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Before The
State Of Wisconsin
MEDICAL EXAMINING BOARD

In the Matter of the Disciplinary Proceedings
Against **BASHIR A. SHEIKH, M.D.**, Respondent

FINAL DECISION AND ORDER
Order No. _____

Division of Legal Services and Compliance Case No. 10 MED 201

000278

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, make 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 at Madison, Wisconsin on the 20 day of November, 2013.

Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION AND ORDER
BASHIR A. SHEIKH, M.D., RESPONDENT	:	DHA CASE NO. SPS-12-0010
	:	0002781

Division of Legal Services and Compliance[1] Case No. 10 MED 201

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

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PROCEDURAL HISTORY

On January 9, 2012, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), filed a formal complaint against Respondent Dr. Bashir A. Sheikh alleging that Dr. Sheikh engaged in four counts of conduct which constituted a danger to the health, welfare, or safety of a patient or the public, which is unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h), with regard to Patients S.H., D.M., H.M.,

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

and B.K.; and that he also engaged in unprofessional conduct by failing to maintain healthcare records consistent with the requirements of Wis. Admin. Code § Med 10.02(2)(za) for Patient H.M. (Complaint, filed on January 9, 2012, ¶¶ 8, 12, 20, 21, 27)

On or about February 13, 2012, counsel for Dr. Sheikh (Attorney Brian Mahany) filed an Answer to the Complaint, denying any professional misconduct. (Answer, filed on February 13, 2012) On March 5, 2012, Attorney Erik Monson indicated he would be taking over representation of Dr. Sheikh. On May 30, 2012, a prehearing conference was held by telephone and the administrative law judge (ALJ), issued a prehearing conference report setting a hearing for November 12-15, 2012 and deadlines for preliminary witness disclosures (August 15, 2012), final witness disclosures (October 26, 2012) and the filing/exchanging of exhibit lists and exhibits (October 26, 2012).

On August 1, 2012, Attorney Monson filed a Motion to Withdraw as Counsel and a Motion for Relief from Scheduling Order. On August 10, 2012, the ALJ issued a Briefing Order and Order Granting Motions to Withdraw as Counsel and to Modify Scheduling Order. In that Order, the ALJ set September 14, 2012 as the deadline for Dr. Sheikh to file a motion to dismiss.

On or about September 18, 2012, Dr. Sheikh, appearing *pro se*, filed a Motion to Dismiss. The hearing on Dr. Sheikh's Motion to Dismiss was held on October 22, 2012. The ALJ issued an order denying Dr. Sheikh's motion to dismiss on October 31, 2012. Dr. Sheikh suggested at the motion hearing that if his motion was denied, he would not attend the scheduled hearing on the merits but would instead file a discrimination claim. (Transcript of October 22, 2012 Motion Hearing, pp. 57, 66-68)

The hearing commenced, as scheduled, on November 12, 2012, in Madison, Wisconsin, at which time Dr. Sheikh did not appear for the hearing. Approximately one half-hour after the time scheduled for hearing, the Division's attorney received a note indicating that Dr. Sheikh

would not be attending because he was ill. The hearing was held and the Division rested its case on November 13, 2012. On or about December 17, 2012, Attorney Paul Erickson filed a Notice of Appearance on Dr. Sheikh's behalf.

On January 8, 2013, the Division filed an Amended Complaint based on the November 12-13, 2012 hearing testimony of Megeen Parker, M.D. The specific allegations of unprofessional conduct contained in the Amended Complaint were as follows:

1. In his treatment of Patient S.H., Dr. Sheikh failed to document the skin exam.
2. In his treatment of Patient D.M., Dr. Sheikh failed to examine Patient D.M. prior to ordering Haldol and diagnosed manic disorder without any supporting exam findings.
3. In his treatment of Patient H.M., Dr. Sheikh failed to maintain healthcare records regarding his involvement in Patient H.M.'s care; failed to order additional x-ray views to fully evaluate the cervical spine; and discharged Patient H.M. to home with elevated cardiac enzymes.
4. Dr. Sheikh failed to note an obvious clavicle fracture during the initial and second clinical examinations of Patient B.K. and missed an obvious acute clavicle fracture on the x-ray taken during the second admission.

(Amended Complaint, ¶¶ 6, 11, 17, 25)

A status conference was set for January 17, 2013, at which time the parties discussed whether a continued hearing was necessary. The continued hearing was held on April 3-4, 2013 in Madison, Wisconsin.

FINDINGS OF FACT

1. Bashir A. Sheikh, M.D., date of birth July 2, 1949, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the state of

Wisconsin pursuant to license number 45705-20, which was first granted on June 4, 2003. (Amended Complaint, ¶1; Answer, ¶1)

2. At the time of the events set out below, Dr. Sheikh was employed as an emergency room physician at Grant Regional Health Center (GRHC) in Lancaster, Wisconsin. Dr. Sheikh was employed at GRHC for only 12 days before his employment was terminated on August 31, 2009. (Amended Complaint, ¶4; Answer ¶4; Hrg. Trans. Vol. II, p. 597, line 4; Vol. III, p. 662, lines 7 – 22; p. 690, line 8 – 691, line 20)

3. Dr. Megeen Parker testified at the hearing as the Division's medical expert. Dr. Parker obtained her M.D. in 1986 and became board certified in family medicine in 1990. She has taught residents in the area of family medicine and, in her capacity as a faculty member at the U.W.-Madison's medical residency program, has overseen residents in evaluating ER patients for admission to the hospital. She has served on medical practice review committees and ethics committees. Dr. Parker did a residency rotation in emergency medicine and worked as an emergency room physician in Charleston, South Carolina, for a year.[2] Approximately 60 percent of the medical problems seen in the ER are the same as what is seen in the family practice setting. In her family practice, Dr. Parker has seen cases of folliculitis, skin infections, clavicle fractures, heart problems and injuries from automobile accidents. These are the same medical issues which were present in the ER visits by Patient S.H., Patient H.M. and Patient B.K. (Hrg. Trans. Vol. I, p. 143, lines 5-16; p. 144, line 12 - p. 145, line 5; p. 145, line 22 - p. 147, line 17; p. 149, line 1- p. 150, line 9; p. 151, line 4 - p. 152, line 2; Exh. 16)

[2] Counsel for Dr. Sheikh states that Dr. Parker has been "discredited" by a Wisconsin circuit court "as her testimony relates to emergency medicine." In support, he cites a decision purportedly from Judge Bastianelli in *Manlove v. State Med. Examining Bd.*, 2006CV361 (Kenosha County Cir. Ct., April 30, 2007). However, counsel has not provided the decision to the ALJ so that counsel's assertions may be verified, it is not this ALJ's responsibility to seek the decision from the circuit court or to create a party's record, and under these circumstances, the decision is inappropriate for official notice under Wis. Stat. § 227.45(3) as it is not a "generally recognized fact" or an "established technical or scientific fact."

4. Dr. Sheikh's medical expert witness at the hearing was Dr. John Dunn. At the time of the hearing, Dr. Dunn had been practicing medicine for 42 years, 39 of which were in emergency medicine. He is board certified in emergency medicine and has been board certified in family practice, though he has not recertified in family practice since 1989. He also received his law degree in 1979. (Hrg. Trans. Vol. III, p. 768, line 19 - p. 769, line 2; Exh. 39)

FACTS RELATING TO PATIENT S.H.

5. Patient S.H. presented to the GRHC emergency room (ER) on August 19, 2009, with a primary complaint of a rash to his right lower extremity. The rash had been dime-sized one week prior and had now spread. Angela Pagenkopf was the triage nurse who performed the initial evaluation of Patient S.H. In addition to her nursing duties, Nurse Pagenkopf is also the ER manager. She has worked as an ER nurse at GRHC since 2000, during which time she has seen a "fair amount" of MRSA[3] cases at GRHC. She took photographs of Patient S.H.'s rash because skin rashes are difficult to describe on paper. Nurse Pagenkopf testified that she "definitely" considered a MRSA infection as a potential cause of the rash based on the rapid spread of the rash over the course of one week, and that this was potentially one of the reasons that she took the photographs. (Hrg. Trans. Vol. I, p. 37, lines 18-25; p. 41, lines 1-20; p. 49, lines 3-14; Exh. 11, p. 2; Exh. 13)

6. Dr. Sheikh then examined Patient S.H. Both Nurse Pagenkopf and Dr. Sheikh documented their examinations and findings regarding Patient S.H. using "T-sheets," which, according to Dr. Dunn, is a template invented in the early 1990s and is currently used in more than 500 hospitals in the United States.[4] The T-sheets contain items for physicians and nurses to check off in order to ensure that their care is appropriate to the chief complaint, items that they

[3] Staph aureus infections which are resistant to methicillin are known as Methicillin-Resistant Staph Aureus, or "MRSA." (Hrg. Trans. Vol. I., p. 157, lines 13-25)

[4] Dr. Dunn testified there are approximately 5,000 hospitals in the Unites States. (Hrg. Trans. Vol. III, p. 780, lines 21-22)

"should think about when they're looking at a patient with a particular kind of complaint." According to Dr. Dunn, there are about 50 different types of T-sheets for various conditions and even T-sheets for procedures, such as fixing a laceration.[5] Dr. Dunn testified that the benefits of using the T-sheet include reminding doctors that they need to document, reducing the risk that something important will be missed, and providing the hospital with a way to bill for the services provided. (Trans. Vol. IV, p. 775, line 18 – p. 778, line 8; p. 781, lines. 9-16)

7. The T-sheet used by Dr. Sheikh was a T-sheet for "Skin Bite/Rash/Abscess." Under Chief Complaint, Dr. Sheikh wrote, "Develop with small spots at the base of hair follicles, which became confluent as ulcerated with ulcers formation, and a huge patch on the back of his knee and lower thigh." In the T-sheet box under "location," Dr. Sheikh stated that the rash was on the "back of the left thigh, left popliteal region, left calf, and right anterior thigh" and also circled the options "itchy," "painful" and "burning." Under the section entitled, "PHYSICAL EXAM," under the subsection, "General Appearance," he checked "no acute distress" and "alert." Under the subsection "Skin," he checked "warm, dry" and "n[ormal] color."[6] He drew the area affected by the rash on the human body charted under "PHYSICAL EXAM" and drew arrows directly to those three affected areas (the thigh on the front of the leg and the calf and upper leg on the back of the leg) and wrote "folliculitis." In the box under "Clinical Impression," Dr. Sheikh circled "eczema" and also wrote "folliculitis with microabscess formation and ulceration." Dr. Sheikh dispensed Kenalog 0.1% and Triple Antibiotic cream and advised Patient S.H. to apply antibiotic ointment every 12 hours. (Hrg. Trans. Vol. I, p. 174, lines 5-13; Exh. 11, pp. 2-5; Exh. 13, pp. 4-5)

