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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
PAUL ELWOOD HUEPENBECKER, M.D., RESPONDENT.	:	ORDER 0000302

Division of Enforcement Case Nos. 07MED190 and 08MED043

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

Paul Elwood Huepenbecker, M.D.
West Clinic
752 N. High Point Road
Madison, WI 53717

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

Wisconsin Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Paul Elwood Huepenbecker, M.D. (DOB December 7, 1954) is duly licensed and currently registered to practice medicine and surgery in the state of Wisconsin under license number 24699-20. This license was first granted on July 2, 1982.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 752 N. High Point Road, Madison, WI 53717.

3. On April 13, 2005, Respondent performed a bilateral laparoscopic hernia repair and umbilical hernia repair on a 63 year-old male. Patient had two prior major intra-abdominal surgeries and the patient was appropriately informed that Respondent would use a laparoscopic approach to the surgery, but that open incisions could be required with a mesh-based repair. The procedures were performed in an outpatient surgical center. During surgery, a malfunctioning cautery device left a 3mm burn on the patient's anterior abdominal wall in the upper right abdomen. Respondent appropriately identified the burn. Patient was discharged after surgery.

4. On April 14, 2005, at 7:57 a.m., the patient reported to an emergency room with diffuse abdominal pain, right shoulder pain, mild nausea and vomiting. Evaluation revealed a low-grade fever, mildly distended tender abdomen and mildly elevated white blood cell count of 12.6. When he presented at the ER, patient had been experiencing symptoms for approximately ten hours, his pain was not controlled with Percocet. Patient had not passed flatus, had been burping, and his pain was aggravated in supine position. Patient was treated with morphine, Toradol, and Phenergan for pain and nausea. Patient continued to complain of abdominal fullness and discomfort. A radiology report concluded postoperative changes with free intraperitoneal air. There was no evidence of a bowel obstruction.

5. The patient was admitted to the hospital by the emergency room physician, under Respondent's care, after discussing the case with Respondent. Respondent noted in the chart on April 14, that the patient's picture was "consistent with ileus".

6. On April 15, the patient was noted to be feeling better and was afebrile. Respondent saw the patient and noted he was "still with ileus" and was maintained NPO until flatus.

7. On April 16, 2005, the patient had developed a low grade fever overnight and the patient was evaluated by Respondent's partner. A CT scan was ordered and intravenous antibiotics were begun.

8. On April 16, 2005, at 2:45 p.m., another general surgeon ordered a CT scan of the abdomen and pelvis, with IV and oral contrast. The report included:

> 1. Fluid & air pockets at multiple sites within the abdomen, particularly adjacent to the right lateral aspect of the liver and extending caudally along the perioicolic gutter. While some air and fluid would be expected postoperatively, clearly there is some degree of loculation and complexity of this raising a concern of possible infection or hemorrhage.
> 2. Several small probably cysts of the liver.
> 3. Probably small gallstone within the gallbladder.
> 4. Evidence of prior prostatectomy.
> 5. Mild to moderate right pleural effusion and right lower lobe infiltrates noted.
> 6. Small left pleural effusion and mild dependent atelactasis in the left lung base.

9. The patient began receiving IV antibiotics during the afternoon of April 16 (Unasyn 3g IV q 6 hrs. Ampicillin-Sulbactam 3g/Dextrose 5% water 100 ml), as ordered by a Resident and co-signed by Respnodent's partner.

10. The patient did get better over the ensuing days and his fever and ileus resolved.

11. On April 22, 2005, Respondent discharged the patient with the following summary:

> Abdominal x-rays were taken which were consistent with ileus: therefore, he was admitted, placed on IV fluids, and kept NPO since he was felt to have an ileus. By the next day his white count had normalized. Although he was still not passing gas, he was kept NPO but continued to have low-grade fevers. A CT scan was obtained which showed some loculated free air and free fluid and he was started on IV antibiotics. Over the next several days, he did start to have flatus and bowel movement, was started on sips of clear liquids, had one episode of bright red blood in his stool; but vital signs remained stable and had no more episodes after this. Over the next several days, he remained afebrile and was tolerating diet; and therefore, he was discharged home.
>
> **Principle Diagnosis:** Digestive system complications not elsewhere classified.
> **Secondary Diagnoses:** Paralytic ileus, blood in stool, hyperlipidemia, tobacco use disorder, personal history of malignant neoplasm of the prostate.

12. Respondent maintains that during the admission patient had no evidence of a leak or absess, but rather a paralytic ileus which resolved nicely by the time of discharge. In Respondent's opinion, CT findings were consistent with infection or localized hemorrhage.

13. On April 25, 2005, the patient's wife called Respondent's office to report a fever of 100 during the night and now 98.6. She spoke with a nurse. The nurse's note indicated:

> Patient called about fever last night of 100 and this AM of 98.6. Had difficulty sleeping since hospital discharge. Was taking one Oxycodone every 6 hrs and antibiotic. Had pain in abd, a "tightening feeling" after he eats which makes it difficult to breathe. At times will feel pretty good. Was passing flautus and had regular BMs. Suture lines did not have redness or drainage. Will begin Ibuprofen 600mg ID and use heat to abd when it feels tight, they will continue to monitor temp, and call back w/concerns.

