct that tended to constitute a danger to patient M.S. in that he attempted the resuscitation of patient M.S. with an improperly placed endotracheal tube, creating the unacceptable risk of inefficient or ineffective artificial respiration and prolonged oxygen deprivation or deficiency, and

hypoxic injury or death." This charge was not proven.

The second charge was that Dr. Boisvert's treatment of patient M.S. "was conduct that tended to constitute a danger to patient M.S. in that he failed to correctly apply anatomical fact to the interpretation of the radiograph he ordered, creating the unacceptable risk that he would fail to recognize or correct the improper placement of an endotracheal tube in his patient's esophagus, leading to prolonged oxygen deficiency or deprivation, and hypoxic injury or death." The phrase "failed to correctly apply anatomical fact to the interpretation of the radiograph" suggests that Dr. Boisvert saw the low placement of the endotracheal tube but failed to realize that it was too low to be in the esophagus; as written, the charge was definitely not proven. However, even if the charge were revised to allege that Dr. Boisvert endangered the patient by failing to see the low placement of the endotracheal tube, the charge was still not proven.

I recommend that the complaint be dismissed.

With regard to costs, if the Board adopts the recommendation to dismiss this case, none of the Department's costs may imposed on Dr. Boisvert, but another issue could arise. The procedural rules for disciplinary cases provide that a respondent w prevails may file a motion to recover his costs, and that such costs shall be awarded unless the Department was substantially jus in taking its position or unless other circumstances exist that would make the award of costs unjust. In order to provide guidan the Board and to the respondent on this point, should such a motion be filed it would be my opinion that – based on the testimo a qualified expert witness -- the Department was substantially justified in its position.

There is one other issue that could become relevant in the Board's deliberations if objections are filed to this Proposed Decision. In his closing statement, Mr. Polewski argued that Dr. Boisvert poses a continuing danger to the public, and that he requires remedial education, because even at the hearing he said he did not know where the tube was positioned. I believe this to be an incorrect characterization of Dr. Boisvert's testimony. Dr. Boisvert said that he agreed with the radiologist who, even viewing the x-ray under the best of conditions, only said that the tube was "probably" in the esophagus. [tr., pp. 185-186] In addition, Mr. Polewski argued as follows:

> "... it's a major agreement between all of the experts. It is undeniable, absolutely unquestioned. Everyone agrees that at the time that x-ray was taken, 11:55 according to the tag, 11:59 according to some other testimony, that the endotracheal tube pictured is in the esophagus, not in the trachea."

[transcript of 4-27-09 proceedings, p. 14] The hearing record instead reflects the following. Dr. Farb testified that "the ET tube clearly appears to be too low" [tr., p, 225] and that the tube "extends down to the diaphragm" [tr., p. 236], but he did not express the opinion that the x-ray showed the endotracheal tube in the esophagus. Dr. Greenhouse testified that he thinks the radiologist was correct, meaning that the tube was probably in esophagus. [tr., p. 285] Dr. Ringer testified that he agreed with the radiologist's conclusion that the tube is "probably in the esophagus". [tr., pp. 318-319] Dr. Thalacker testified that "it is impossible to know exactly the position of that endotracheal tube precisely. You need a lateral view in order to ascertain the exact location of it." [tr., p. 370] Dr. Boisvert's position was not out of line from the opinions expressed by the other witnesses, except Dr. Timmerman, and it is my opinion that he does not pose a continuing threat to the public or require remedial education for being unwilling to be more certain of the tube placement than the radiologist was.

Dated and signed: May _____, 2009

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Nick Schweitzer
Administrative Law Judge
Department of Regulation and Licensing

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[1] Gilbert v. Medical Examining Board, 119 Wis.2d 168, 349 N.W.2d 68 (1984).
[2] Gimenez v. State Medical Examining Board, 203 Wis.2d 349, 552 N.W.2d 863 (Ct.App., 1996).