[5] Dr. Dunn testified that the T-sheet was actually invented by his friend, Woody Gandy. (Hrg. Trans. Vol. III, p. 775, lines 18-22)

[6] Dr. Sheikh's finding that the skin was normal in color is inconsistent with the photographs which clearly depict erythema or redness of the skin. (Exh. 13)

8. Under the section "ROS" (Review of Systems), Dr. Sheikh checked the box "all systems neg[ative] except as marked." In that section, he drew slash marks through several items, including, "fever," "chills" and the sections related to lymphatic system. In the "PAST RX" section, he checked the line next to "negative," which appears to apply to all of the items listed in that section. Those include "allergy to poison ivy." In the section, "HPI" (history of present illness), after "Identified cause?", Dr. Sheikh circled "no" and crossed out the items listed in that section under "Exposure (context)." Those items include categories for medication, food and "other." The category "other" includes items such as insect bites, "poison ivy/oak," "infectious illness" and "soap/detergent." (Exh. 11, p. 4)

9. Dr. Sheikh's T-sheet indicates that he had reviewed the nurse's T-Sheet. On his T-Sheet, he checked the boxes for "Nursing Assessment Reviewed" and ""Vitals Reviewed," and circled the option "see nurse[']s note" under the categories, "Medications" and "Allergies." On the nurse's T-sheet, under the section entitled, "CHIEF COMPLAINT," the nurse wrote, "1 week ago had dime sized area of rash" "now has spread." The nurse documented Patient S.H.'s "vitals," including his temperature, weight and blood pressure. Under "EXTREMETIES," the nurse wrote, "rash to posterior anterior right leg and itchy elbow." Under "ADDITIONAL FINDINGS," she wrote, "Varying sizes of blistery spots [with] flat open areas surrounded by inflamed skin." The nurse's T-sheet indicates that photos had been taken and were part of the chart. The nurse wrote, "see photos" under "CHIEF COMPLAINT" and wrote "photos taken" under "ADDITIONAL FINDINGS." The photos clearly show patches of red and darkish spots in the areas described in the T-sheets. (Exh. 11, pp. 2, 4-5; Exh. 13)

10. "Folliculitis" refers to varying degrees of inflammation centered around the hair follicles. Folliculitis can be superficial, but deeper forms or complications of folliculitis can involve an infection which can result in cellulitis or abscesses. Miscroabscess formation and

ulceration implies that the infection has spread beyond inflammation of just the hair shaft opening itself. The most common types of skin infections result from bacteria on the skin, which are predominantly staph and strep species. Staph aureus infections which are resistant to methicillin and a group of penicillins (antibiotics used to treat infections) are known as Methicillin-Resistant Staph Aureus, or "MRSA." Folliculitis can present in "many different ways." Folliculitis tends to be a staph infection and MRSA is merely a staph infection that can be very difficult to treat. Folliculitis can be caused by MRSA. (Hrg. Trans. Vol. I., p. 47, lines 5-8; p. 49, line 25 – p. 50, line 2; p. 156, line 18 – p. 158, line 10; p. 174, line 16 – p. 175, line 11; Exh. 11, p. 2)

11. Dr. Parker testified that Dr. Sheikh did not meet the minimal standard of competency with regard to describing Patient S.H.'s skin condition. Dr. Parker opined that Dr. Sheikh's documentation was deficient because it did not note the following: whether there were pertinent negatives, such as fever, chills and leg pain; whether the area was itchy or painful; whether there was draining, pus, induration or thickening; or whether there was potential exposure, such as being around someone with a similar skin infection or exposure to poison ivy. When she realized that Dr. Sheikh had in fact circled "itchy," "painful" and "burning," she testified, "But that's from the patient's account. Painful is not the same as pressing on it and saying it is tender. Is it thickened? Is there a big pocket of pus or an abscess sitting in its thigh [sic] that needs to be drained. That's what's missing."

12. Dr. Parker testified that a skin exam should also include the color of the affected area and the type of skin lesion. She opined that it is important to describe features of the skin infections such as depth of the ulcer, whether the infected area was warm or had oozing, tenderness, crusting, or "streaking along the lymphatic drainage lines leading to the lymph nodes leading to widespread infection if there is one." She also criticized Dr. Sheikh's documentation

because it did not indicate that he viewed the photographs or that he considered MRSA as a possible cause of Patient S.H.'s skin condition. (Hrg. Trans. Vol. I, p. 178, line 14 – p. 181, line 20; p. 201, line 8 – p. 202, line 7; Exh. 11, pp. 4-5).

13. When discussing pertinent negatives, Dr. Parker stated that he "could have simply written healthy, otherwise healthy, noted that this person had no past history of skin infections, had no risk factors, if you believe that in your community, the incidence of MRSA was low was just restricted to those people with risk factors. . . " (Hrg. Trans. Vol. I, p. 185, lines 13- 23)

14. When questioned by the ALJ, Dr. Parker agreed that Dr. Sheikh did not need to document all of the same questions and answers that were already asked by the nurse. However, she stated that he should have written "see nurse's note" or otherwise documented that he reviewed the nurse's notes. She testified that there was "no documentation that he looked at anything other than the medications on the nurse's note and allergies on the nurse's note. So there is no reference to the nurse's note." (Hrg. Trans. Vol. I, p. 197, line 13 - p. 198, line 22)

15. Dr. Parker testified that his failure to adequately document "led to a misdiagnosis." At some points Dr. Parker indicated that Dr. Sheikh's misdiagnosis was "simple folliculitis" and at other points suggested that the misdiagnosis was folliculitis generally, not just "simple" folliculitis. (Hrg. Trans. Vol. I, p. 181, line 8-11; p. 182, line 6; p. 194, lines 2-6)

16. Dr. Dunn testified that Dr. Sheik's treatment of Patient S.H. met the standard of care and that he provided the patient with appropriate treatment. He stated that Dr. Sheikh's documentation with respect to Patient S.H. was "good" and that his records actually show a "certain level of compulsiveness that I think he demonstrated here on the stand." He stated that Dr. Sheikh "doesn't mind going into detail" and that the records are "very topnotch in terms of completeness." With regard to Dr. Sheikh's notes under "Clinical Impression" stating "Folliculitis with microabscess formation and ulceration," Dr. Dunn opined, "I thought that was

pretty grand. I mean, I would have just said folliculitis because it implies those things." Dr. Dunn stated that Dr. Sheikh appropriately documented his examination of Patient S.H. He further opined that the prescribed treatment of Kenalog and Triple Antibiotic was appropriate and that, if the infection was on the surface of the skin, as was the case for Patient S.H., Triple Antibiotic would also take care of any MRSA. (Hrg. Trans. Vol. III, p. 779, line 14 – p. 785, line 6; p. 788, lines 7-16; p. 789, lines 22-24)

17. In referring to the term "folliculitis," Dr. Dunn testified: "It's what we would call tautological, if we were talking with lawyers. It defines itself. If I tell you folliculitis and you're a doctor, then you know what I mean. You might ask me questions about where, how severe it is, but if it's described as folliculitis, it means something. The diagnosis is descriptive, and it is clearly definitive too. So you don't have to say anything more. If you say that the patient has folliculitis, you don't need to say anything more." (Hrg. Trans. Vol. III, p. 782, line 17 - p. 783, line 2)

18. On August 21, 2009, two days following his visit in the ER with Dr. Sheikh, Patient S.H. visited the clinic regarding his rash, which had "started over the last week" but "is spreading very fast." He informed the nurse that the rash was "a little bit better today." The nurse noted that the rash was "quite pruritic" and "quite erythematous." She further noted that Patient S.H. had been diagnosed with folliculitis at the ER on August 19, 2009 and had been prescribed antibiotic ointment and told to pick up over-the-counter triamcinolone cream. The nurse's notes for the clinic visit on August 21, 2009 indicate that she explained contact dermatitis to Patient S.H. and that he was given samples of Avelox and a prescription for Triamcinolone .1% cream. The nurse also ordered a culture, which tested positive for MRSA (Exh. 12, pp. 4-5)

19. On September 8, 2009, Patient S.H. presented to the clinic for a follow-up. According to the nurse's notes, the rash had "subsided substantially." The notes further indicate

that Patient S.H. had finished his antibiotics several days ago but "now finds that several sores are starting to get red and reoccur." The nurse notes that he "has about three red, angry-looking scabs on the anterior aspect of his right thigh," that "the remainder of the rash has pretty much subsided" but that "on his back calf he has about five reddened areas in various stages of appearance, anywhere from 2 mm to 6 mm in size" that "look like they are starting to reappear and not necessarily dissipate." He was prescribed Bactrim DS for the rash. (Exh. 12, p. 3)

FACTS RELATING TO PATIENT D.M.