14. On April 27, 2005, the patient was not eating, had a fever and pain on his right side. The patient's wife came to the clinic and spoke with a nurse who spoke with Respondent over the phone. He recommended that the patient be seen, probably in the ER. In the ER he was noted to be tachycardic, had loose stools and an elevated white blood cell count. A CT scan at the time was abnormal, showing a large amount of free air under the right diaphragm. Patient was admitted to the hospital that night by Respondent's partner. Respondent saw him the following morning and scheduled immediate surgery.

15. Respondent performed an exploratory laparotomy and drainage of an intraperitoneal abcess. Respondent's operative report of April 28, 2005, stated in relevant part:

> CT scanning was somewhat confusing but appeared to show either an abscess or free air in the right upper quadrant. This was repeated again today and there did not appear to be a breach within the colon but again it was felt that there was an abscess including interloop abscess."
>
> **Procedure:** "....in the midline exiting to the right abdomen there was noted to be significant inflammation. This was digitally dissected and the abscess cavity ultimately was identified by a gush of a greenish, foul-smelling fluid. At first it was difficult to tell whether the abscess cavity actually contained the transverse colon. I discussed with Dr. Andres the CT finding which again did not reveal an obvious breach of the colon. Ultimate with full dissection it was felt that the colon itself was deep to the abscess cavity. At no time during the course of this procedure was any leak identified. It was felt best to remove the previously placed mesh; this was done after carefully dissecting both groins. A fairly large fluid collection was present in the right groin region.....As much of the bowel as possible was run again. There was no evidence of any type of success leak of any type. It was felt that there probably was some type of a leak that had sealed and at this point was simply not able to be identified. It was then felt the best strategy at this point was to drain the 2 areas of significant abscess..."

16. Patient had a lengthy course in the ICU. On June 9, 2005, the patient was discharged. The following is from the discharge summary:

> "...At the time of his presentation, [a general surgeon] was called to evaluate him, and found him to be suffering a white count of 12.7 and a repeat CT scan of the abdomen shows a large air fluid collection on the right side of the abdomen, which the radiologist did not feel looks like a classic abscess, but did feel that there was something clinically suspicious...[Patient] was admitted...and placed on IV antibiotics to be evaluated by his primary surgeon, [Respondent] the following morning...[Respondent] diagnosed him as suffering from a likely bowel perforation and abscess. Immediate surgery was recommended...Findings at the time of surgery showed a large loculated abscess extending from the right scrotum all the way to the right subdiaphragmatic space...thorough exam of the abdomen did not show an obvious leak. ..intraoperative cultures grew Klebsiella...surgical wound became infected requiring removal of the wound staples in 2 places...
>
> **Principal Diagnosis:** Intraabdominal abscess.
> **Complications:** Postoperative sepsis requiring prolonged mechanical ventilation, extended intensive care unit stay related to number one, superficial wound infection, and line sepsis with methicillin-resistant Staphylococcus aureus.

17. Between April 15, 2005 and April 16, 2005, Respondent exhibited unprofessional conduct by failing to order a CT scan and implement antibiotics earlier. On April 25, 2005,

Respondent exhibited unprofessional conduct because he did not direct the nurse to have the patient come in and be seen that day by himself or one of his partners. Failure to do so created an unacceptable risk that a postsurgical complication would not be timely diagnosed.

18. Respondent is currently medically unable to perform surgery and has voluntarily relinquished the practice of surgery.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in the conduct set out above is in violation of Wis. Admin. Code § Med 10.02(2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

IT IS HEREBY ORDERED that Paul Elwood Huepenbecker, M.D. is hereby REPRIMANDED.

IT IS FURTHER ORDERED that:

1. If, at any time in the future Respondent's health improves and he believes he is medically able to resume surgical practice, Respondent shall first provide the Medical Examining Board with a statement from his physician indicating that he is medically able to perform surgery. Respondent shall, prior to commencing surgical practice, take whatever continuing education the Board at that time determines is necessary to assure Respondent is capable of providing competent surgical care, including postoperative care.

2. Respondent shall, within sixty (60) days from the date of this Order, pay costs of this proceeding in the amount of one thousand four hundred fifty ($1,450.00) dollars.

3. Payments due shall be made payable to the Wisconsin Department of Regulation and Licensing. Any notification of intent to resume surgical practice and payments shall be mailed to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, Wisconsin 53708-8935

All materials and payments to be filed with the Medical Examining Board will be deemed filed upon receipt by the Department Monitor.

4. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit (payment of the costs or payment of the forfeiture as ordered or fails to comply with the ordered continuing education) as set forth above, the Respondent's license (No. 24699-20) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with (payment of the costs or forfeiture or completion of the continuing education).

5. It is further ordered that 08MED043 be closed for prosecutorial discretion.

6. This Order is effective on the date of its signing.

MEDICAL EXAMINING BOARD

By: S/Raik 7/21/10

A Member ~~of the Board~~ Date