20. On August 10, 2009, Patient D.M. was brought to the GRHC ER in physical restraints by police. Patient D.M. testified positive for benzodiazepine, cocaine and opiates. His blood alcohol concentration was .258. Dr. Sheikh saw Patient D.M. and noted in his records that Patient D.M. had gotten drunk that evening and had fallen off a porch, telling people around him that he had overdosed himself with 40 tablets of lithium and some unknown number of methadone tablets. Dr. Sheikh noted that Patient D.M. was on lithium for a bi-polar disorder and on methadone for abuse of narcotics. Dr. Sheikh further noted that Patient D.M. had "a long history of maniac [sic] depression which caused acute episodes of agitation." His notes also indicate that Patient D.M. "also has a history of drug behavior where he has been manipulating and sometimes assaulting the law for getting the drugs. He was recently admitted to Mendota and is a regular visitor at that mental hospital." Dr. Sheikh noted that Patient D.M. was "extremely agitated, uncontrollable with hallucinative behavior, which acquires sometimes verbal as well as physical assault." (sic). Dr. Sheikh's "clinical impression" was that Patient D.M. "ha[d] an acute episode of mania, possibly precipitated by cocaine and his original mental disorder." The nurse's notes indicate that Patient D.M. was "out of control" and suicidal. They also indicate that when he was brought in by police in handcuffs, he was screaming, kicking, rocking, swearing and making sexually explicit remarks to GRHC staff and police. He spit in the

nurse's face. Dr. Sheikh ordered that he be administered 5 milligrams of Haldol at 3:30 a.m. and again at 9:25 a.m. He was eventually transferred to Mendota Mental Health Institute, but released sometime prior to August 16, 2009. (Hrg. Trans. Vol. III, p. 671, line 1 – p. 676, line 20; Exh. 42, pp. 1706, 1707, 1710-1712, 1716)

21. Six days later, on August 16, 2009, Patient D.M. again presented to GRHC ER with acute appendicitis and received an appendectomy. There is no indication of any violence or outbursts during this admission. (Exh. 29)

22. On the date at issue, August 23, 2009, at approximately 3:39 a.m., Patient D.M. was again brought into the GRHC ER via ambulance. GRHC Nurses Becky Johnstone and Marie Streif worked together on Patient D.M.'s case, each filling out portions of the nursing triage note. It was their responsibility to triage patients when they initially presented to the ER and to perform an assessment before contacting the physician to see the patient. On that date, Patient D.M. was complaining of a headache, leg pain and nausea. The nurse's notes reflect that Patient D.M. had had an appendectomy less than a week before the August 23, 2009 visit. (Exh. 14, pp. 2-3; Hrg. Trans. Vol. I, p. 57, line 7 – p. 58, line 2; p. 66, lines 9-12; p. 68, lines 12-25; p. 212, lines 11-13)

23. Nurse Johnstone knew Patient D.M. from previous visits to the ER. She was not intimidated or fearful of him and was familiar with how Patient D.M. would put on a "show" when he was looking for pain medications by writhing around on the bed, crying and holding his head or abdomen. Patient D.M. was described in the T-sheet as alert, anxious and restless. Nurse Johnstone had not known him to ever hurt anybody. On August 23, 2009, Patient D.M. was not violent, just restless. Nurse Johnstone was aware that on that date, Dr. Sheikh ordered Haldol for Patient D.M. prior to evaluating the patient. (Exh. 14, pp. 203; Hrg. Trans. Vol. I, p. 59, line 12 – p. 60, line 15; p. 61, line 12 – p. 62, line 1; p. 65, lines 7-12)

24. Nurse Streif has been a nurse for 42 years. She has known Patient D.M. since he was a baby because he grew up in the same community that she lived in. Nurse Streif was not intimidated or frightened of Patient D.M. on August 23, 2009. After she and Nurse Johnstone completed their initial assessment of Patient D.M., Nurse Streif telephoned Dr. Sheikh to come see the patient. Dr. Sheikh asked Nurse Streif what was going on with the patient and Nurse Streif explained that Patient D.M. was in a lot of pain and that he was complaining of leg cramping and pain, which he had never complained of before. She was concerned because what was going on with him was something more than what they normally saw him for. Dr. Sheikh asked the name of the patient and when Nurse Streif told him, Dr. Sheikh stated that he had seen Patient D.M. prior to this visit and he then ordered that Haldol be administered. Nurse Streif responded that she was not comfortable doing that and that she did not think that was reasonable. Dr. Sheikh restated that that was his order. Nurse Streif testified, "I asked him if he was going to come out to assess the patient prior to me giving it. He said he would be out. It was a long time before he came out." "My only regret . . . is the fact that I gave him that with maybe not being more insistent on him coming out." (Hrg. Trans. Vol. I, p. 68, lines 6-9; p. 71, line 14 – p. 75, line 17; p. 82, lines 1-7; p. 79, lines 2-9)

25. As between Dr. Sheikh and Patient D.M., Nurse Streif felt that Dr. Sheikh was definitely the more intimidating person that day. She felt like she was being told that it was not her place to question his order. Nurse Streif did as Dr. Sheikh ordered and administered the Haldol shot to Patient D.M. She testified that she "tried so hard" to get Dr. Sheikh to come out of his room. (Hrg. Trans. Vol. I. p. 74, lines 7-8; p. 75, lines 13-17; p. 76, lines 19-22)

26. On the T-sheet, under "Additional Notes," Nurse Streif wrote: "Patient upset when he was told by Dr. Sheikh that he would not be getting any narcotics. He left the ER without conversation. This nurse did inform the Sheriff's Office just to keep an eye on him due to Pts.

possible outbursts." At hearing, Nurse Streif explained why she called the police: "So [Patient D.M.] was very, very upset when he left. He was very agitated. My concern for him was I called the cops, not because I was concerned about us. I called the cops because we had just given him Haldol and now were sending him out the door. So I was concerned about the patient's safety." She also explained what she meant by "outbursts:" "Whenever he gets like this, he'll start where he'll start yelling, he walks really fast. But I was worried that the mixture of the Haldol and never having it before,[7] I was worried that something would happen. That's why I used the word outbursts." (Exh. 14, p. 3; Hrg. Trans. Vol. I, p. 76, lines 12-18, p. 77, lines 15-21)

27. Haldol is the brand name for Haloperidol which is an antipsychotic. It is used to help people who are disoriented, highly aggressive, hallucinating or delusional. Haldol operates on the brain chemistry, and the potential side effects of Haldol include altering blood pressure, causing fainting, disrupting heart rhythm, and causing irreversible abnormal movements of the mouth, face, tongue or limbs. (Hrg. Trans. Vol. I, p. 206, line 8 – p. 207, line 8; Vol. III, p. 805, lines 2-3)[8]

28. Dr. Sheikh refused to see Patient D.M. until the Haldol was administered. At hearing, Dr. Sheikh was asked, "And isn't it true that you would not see Patient D.M. until he was first sedated with Haldol?" and he responded, "No. That's not true. That's not true." However, Dr. Sheikh was then confronted with his deposition testimony in which the following exchange occurred:

> You did not see Patient D.M. prior to ordering Haldol for him on August 23, 2009, correct? Answer: On August 2009, in this episode, when the nurse gave the history, I could not see him unless the patient was sedated first. Question: So

[7] Nurse Streif was incorrect regarding her belief that Patient D.M. had not been given Haldol before. As stated above, he was given Haldol on August 10, 2009.

[8] Dr. Sheikh's expert, Dr. Dunn, agreed with Dr. Parker's general description of Haldol, testifying: "Haldol is the accepted antipsychotic sedative in patients who are severely violent." (Hrg. Trans. Vol 4, p. 805, lines 2-3).

you did not see Patient D.M. on August 23, 2009 prior to ordering Haldol for him, correct? Answer: I had to allay his agitation. Yes, that's true. I did not.

After hearing this deposition testimony, Dr. Sheikh modified his response to the Division's initial question as follows: "Yeah, I mean, I had to take a history from him, and unless he would be calm and comfortable, I could not take a history and a physical examination. Because if [a] person is pacing the floor, he is virtually restless. So you have to be able to sit at a single place and to hold a conversation with the doctor, so as to be able to give him a history, and that was important." (Hrg. Trans. Vol. III, p. 759, line 24 – p. 760, line 24; p. 684, line 16 – p. 686, line 17)

29. On August 21, 2009, Vice President of Professional Services Jennifer Rutkowski sent an email to Nurse Johnston and another nurse asking them to have the ER nurse report on how Dr. Sheikh's shift went and stating that she was "looking for both good & bad." The email explained: "Angie spent some [] time orienting Dr. S this week so I need feedback if there are other things we need to cover." In an email to Ms. Rutkowski dated August 23, 2009, Nurse Johnstone responded: "We also had [Patient D.M.] come in by squad around 3 am. His complaints were headache and leg pain. Dr. S gave Marie [Streif] a Haldol order without even coming to see him. Marie had to call him back finally to have him come out just to see him. I believe the time frame was about 20 to 25 min. Oh and he also ordered Phenergan when she called him back. I know Dr. Sheikh de[a]lt with him 2 weeks ago when he came in all crazy, but he still should have come to lay eyes on him." (Exh. 14, p. 16; Hrg. Trans. Vol. III, p. 856, lines 1-11)

30. According to the T-sheet, Patient D.M. was admitted to the ER at 3:39 a.m., was given Haldol at 4:00 a.m. and was discharged at 4:15 a.m. (Exh. 14, pp. 2-3)

31. Dr. Sheikh testified that the most important goals of Haldol are to control the patient so he does not hurt himself or others. There was no evidence prior to the administration of

Haldol on August 23, 2009, that Patient D.M. posed a threat of harm to himself or to the two nurses or anyone else assessing him. He had not escaped from police monitoring as Dr. Sheikh had previously claimed. Dr. Sheikh conceded that Patient D.M. had not been violent on August 23, 2009; however, he testified that because Patient D.M. was pacing the floor, he was necessarily angry and agitated. (Hrg. Trans. Vol. III, p. 677, lines 4 – 10; p. 755, line 12 – p. 758, line 1; p. 759, lines 11-23)

32. Dr. Parker testified that, with rare exception, before a physician orders that a powerful antipsychotic medication like Haldol be administered, it is necessary to evaluate the patient in person first and that in not examining Patient D.M. prior to ordering the administration of Haldol, Dr. Sheikh did not meet the minimal standard of competency. She also testified that Dr. Sheikh's conduct created an unacceptable risk to Patient D.M. because Dr. Sheikh administered potentially harmful and sedating medication unnecessarily and then allowed Patient D.M. to leave the emergency room. She stated the medication could have masked other problems that could have been the potential cause of his behavior and/or complaints, could have made Patient D.M.'s headache and restless legs worse, and could affect the physician's ability to interview a patient because it has a sedating effect. She further testified that after administering Haldol, it is necessary to observe the patient for two to three hours to watch that the patient does not have a dangerous change in blood pressure, that the patient's heart rhythm remains stable, and that the patient does not pass out.[9] (Hrg. Trans. Vol. I, p. 208, line 16 – p. 210, line 19, p. 220, lines 21-25; p. 226, line 7 - p. 227, line 23)

33. Dr. Dunn testified that it is appropriate for a physician to order Haldol without viewing the patient when the physician receives information from other medical staff who have

[9] It is unclear from the record whether Dr. Parker believes that such observation is necessary where, as here, the patient has been administered Haldol 2 weeks previously and the record does not show that he had negative side effects.

personally observed that the patient was potentially violent. Dr. Dunn agreed that "[P]eople tend to be different on different - - different times of the day and under different circumstances" and that "whether you give him Haldol or not is going to be based to some extent on the circumstances and the situation." He acknowledged that he has had patients present to the ER who were in an explosive violent state due to the ingestion of drugs or a mental health disorder and then subsequently present to the ER when they were fine. When the patient presented in a non-violent state, there have been times that he did not administer Haldol. He explained that he had to make a judgment "about a particular situation and a particular visit based upon the circumstances." However, he nonetheless opined that it would have been appropriate to administer Haldol to Patient D.M. "anytime that Patient D.M. presents to the ER where he is appearing anxious" and that the ambulance personnel he supervises would have "absolute authority" to give Patient D.M. Haldol "whenever they came into contact with him" without being viewed by a physician. (Exh. 25, p. 71, line 13; p. 72, line 22 – p. 73, line 22; Hrg. Trans. Vol. III, p. 802, lines 4-5)

34. Dr. Dunn testified that in administering Haldol to Patient D.M. on August 23, 2009, Dr. Sheikh exercised the appropriate standard of care. While acknowledging that there was no reason to administer Haldol to Patient D.M. during other hospital visits by Patient D.M. between August 16 - 23, 2009, he believed it was appropriate on August 23, 2009 because of Patient's conduct on August 10, 2009 and because on August 23, 2009, he was brought in by ambulance at approximately 3:50 a.m., was described as "anxious," and was a drug seeker with a prior mental health admission. (Hrg. Trans. Vol. III, p. 799, lines 2-11; Exh. 25, p. 53, line 14 – p. 76, line 23; Exh. 29)

35. In the present case, there was no concern expressed by either Nurse Streif or Nurse Johnstone about potential violence from Patient D.M., nor does the paramedic report reflect that Patient D.M. was potentially violent or uncooperative.[10] (Exh. 14, pp. 9-11)

36. On his T-sheet for August 23, 2009, Dr. Sheikh noted under past history that Patient D.M. had "maniac disorder" [sic] and drug addiction. Under "Clinical Impression," Dr. Sheikh wrote, "Drug seeker with mania." Nothing documented by Dr. Sheikh regarding Patient D.M.'s mental status on August 23, 2009 supports the diagnosis of mania. Patient D.M.'s general appearance was noted to be anxious and restless in the nursing triage record, which is consistent with both triage nurses' testimony. He was alert and oriented with clear speech according to the nursing assessment notes. Similarly, Dr. Sheikh documented that Patient D.M. was fully oriented, alert and had normal speech. Dr. Sheikh's only abnormal finding in support of the diagnosis of mania was circling "abnormal thought processes and/or cognition" and noting he has a known history of bipolar disorder. Although Dr. Sheikh testified at hearing that Patient D.M. became angry, agitated and upset when Dr. Sheikh refused to prescribe narcotics, Dr. Sheikh's hearing testimony did not suggest any additional exam findings that supported a diagnosis of mania. In fact, he testified that he informed Patient D.M. that he had examined him and that the patient had "no physical problems" and further told the patient, "I understand that you have a headache. The best I can offer you is Motrin or Tylenol." (Exh. 14, pp. 2- 5; Hrg. Trans. Vol. I, p. 218, line 9 – p. 220, line 15; Vol. III, p. 688, lines 4-21)

37. Dr. Parker testified that the minimal standard of competency for evaluating and diagnosing Patient D.M. required addressing and exploring the patient's symptoms and not making assumptions based on prior experience that are not substantiated at this particular visit. She further testified that a full psychiatric history and examination should have been taken. She

[10] The paramedic report notes, "Once inside the squad the patient kicked his shoes off." (Exh. 14, p. 9) This is not sufficient evidence violence.

further stated that in order to properly diagnose someone with mania, that person must be *manic* and that patients with mania are commonly characterized by self-aggrandizing, thinking they are on top of the world and can do anything, overspending or engaging in other risky behavior, talking fast and having flight of ideas. She stated that Dr. Sheik's conduct resulted in a misdiagnosis of mania. (Hrg. Trans. Vol. I, p. 217, line 3 – p. 218, line 8; p. 220, lines 16-18)

38. Dr. Dunn's testimony was equivocal as to what Patient D.M.'s mental state was on August 23, 2009. Dr. Dunn first testified that Patient D.M. was manic depressive or bipolar. Then he suggested that he presented with manic psychosis on August 23, 2009:

> Q: You would agree that Patient DM did not present in manic psychosis on August 23, 2009?
> A: No. But now, see, that's the trap that you get into with the DSM-IV. They said the psychosis should be only diagnosed if the patient is having hallucinations and - - what was the other one that they used? What was the other word?

Then he testified that Patient D.M. did not present with manic psychosis on August 23, 2009:

> Q: You would agree that on August 23, 2009, which is the date in question, with regard to the complaint in this particular case, that Patient DM did not present in a manic psychotic state?
> A: You and I agree on that. Yes, ma'am.

(Hrg. Trans. Vol. III, p. 801, lines 13-15; p. 845, lines 14-20; p. 847, lines 5-9)

FACTS RELATING TO PATIENT H.M.

39. On August 31, 2009, Patient H.M. was brought to the GRHC ER at approximately 12:35 p.m. via ambulance following a motor vehicle accident. At that time, her chief complaint was of injury to her chest. At or about the same time that Patient H.M. arrived in the ER, Patient B.E. was also brought to the ER via a separate ambulance, having been involved in the same accident. (Hrg. Trans. Vol. I, p. 89, lines 9-20; p. 90, line 10; Exh. 15, p. 6)

40. Leslie Newhouse is a physician assistant and was on duty when Patients H.M. and B.E. arrived in the ER. The ER at GRHC is staffed by a physician assistant and a nurse, with an emergency room physician as a backup. The physician backup will help the physician assistant

when needed for difficult cases or when multiple patients present to the ER at the same time. Dr. Sheikh was the backup emergency physician on August 31, 2009, when the two patients were brought to the ER. (Hrg. Trans. Vol. I, p. 84, lines 8-12; p. 86, line 6 – p. 87, line 25; p. 88, line 17 – p. 89, line 2; p. 100, line 18 – p. 101, line 1)

41. Patient H.M. arrived first and Mr. Newhouse performed a quick assessment of how critical she was. He did so by looking at her vital signs (blood pressure, pulse, respirations), speaking to the patient to ask her where she was hurt, and looking for any obvious bleeding or signs of any deformity. He did not note anything outside of the normal limits based on his brief assessment of Patient H.M.

42. The records indicate that Mr. Newhouse initially ordered x-rays as well for Patient H.M., including a three-view cervical spine x-ray and a one-view chest x-ray. Dr. Sheikh verbally cancelled the x-rays. He did so by directly telling the radiology technologist Tiffany Degenhardt that they were cancelled. Ms. Degenhardt reported these events to the radiology director, Kim Moore. Instead, Dr. Sheikh ordered a one-view cervical spine x-ray and a 2-view chest x-ray. GRHC's Physician History Orders shows Dr. Sheikh as the ordering physician for the one-view cervical spine and 2-view chest x-rays, and reflects that at 1:15 p.m. (1315) and 1:16 p.m. (1316), Tiffany Degenhardt made approved changes from the radiology department. In addition, Ms. Moore was asked during her deposition to view the one-view spine x-ray and noted that the x-ray itself shows Dr. Sheikh as the ordering physician. (Hrg. Trans. Vol. I, p. 90, line 13 – p. 91, line 6; Exh. 4; Exh. 8, p. 33, line 25 – p. 38, line 11; Exh. B, pp. 8, 15)

43. After his brief assessment of Patient H.M., Mr. Newhouse turned his attention to Patient B.E. to perform an assessment of her condition in room 5. At about that same time, Dr. Sheikh arrived in the ER and took over managing Patient H.M.'s medical treatment in room 6. Mr. Newhouse saw Dr. Sheikh go into exam room 6, but did not see Dr. Sheikh perform an

examination of Patient H.M. (Hrg. Trans. Vol. I, p. 91, lines 10-18; p. 96, line 17 – p. 97, line 10)

44. GRHC computer records reflect that Dr. Sheikh ordered several lab tests for Patient H.M. at 1:59 p.m., which were entered into the computer by Kate Reuter, whose initials appear as "KCR." Those lab tests included CK, troponin and myoglobin. Once the lab studies have been ordered, the ordering provider can pull up the lab results in the computer and they are also generated in printed form from the computer printer. It is a common practice for a nurse to enter orders into the computer on behalf of the ordering physician. Nursing records for GRHC Nurse Darcy Ploessel are stamped with Dr. Sheikh's name. (Hrg. Trans. Vol. I, p. 102, lines 13-21; p. 103, line 23 - p. 104, line 19; Exh. 4; Exh. 15, pp. 4-5)

45. Patient H.M.'s chemistry labs for CK, troponin and myoglobin were drawn at 2:10 p.m. (1410)[11] and reported at 2:49 p.m. (1449) on August 31, 2009. The initial results for the CK, CK-MB (fractionated CK test), and myoglobin all had elevated values, outside the normal range. The CK value was 309 (normal range of 26-140), the CK-MB value was 20.8 (normal range 0.6 – 6.3) and the myoglobin was 1,036 (normal range of 14-66). These three chemicals are known as cardiac enzymes or proteins that are released when there is muscle damage in the body. Myoglobin is released when there is muscle damage from skeletal or heart muscle. Myoglobin would typically be the first marker to become elevated. CK is an enzyme marker that is released from the muscle when there is damage and measures skeletal, heart and brain damage. CK-MB is the fractionated portion of the CK test and is an enzyme that elevates when there is specifically heart damage. Troponin is the most specific marker for cardiac damage; however, that marker does not elevate immediately when muscle injury occurs. GRHC Nurse Jolene Ziebart testified that it takes over 4 hours after the injury for troponin to elevate; Dr. Parker

[11] Exhibit B reflects that the specimen was logged into the lab at 2:10 p.m. (1410) and that the results were ultimately completed at 2:48 p.m.

testified it takes between 2-6 hours to elevate, "maybe sooner;" and Dr. Dunn testified it takes 1-2 hours for troponin to elevate. (Hrg. Trans. Vol. I, p. 105, line 2 – p. 107, line 2, p. 256, line 4 – p. 259, line 13; Exh. 15, p. 12; Exh. 25, p. 80, lines 17-20)

46. At 3:23 p.m. (1523), approximately three hours after Patient H.M. was admitted, Dr. Sheikh discharged her from GRHC to home. Prior to discharging Patient H.M., all of the lab test results from 2:10 p.m. (1410) (as reported at 2:49 p.m. (1449)) were available for Dr. Sheikh's review. (Exh. 15, pp. 4, 12; Hrg. Trans. Vol. I, p. 119, line 8 – p. 120, line 19)

47. Nurse Ziebart is a registered nurse with additional prescribing privileges which allow her to act as nurse practitioner. She is an ER provider at GRHC and is qualified to perform many of the same duties as an emergency room physician and, in fact, practices independently from a supervising physician. Nurse Ziebart's ER shift on August 31, 2009, began at 5:00 p.m., which is when Mr. Newhouse's shift ended. Mr. Newhouse provided her with an update regarding Patient H.M. during the shift changeover. He advised Nurse Ziebart that two ladies had been brought in following a car accident and that he had taken care of patient B.E. and that Dr. Sheikh was taking care of Patient H.M. (Hrg. Trans. Vol. I, p. 98, lines 8 - 23; p. 99, lines 13 - 21; p. 101, line 16 – p. 102, line 9; p. 118, lines 20 - 25)

48. At some point during the shift changeover, both Mr. Newhouse and Nurse Ziebart became aware of Patient H.M.'s lab test results.[12] After Nurse Ziebart reviewed Patient H.M.'s lab test results, she had the ER staff contact Patient H.M. to return to the ER to be reassessed. Patient H.M. presented to the GRHC ER again at 6:25 p.m. (1825). At that time, Patient H.M.

[12] Nurse Ziebart testified that she noticed that there were patient charts on the desk and reviewed some of them for Patient H.M. She noted that Patient H.M.'s cardiac enzymes were elevated in her lab test results and that the patient had already been discharged. Mr. Newhouse recollected that after he had reviewed some x-rays on the computer in the ER for the other car accident patient (Patient B.E.), he pulled up lab work for Patient H.M. and noticed that her cardiac enzymes were quite elevated. These lab test results made him concerned that Patient H.M. had sustained either a myocardial infarction (heart attack) or a cardiac contusion. This prompted Mr. Newhouse to tell Nurse Ziebart that they needed to have Patient H.M. return to the ER. (Hrg. Trans. Vol. I, p. 101, line 24 – p. 102, line 12; Exh. 28-B, p. 14, line 12 – p. 15, line 4)

continued to complain about chest and neck pain so a cervical collar was placed on her. Nurse Ziebart ordered a CT scan of Patient H.M.'s cervical spine, a repeat EKG and repeat cardiac enzyme test. Nurse Ziebart ordered the cervical spine CT because she noted that the initial cervical spine x-rays did not clear the entire spine, omitting levels C-7 and T-1. The radiologist's report indicates that the cervical spine x-ray was an incomplete exam, especially at the cervical thoracic junction. The CT ordered by Nurse Ziebart revealed fractures in the cervical spine that could not be seen on the initial x-rays during Patient H.M.'s first admission. (Hrg. Trans. Vol. I, p. 108, lines 11 – 20; p. 109, line 5 – p. 112, line 4; p. 116, lines 7-25; Exh. 15, pp. 2, 25)

49. Patient H.M.'s repeat cardiac enzyme labs at 7:05 p.m. (1905) showed the following values: CK-MB of 38.5 (normal range 0.6 – 6.3), CK of 754 (normal range 26-140) and troponin of 0.04 (normal range 0.00 – 0.03). Based on the increasingly elevated cardiac enzyme values and the now-elevated troponin level, Nurse Ziebart felt that additional studies were needed and transferred the patient to University of Wisconsin Hospital and Clinics for additional studies. (Hrg. Trans. Vol. I, p. 113, lines 7-14; Exh. 15, p. 12)

50. Dr. Sheikh's denial that he had any involvement in Patient H.M.'s care is not credible. The abundance of circumstantial evidence indicating that he did, in fact, participate in Patient H.M.'s care is more credible than Dr. Sheikh's direct testimony that he did not.

51. Dr. Parker and Dr. Dunn agreed that if Dr. Sheikh participated in Patient H.M.'s care, the standard of minimal competence required him to document his medical care and treatment of Patient H.M. during her initial ER visit on August 31, 2009. (Hrg. Trans. Vol. I, p. 234, line 23 – p. 239, line 8; Exh. 25, p. 78, line 11 – p. 79, line 17)

52. Dr. Sheikh's failure to document his evaluation and treatment of Patient H.M. created an unacceptable risk of harm to the patient because he failed to accept direct responsibility for

her care in terms of any follow-up, there is no way to determine why he did what he did because there is no record of the thought process, and, apart from the diagnostic testing and laboratory studies, there is no way to know what was done or not done during Patient H.M.'s initial ER visit. (Hrg. Trans. Vol. I, p. 236, line 19 – p. 238, line 20)

53. Both Dr. Parker and Dr. Dunn agreed that a cervical spine x-ray should depict all of the bones in the neck to rule out a cervical spine fracture. Dr. Dunn testified that most emergency physicians would have wanted the neck to be cleared with an x-ray and that it was "appropriate to bring the patient back to do a better study." (Hrg. Trans. Vol. I, p. 253, lines 1-15; Hrg. Trans. Vol. III, p. 824, lines 5-25)

54. Given that Patient H.M. presented to the ER with a complaint of neck pain, the standard of minimal competence required Dr. Sheikh to make sure that Patient H.M. did not have any cervical spine, or neck fractures. He failed to do so because the one-view cervical spine x-ray was insufficient to be able to see all of the vertebrae in the neck down to the level of the first thoracic vertebrae. Under those circumstances, the standard of minimal competence required Dr. Sheikh to either order a repeat cervical spine x-ray or order a CAT scan which would provide more detail than an x-ray. Instead, Dr. Sheikh ordered that Patient H.M. be discharged to home without clearing the cervical spine. (Hrg. Trans. Vol. I, p. 252, lines 7 - 23; p. 253, lines 1 - p. 254, line 19; p. 260, line 17 - p. 261, line 15; p. 263, line 22 - p. 264, line 7)

55. Dr. Sheikh's conduct in discharging Patient H.M. to home without adequately clearing her cervical spine posed an unacceptable risk of harm to the patient in that if she had an unstable fracture of C-6 or C-7, that fracture could have injured part of her spinal cord, potentially rendering her permanently paralyzed. (Hrg. Trans. Vol. I, p. 253, lines 16 – 22)

56. Patient H.M. was 90 years old at the time of her initial ER presentation on August 31, 2009. She had a pacemaker which indicates that she has a significantly diseased heart. The fact

that she had a pacemaker alters how the electrical tracing looks on an EKG so that one cannot reliably read signs of a heart attack, angina or ischemia. The records reflect that Dr. Sheikh ordered an EKG which was performed at 1:50 p.m. and revealed an irregular heart rate called atrial flutter. In addition, lab tests revealed significantly elevated CK and myoglobin values at 2:10 p.m. (1410). Those studies can indicate heart muscle damage. At a minimum, Dr. Sheikh should have noted the elevated enzymes and observed the patient for at least several more hours until another set of cardiac enzymes could be drawn and to make sure she was not at risk to have a heart attack. (Hrg. Trans. Vol. I, p. 107, line 25 - 108, line 3; p. 254, line 20 - p. 260, line 61; Exh. 15, pp. 6, 12, 30)

57. Dr. Sheikh's conduct created an unacceptable risk of harm to Patient H.M. in that there were enough warning signs to indicate she was at risk for having a heart attack. This warranted keeping her in the ER for an observation period for several more hours. (Hrg. Trans. Vol. I, p. 123, line 17 - p. 124, line 1; p. 259, line 14 - p. 260, line 7)

FACTS RELATING TO PATIENT B.K.

58. On August 22, 2009, at 11:24 a.m., Patient B.K., a one year-old child, was brought to the GRHC ER by his mother who reported that the child had fallen down a full set of carpeted stairs. The mother reported that Patient B.K. started crying immediately after the fall and was still crying. The triage nurse noted that the child was crying but saw no obvious signs of injury. The nurse noted the child's pain level to be 5/5. (Exh. 10, pp. 2-3)

59. Dr. Sheikh examined Patient B.K., at which time he noted that the child fell on the stairs and rolled over several steps. He noted that the child was crying persistently. Dr. Sheikh's documented extremity exam findings included "moves all extremities" and "non-tender;" however, he left the section blank for range of motion in the child's extremities. Nurse Ploessel, who initially examined Patient B.K., noted a normal range of motion in the extremities, that there

was no evidence of trauma in them and that Patient B.K moves all extremities. Testing the range of motion in Patient B.K.'s upper extremities was important because, with a clavicle fracture, when the arm is raised, the muscles will pull the ends of the fracture apart which will cause pain. Dr. Sheikh did not order any x-rays. No injuries were noted in either Nurse Ploessel's or Dr. Sheikh's T-sheets. Dr. Sheikh's clinical impression was "rolled over the steps (fall)" and he gave the mother "child rearing instructions" before discharging the patient to home. (Hrg. Trans. Vol. I, p. 276, line 8 – p. 277, line1; p. 290, lines 6-24; Vol. III, p. 730, lines 15-16; Exh. 10, pp. 2, 4-5)

60. On that same date, August 22, 2009, at 6:25 p.m., Patient B.K. was again brought to the emergency room by his mother reporting that she was unable to pick the child up. Nurse Ploessel noted that Patient B.K. moved all extremities, that they were non-tender and that they had good muscle tone. She further noted that the child was currently sleeping on his mother's chest, and under "General Appearance," noted that the child had "no acute distress" and was "consolable." Dr. Sheikh examined Patient B.K. again and his documented extremity exam findings included "moves all extremities," "non-tender" and normal range of motion. Dr. Sheikh ordered a chest x-ray, which he called a "babygram," which showed an obvious left clavicle fracture. He documented that the babygram was "normal" and discharged Patient B.K. home with Tylenol, as needed. (Exh. 7; Exh. 10, pp. 13-16; Hrg. Trans. Vol. I, p. 282, line 9 – p. 283, line 23)

61. All of the other physicians involved in Patient B.K.'s case agreed that the x-ray demonstrated a left clavical fracture. Dr. Parker testified: "he missed an obvious collarbone fracture;" "I think that's an obvious fracture;" and "it's quite obvious there's a fracture in the collarbone right here." Dr. Christine Duranceau, in her report under "Assessment," wrote, "Left clavicle fracture." Dr. Cornell Overbeeke, in his report under "Impression," wrote, "Left

clavicular fracture;" and at hearing stated, "it was an acute fracture;" and "I said it was a fracture." Dr. Dunn testified in his deposition that "It's just a simple fracture of the clavicle;" "an uncomplicated minor fracture that had no displacement;" and at hearing characterized it as a "fracture" where "the bone has been broken all the way through from the top to the bottom." Even Dr. Sheikh conceded at hearing that the x-ray at issue depicted a "complete fracture;" however, he contended that this x-ray was not the babygram he ordered or reviewed on August 22, 2009. (Hrg. Trans. Vol. I, p. 282, lines 18-20; p. 294, lines 14-19; p. 303, line 20; Vol. III, p. 664, lines 1-3; p. 665, line 22 – p. 666, line 23; p. 689, lines 21-22; p. 742, line 25 – p. 743, line 3; p. 792, p. 14-16; p. 870, lines 2-3; Exh. 25, p. 31, line 18; p. 34, line 18; Exh. 9, p. 5)

62. The following morning, on August 23, 2009, Patient B.K. was brought by his mother to a physician at another hospital, reporting that the child continued to cry following the fall down the steps. The physician's examination revealed that the child had pain when he raised his left arm greater than 90 degrees and when she was "poking at" his left clavicle. The physician suspected a clavicle fracture and called GRHC to review the chest x-ray, at which time a greenstick fracture of the left clavicle was noted. She diagnosed Patient B.K. with a clavicular fracture. She instructed the mother not to lift the child by the chest but to lift him by his lower body, that the fracture should heal within three weeks, and to follow up with her private doctor. (Exh. 9, pp. 4-5)

63. Kimberly A. Moore is the radiology department manager at Grant Regional Health Center (GRHC) and has been since approximately 2002. Her duties include patient care, budgeting, employee scheduling and issues relating to employees or patient satisfaction. She performs patient radiology exams on a daily basis. Ms. Moore is able to perform general radiography which would include plain films, fluoroscopy, mammography, and CT. Plain films

would include cervical spine and chest x-rays. (Exh. 8, p. 5, line 17 – p. 6, line 15; p. 7, line 17 – p. 8, line 2)

64. The Picture Archive and Communication System ("PACS") is the digital storage system which was used in the radiology department in August of 2009 and which is currently being used. All of the imaging studies are stored digitally in PACS. Ms. Moore was trained on PACS in 2008 when it was introduced at GRHC. Training included learning to use the system, retrieving prior exams, completing exams and learning administrative tools for reporting. (Exh. 8, p. 8, line 3 – p. 9, line 23)

65. PACS interfaces with both the Healthland system (the hospital information system) and the radiology equipment and machines. When information is entered into Healthland, it transfers to PACS. PACS then communicates all of the patient demographic information to the machine being used to perform the imaging study. When the technologist performs the exam, the patient information automatically associates with the image which is then sent back to PACS. From PACS, the image can be viewed from the emergency room by the ordering physician on a dedicated PACS workstation. Only radiology images from the previous 24 hours would show up on the workstation, with the most recent imaging study appearing at the top. The patient information that would be visible along with the image to the ordering physician would include patient name, date of birth, gender, medical record number, accession number, date of the exam, time of the exam, the exam that was ordered, the resolution, the window, and the leveling. (Exh. 7; Exh. 8, p. 10, line 1 – p. 14, line 15; p. 27, line 20 – p. 28, line 10; p. 29, line 17 – p. 30, line 24)

66. Ms. Moore is aware of the term "babygram" which is an old term used by physicians. There is no CPT (Current Procedural Terminology) code for a babygram. As such, a facility cannot bill for a "babygram." Instead, if a physician orders a babygram, the technologist will

consult with the physician to clarify what he/she is looking for. The technologist will then indicate for the physician to order either a chest x-ray or an abdomen x-ray. Ms. Moore was advised by staff technologist Jenae Wittman (formerly known as Jenae Harrington) that Dr. Sheikh had ordered a babygram on August 22, 2009. She learned that Ms. Wittman spoke with Dr. Sheikh and they decided to charge for just the chest x-ray but to include the chest and abdomen on Patient B.K.'s imaging study. (Exh. 8, p. 14, line 19 – p. 16, line 11)

67. Ms. Moore personally trained Ms. Wittman in all general radiography exams, mammography and all software, including PACS and Healthland. She considered Ms. Wittman to be competent in using PACS. As the radiology department manager, Ms. Moore has administrative abilities in PACS that Ms. Wittman did not have. Specifically, Ms. Moore had the ability to change patient demographic information in PACS such as the patient's name or address. This would enable her to change the patient information associated with an image in PACS. Ms. Wittman did not have the authority to make such changes so there was no way that she could have changed the image that was associated with Patient B.K. on August 22, 2009. (Exh. 8, p. 17, line 1 – p. 19, line 5; p. 26, line 18 – p. 27, line 3)

68. Ms. Wittman was a radiology technologist at GRHC in August 2009. At that time, GRHC used PACS. She received training on PACS in 2008 at GRHC through her supervising manager, Kim Moore. Ms. Wittman's duties included performing CAT scans, mammograms, plain films, and fluoroscopy procedures. (Hrg. Trans. Vol. I, p. 21, line 16 - p. 23, line 13)

69. Ms. Wittman was familiar with the term "babygram" which was used by physicians to describe an image that includes the chest and abdomen area. Babygrams were done at GRHC, but there is no CPT code for that type of study so it would be coded as a chest x-ray. (Hrg. Trans. Vol. I, p. 23, line 14 – p. 24, line 16)

70. On August 22, 2009, Ms. Wittman spoke with Dr. Sheikh about his order for a babygram for Patient B.K. After speaking to Dr. Sheikh in the ER, Ms. Wittman entered an order for a chest x-ray for Patient B.K. into the Healthland system. She proceeded to transport Patient B.K. to the x-ray department to take the x-ray. Ms. Wittman only had access to the one image that she took of Patient B.K. on August 22, 2009. After she accepted that image, it was automatically sent to Dr. Sheikh. Ms. Wittman referred to the Interworks system as the way that Dr. Sheikh would be able to view the image.[13] It was not possible for Ms. Wittman to have sent a different x-ray to the system for Dr. Sheikh to view. (Exh. 2; Exh. 3; Hrg. Trans. Vol. I, p. 25, line 12 – p. 27, line 22; p. 31, lines 5 – 13; p. 33, line 4 – p. 34, line 4)

71. Dr. Parker testified that Dr. Sheikh's clinical examinations of Patient B.K. at both the initial and second visits on August 22, 2009 failed to meet the minimal standard of competency because he missed Patient B.K.'s clavicle fracture and failed to do a focused physical examination that would have revealed the fracture. She stated that there was no question in her mind that if Dr. Sheikh had actually touched Patient B.K.'s collarbone within an hour after Patient B.K. broke it, the child would have indicated that it was painful. (Hrg. Trans. Vol. I, p. 288, line 10 – p. 294, line 21; Exh. 10, p. 5)

72. Dr. Parker also testified that Dr. Sheikh failed to meet the standard of minimal competence because he documented the x-ray as "normal" and failed to recognize the "quite obvious" clavicle fracture on Patient B.K.'s x-ray and to advise the parent about the fracture, healing time and precautions to take. (Hrg. Trans. Vol. I, p. 282, lines 9-25; p. 295, line 9 – p. 296, line 7; p. 297, line 16 - p. 298, line 5; Exh. 10, p. 16)

73. Dr. Dunn likewise testified during his deposition that, assuming Dr. Sheikh was reviewing the x-ray at issue, his notation in Patient B.K.'s medical record that the chest x-ray

[13] Witness Kimberly Moore referred to it as the PACS master folder.

was "normal" fell below the standard of minimal competence. (Exh. 25, p. 35, line 9 – p. 36, line 13)

74. Dr. Parker testified that the unacceptable risk of harm posed by Dr. Sheikh's failure to recognize and diagnose the clavicle fracture is that a source of pain for a toddler was not addressed. In addition, the parent was not given appropriate instruction and guidance about picking the child up and about follow-up visits for the child. (Hrg. Trans. Vol. I, p. 296, line 8 – p. 297, line 15)

DISCUSSION

Burden of Proof

The burden of proof in disciplinary proceedings is on the Division to show by a preponderance of the evidence that the events constituting the alleged violations occurred. Wis. Stat. § 440.20(3); *see also* Wis. Admin. Code § HA 1.17(2). To prove by a preponderance of the evidence means that it is "more likely than not" that the examined action occurred. *See State v. Rodriguez*, 2007 WI App. 252, ¶ 18, 306 Wis. 2d. 129, 743 N.W.2d 460, citing *United States v. Saulter,* 60 F.3d 270, 280 (7th Cir. 1995).

Allegations of Unprofessional Conduct

Wisconsin Admin. Code § Med 10.02(2)(h) defines unprofessional conduct to include "[A]ny practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public." In interpreting this language, the Wisconsin Supreme Court has stated that "unprofessional conduct" is conduct which does not meet the level of minimal competence using accepted medical standards and which poses an unacceptable risk to the health, welfare or safety of the patients. *Gilbert v. Medical Examining Board*, 119 Wis.2d 168, 196, 349 N.W.2d 68 (1984).

Wisconsin Admin. Code § Med 10.02(2)(za) defines unprofessional conduct to include "failure by a physician or physician assistant to maintain patient health care records consistent with the requirements of ch. Med 21." Wisconsin Admin. Code § Med 21.03 provides that a physician "shall maintain patient health care records on every patient administered to" and that the patient health care record shall contain the following clinical health care information which applies to the patient's medical condition:

(a) Pertinent patient history.

(b) Pertinent objective findings related to examination and test results.

(c) Assessment or diagnosis.

(d) Plan of treatment for the patient.

Allegations Relating to Patient S.H.

The Division argues that Dr. Sheikh failed to document a skin examination of Patient S.H., thereby engaging in conduct that tended to constitute a danger to the health, welfare or safety of Patient S.H., in violation of Wisconsin Admin. Code § Med 10.02(2)(h). The Division asserts that Dr. Sheikh's failure to document a skin examination fell below the standard of minimal competence.[14] (Amended Complaint, ¶¶ 6,8; Complainant's Recommended Proposed Decision and Order, pp. 26, 28)

Upon review of the entire record, I conclude that a preponderance of evidence does not support the Division's assertion that Dr. Sheikh failed to document a skin examination, much less that any inadequacy in Dr. Sheikh's documentation constituted a danger to the health, welfare or safety of Patient S.H. As set forth in great detail in findings of fact 6-9, above, Dr. Sheikh documented his skin examination of S.H. Under "Chief Complaint," Dr. Sheikh wrote,

[14] The Amended Complaint also alleged that Dr. Sheikh "did not culture the rash." (Amended Complaint, ¶ 5) However, that claim has not been pursued in the Division's post-hearing submissions in light of its expert's unequivocal hearing testimony that Dr. Sheikh was not required to do a culture for MRSA; rather, he should have "considered" it. (Hrg. Trans. Vol. I, p. 181, lines 17-20)

"Develop with small spots at the base of hair follicles, which became confluent as ulcerated with ulcers formation, and a huge patch on the back of his knee and lower thigh." Dr. Sheikh described the location, stating that it was on the "back of the left thigh, left popliteal region, left calf, and right anterior thigh" and drew the areas affected by the rash on the human body diagrams contained on the T-sheet. He drew arrows from the word "folliculitis" to the three areas he drew on the diagrams. He circled the options "itchy," "painful" and "burning" on the T-sheet and under the subsection "Skin," checked "warm, dry" and "n[ormal] color." In the box under "Clinical Impression," Dr. Sheikh circled "eczema" (apparently relating to the patient's elbow) and also wrote "folliculitis with microabscess formation and ulceration," referring to the leg rash. In the Review of Systems sections, Dr. Sheikh checked the box "all systems neg[ative] except as marked" and drew slash marks through several items, including, "fever," "chills" and the sections related to lymphatic system. In the "PAST RX" section, he checked the line next to "negative," which applies to all of the items listed in that section, including "allergy to poison ivy." In the section "HPI" (history of present illness), after "Identified cause?", Dr. Sheikh circled "no," and crossed out the items listed in that section under "Exposure (context)." Those items include categories for medication, food and "other." "Other" includes items such as insect bites, "poison ivy/oak," "infectious illness" and "soap/detergent."

In addition, Dr. Sheikh's T-sheet indicates that he had reviewed the nurse's T-Sheet. The Divisions' expert, Dr. Parker, conceded that a physician did not need to ask about and document all of the items which had already been addressed and documented by a nurse. Indeed, such redundancy might be viewed burdensome and irritating to the patient, particularly in the context of an emergency room. The nurse's T-sheet includes not only Patient S.H.'s temperature, weight and blood pressure, but also the following notations from the nurse: "1 week ago had dime sized area of rash . . . now has spread;" "rash to posterior anterior right leg and itchy elbow;"

"[v]arying sizes of blistery spots [with] flat open areas surrounded by inflamed skin." Patient S.H.'s chart includes photos, referred to in the nurse's T-sheet. While Dr. Sheikh did not refer to the photos in his T-sheet, it cannot be assumed that he did not review the photos in the chart, which quite vividly portray the patient's rash.

As set forth in findings of fact 6-14, many of the items which Dr. Parker said should be documented for a skin examination actually were documented by either Dr. Sheikh or by the nurse, whose notes Dr. Sheikh indicated he reviewed. As to those items that Dr. Parker states should have been included and in fact were not included, the Division has failed to show that documenting such items is necessary to meet the minimal standards of competency or that failing to do so created an unacceptable risk to the health, welfare, or safety of Patient S.H. Dr. Parker claimed that failure to document led to a misdiagnosis of folliculitis; however, that claim was not supported by a preponderance of the evidence. First, the Division has not adequately shown the nexus between the alleged documentation deficiency and an improper diagnosis or a risk thereof. If the Division is correct that Dr. Sheikh improperly diagnosed folliculitis, it is unclear how further documentation would have led him to an alternative diagnosis.

I note that the Division has not alleged in its amended complaint or in its post-hearing submissions that Dr. Sheikh committed unprofessional conduct (or negligence) by improperly diagnosing S.H.; rather, the Division's allegation relates to his documentation. However, even if the Division had alleged an improper diagnosis as the basis of its amended complaint, it has not been proven by a preponderance of the evidence that Dr. Sheikh's diagnosis of folliculitis constituted unprofessional conduct or even that it was incorrect. That Patient S.H. also later tested positive for MRSA does not mean that he did not have folliculitis, particularly given Dr. Parker's testimony that MRSA can cause folliculitis and her testimony that medical standards did not *require* Dr. Sheikh to do a culture for MRSA during the August 19, 2009 visit. Moreover,

Dr. Parker's testimony was somewhat equivocal in whether she believed the diagnosis was incorrect because it was a diagnosis of folliculitis generally or because she believed he had diagnosed Patient S.H .with "simple folliculitis." The record does not contain an explanation as to what the phrase "simple folliculitis" means, nor does the record show that what Dr. Sheikh diagnosed was a "simple" folliculitis versus a more complicated one, particularly in light of the other adjectives he used to describe it, such as "folliculitis with microabscess formation and ulceration" and "confluent as ulcerated with ulcers formation, and a huge patch on the back of his knee and lower thigh."

Based on the foregoing, a preponderance of the evidence does not support the Division's allegation that Dr. Sheikh failed to document a skin exam of Patient S.H. or that his conduct constituted unprofessional conduct under Wisconsin Admin. Code § Med 10.02(2)(h).

Allegations Relating to Patient D.M.

A preponderance of evidence establishes that Dr. Sheikh engaged in unprofessional conduct on August 23, 2009 by failing to examine Patient D.M. prior to ordering Haldol where he had received no information from other medical staff that would support ordering Haldol, and by diagnosing Patient D.M. with mania without any supporting exam findings.[15]

Dr. Sheikh refused to see or evaluate Patient D.M. until Haldol was administered. Neither of the nurses that participated in Patient D.M.'s triage care felt that Haldol was appropriate or reasonable under the circumstances. The record shows that with respect to Patient D.M.'s conduct on August 23, 2009, the worst that could have been conveyed to Dr. Sheikh was that he was anxious and was pacing. Patient D.M. complained of restless legs, a headache and leg cramps. The ambulance report, which it is not clear Dr. Sheikh reviewed, indicated Patient

[15] In its Amended Complaint, the Division stated that Dr. Sheikh "failed to examine Patient D.M. for a potential blood clot or infection even though he was complaining of leg pain following a recent appendectomy." (Amended Complaint, ¶ 10) By not arguing that point in its post-hearing submissions or seeking to prove it at hearing, the Division has evidently abandoned that allegation.

D.M. had "kicked off" his shoes. Dr. Parker testified that "with rare exception" a physician is required to evaluate a patient in person before administering Haldol. While Dr. Dunn's disagreed, he also testified that the circumstances in which it was appropriate to order that Haldol without evaluating the patient in person were where the patient was potentially violent. His view was that based on Patient D.M.'s conduct on August 10, 2009, Patient D.M. was *always* potentially violent and that therefore administering Haldol prior to seeing Patient D.M. was *always* appropriate when Patient D.M. presented to the ER. I find this conclusion unreasonable. First, Dr. Dunn completely ignores the fact that when Patient D.M. was brought to the ER on August 10, 2009, he was under the extreme influence of alcohol and drugs, such as benzodiazepine, cocaine and opiates, and had a blood alcohol concentration of .258. Even Dr. Sheikh acknowledged on August 10, 2009 that his "mania" diagnosis of Patient D.M. on that date could have been "precipitated by cocaine and his original mental disorder." Dr. Dunn likewise acknowledged that mania can be brought about by drug ingestion.

Second, if Dr. Dunn's position were to be adopted, this would mean that if Patient D.M. came to the ER with a broken arm, strep throat, or an ear infection, he could be administered Haldol without being evaluated by a physician, or would have to take Haldol as a precondition to being seen by a physician. Even if Dr. Dunn's testimony were to be construed to mean that there must also be evidence that Patient D.M. is "anxious" to administer Haldol without an evaluation, his position would nevertheless be unreasonable.

In the instant case, on August 23, 2009, when Dr. Sheikh ordered Haldol without evaluating Patient D.M., he had no indication of symptoms that were consistent with such an order. His decision to administer Haldol appears to have been based primarily, if not exclusively, on the prior visit when the patient presented in a state of acute alcohol and drug intoxication. Ordering that Haldol be administered without evaluating the patient and without

receiving any information that Patient D.M. was violent or likely to be so on August 23, 2009 created the unacceptable risk that Patient D.M. was administered Haldol, a potent antipsychotic with some potentially serious side effects used on violent people, when Haldol was not indicated. Based on the foregoing, I conclude that the Division met its burden of establishing that Dr. Sheikh committed unprofessional conduct by ordering Haldol without evaluating Patient D.M. and where there was no information that Patient D.M. was violent or presented a danger to himself or others on that date.

I further conclude that Dr. Sheikh diagnosed Patient D.M. with "mania" without any supporting exam findings, and that this created the unacceptable risk of a misdiagnosis. Dr. Sheikh noted that Patient D.M. had a history of "maniac disorder" and drug addiction. Nothing documented by Dr. Sheikh or the triage nurses regarding Patient D.M.'s mental status supports the diagnosis of mania on August 23, 2009. Patient D.M.'s general appearance was noted to be anxious and restless in the nursing triage record, which is consistent with both triage nurses' testimony. He was alert and oriented with clear speech according to the nursing assessment notes. Similarly, Dr. Sheikh documented that Patient D.M. was fully oriented, alert and had normal speech. Dr. Sheikh's only abnormal finding was abnormal thought processes and/or cognition and that he has a known history of bipolar disorder. Dr. Sheikh's hearing testimony did not suggest any further additional exam findings that supported a finding of mania. Although Dr. Dunn's testimony was unclear on the subject of Patient D.M.s' mental status on August 23, 2009, his last word on the topic was that Patient D.M. did not present in a manic psychotic state on August 23, 2009. Accordingly, I conclude that Dr. Sheikh's diagnosis of "mania" without any supporting exam findings constituted unprofessional conduct under Wis. Admin. Code § 10.02(2)(h).

Allegations Relating to Patient H.M.

The Division alleges that Dr. Sheikh engaged in unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(h) by failing to create a medical chart regarding his involvement in Patient H.M.'s care, failing to order additional x-ray views to fully evaluate the cervical spine, and discharging Patient H.M. to home with elevated cardiac enzymes. The Department further alleges that Dr. Sheikh's failure to create a medical chart regarding his involvement in Patient H.M.'s care constitutes unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(za).

Dr. Sheikh's Involvement with Patient H.M.

The threshold issue regarding Patient H.M. is whether Dr. Sheikh participated in her care. Dr. Sheikh suggests that it was actually Mr. Newhouse who provided care to H.M., and that Mr. Newhouse was motivated to blame Dr. Sheikh for Patient H.M.'s care because Dr. Sheikh had been critical of Mr. Newhouse's work and because Mr. Newhouse wished to absolve himself of responsibility.

I do not find Dr. Sheikh's denial of involvement credible and conclude that a preponderance of the evidence demonstrates that he did participate in Patient H.M.'s care. Specifically, Dr. Sheikh verbally cancelled x-rays ordered by Mr. Newhouse, telling the radiology technologist, Ms. Degenhardt, that they were cancelled; Mr. Newhouse saw Dr. Sheikh go into exam room 6 where Patient H.M. was roomed; GRHC computer records reflect that Dr. Sheikh ordered several lab tests for Patient H.M. at 1:59 p.m., which were entered into the computer by a nurse as was a common practice in the ER; his name appears as the physician on various other documents, including Nurse Ploessel's T-sheet, an x-ray, and GRHC's Physician History Orders.

In addition, under Dr. Sheikh's theory, not only would Mr. Newhouse have been involved in efforts to sabotage Dr. Sheikh, but so too would many other GRHC staff. Dr. Sheikh

has presented no credible evidence which supports a motivation for such wide-spread acts against him. I do not find credible Dr. Sheikh's allegation that they were motivated by racism. He presented no evidence other than his own testimony to support this allegation. Moreover, he has a history of labeling those who disagree with him racist or part of a racist conspiracy, such as the Division's expert, Dr. Parker, the Division attorney herself and staff of both the Michael Reese residency program in Chicago and the Berkshire Medical Center residency program in Massachusetts, whom he sued (as well as the Illinois Department of Professional Regulation) for racial discrimination after he was terminated from their residency programs. (Exh. 31; Hrg. Trans. Vol. III, p. 711, line 23 – p. 715, line 9; p. 734, line 14 – p. 750, line 8; Respondent's October 9, 2012 "Motion to Order Following Findings and Conclusions of Fact as Undisputed")

Also, Dr. Sheikh has demonstrated a distinct lack of candor in these proceedings. For example, he was untruthful when he testified and documented in his CV that it was due to his wife's ill health that he left his residency programs at Michael Reese Hospital and at Berkshire Medical Center. He was impeached during cross-examination when he was confronted with evidence that he was terminated from those programs for substandard performance and concerns about possible mental health issues. (Hrg. Trans. Vol. III, p. 566, line 19 – p. 567, line 25; p. 713, line 2 – p. 715, line 23; Exhs. 31, 32, 38) With regard to Patient D.M., he testified that he did not refuse to see the patient until he was given Haldol, and then when confronted with his deposition testimony indicating otherwise, he again changed his story. Based on the evidence demonstrating that Dr. Sheikh was involved in Patient H.M.'s care and given Dr. Sheikh's demonstrated lack of credibility, I conclude that Dr. Sheikh was responsible for Patient H.M.'s care.

Failure to Create Patient Records

There is no dispute in this case that Dr. Sheikh created no records with regard to his evaluation or treatment of Patient H.M. This conduct is unprofessional conduct under Wisconsin Admin. Code § Med 10.02(2)(za), the language of which is set forth above.

It is also undisputed that a physician's failure to create patient records falls below the level of minimal competency and created an unacceptable risk to Patient H.M.'s health, welfare or safety. Thus, the conduct is also unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(h).

Discharging Patient H.M. with Elevated Cardiac Enzymes

Patient H.M. was 90 years old at the time of her ER presentation on August 31, 2009. She had a pacemaker which indicates that she has a significantly diseased heart. The records reflect that Dr. Sheikh ordered an EKG which was performed at 1:50 p.m. and revealed an irregular heart rate called atrial flutter. In addition, lab tests revealed significantly elevated CK, CK-MB and myoglobin values at 2:10 p.m. Those studies can indicate heart muscle damage. At a minimum, rather than discharging her to home, Dr. Sheikh should have observed the patient for at least several more hours until another set of cardiac enzymes could be drawn and to ensure she was not at risk to have a heart attack.

I do not find persuasive Dr. Dunn's testimony that Patient H.M. was not inappropriately discharged with elevated cardiac enzymes. Dr. Dunn did not dispute that CK-MB is a cardiac enzyme, that Patent H.M.'s CK and CK-MB levels were elevated, and that CK-MB is a marker for heart muscle. However, he testified that CK-MB levels automatically elevate by a 5% ratio when CK levels elevate, and that because CK levels may elevate where there is *any* muscle damage (not just heart muscle damage), the elevated CK and CK-MB levels were not concerning and were actually "normal" as compared to each other. Furthermore, he stated that the "ratio" of

the CK to the CK-MB values was "not helpful" and that it "doesn't mean anything." Given this opinion as to the insignificance of the elevated CK and CK-MB values and the normal first troponin test, he contended it was appropriate to discharge Patient H.M. home. (Hrg. Trans. Vol. III, p. 810, line 6 – p. 816, line 2)

However, even assuming that Dr. Dunn is correct with regard to the CK/CK-MB ratio, it does not follow that the elevated readings of these enzymes was not concerning. It remains undisputed that elevated CK and CK-MB levels may be a sign of heart damage and that Patient H.M. had other indicators of heart problems, including having a pacemaker, an irregular heart rate and pain in her chest. Moreover, while Dr. Dunn correctly acknowledged that one would have to look at the troponin level to definitely determine whether anything was wrong with the heart muscle, I do not credit his deposition testimony that troponin would elevate within "an hour or two" if there was injury to the cardiac muscle. The normal troponin test was reported at 2:29 p.m. and Patient H.M. was admitted into GRCH approximately 2 hours earlier. Dr. Dunn's testimony that the troponin value would have increased within that 2-hour time frame if there were heart damage was proven wrong by the second troponin test at 7:05 p.m., which was elevated. If the CK and CK-MB values were truly insignificant and if it only took "an hour or two" for troponin to trend upward, then one would have expected the second troponin test result to be within the normal range as well. It was not. It was elevated to 0.04 (normal range of 0.00 - 0.03).

As a result, I am unconvinced by Dr. Dunn's testimony regarding the purported insignificance of the elevated CK and CK-MB levels and the time it takes for troponin to elevate following injury to the heart muscle. In fact, the initial elevated CK and CK-MB levels were signaling an injury to the heart muscle which was confirmed by the second troponin level of 0.04. Nurse Ziebart and Dr. Parker were correct in their opinions that troponin may take

between 2-6 hours to elevate following injury to the heart muscle and that the CK and CK-MB levels were concerning. Based on the evidence in this case, I conclude that Dr. Sheikh discharged Patient S.H with elevated cardiac enzymes and that this conduct constituted unprofessional conduct.

Discharging Patient H.M. Without Clearing her Cervical Spine

Given that Patient H.M. had been in a car accident and presented to the ER with a complaint of neck pain, the standard of minimal competence required that Dr. Sheikh ensure that Patient H.M. did not have any cervical spine or neck fractures. The one-view cervical spine x-ray was insufficient to be able to see all of the vertebrae in the neck down to the level of the first thoracic vertebrae.

Both Dr. Parker and Dr. Dunn agreed that a cervical spine x-ray should depict all of the bones in the neck to rule out a cervical spine fracture. Dr. Dunn testified that most emergency physicians would have wanted the neck to be cleared with an x-ray and that it was "appropriate to bring the patient back to do a better study." However, he attempted to downplay the fractures that were ultimately discovered when Patient H.M. returned for a cervical CT scan, calling them "subtle" and "insignificant" fractures. (Hrg. Trans. Vol. III, p. 825, line 14; p. 826, line 11) Nevertheless, there is no denying that it was necessary to bring Patient H.M. back to the hospital for the additional studies and that the fractures could have been more significant. I find credible Dr. Parker's opinion that a minimally competent physician would have cleared the cervical spine before discharging Patient H.M. The Division has met its burden of establishing that it was unprofessional conduct for Dr. Sheikh to discharge Patient H.M. before clearing her cervical spine.

Allegations Relating to Patient B.K.

The Division alleged one count of unprofessional conduct based on Dr. Sheikh's failure to discover a clavical fracture on Patient B.K. during his initial and second clinical examinations, and missing an obvious fracture in the patient's x-ray. Based on all of the evidence, I conclude that a preponderance of the evidence supports the allegation of unprofessional conduct with respect to Dr. Sheikh's failure to note the fracture in the x-ray, but not with respect to his failure to discover the fracture during his initial and second clinical examinations.

Regarding the initial clinical examination, Nurse Ploessel noted that the child was crying and the pain level was 5/5 but that she saw no obvious signs of injury. She noted a normal range of motion in the extremities, that there was no evidence of trauma and that the patient moved all extremities. Dr. Sheikh noted that the child was crying persistently and his documented extremity exam findings included "moves all extremities" and "non-tender." Unlike Nurse Ploessel, who noted normal range of motion in the extremities, Dr. Sheikh left the section blank for range of motion. No injuries were noted in either Nurse Ploessel's or Dr. Sheikh's T-sheets. The evidence is insufficient to support the conclusion that it fell below the minimal standard of competence to not determine from the initial clinical examination that there was a clavicle fracture.

With respect to the second clinical examination, that presents a closer call, particularly given that the mother had returned with the child that same date, reporting that the child was still crying and that she could not pick the child up. However, I also note that the child was sleeping on the mother's chest during the second visit, which was in the early evening, that Nurse Ploessel noted under "General Appearance" that the child had "no acute distress" and was "consolable," and that the child moved all extremities and the extremities were not tender and had good muscle tone. Dr. Sheikh likewise noted that Patient B.K. "moves all extremities," that the extremities

were "non-tender" and had a normal range of motion. He then ordered an x-ray. Based on the foregoing and in reviewing the entire record, I cannot conclude that it was unprofessional conduct to miss a clavicle fracture based solely on the clinical exams, without the information contained in the x-ray.

With regard to the x-ray, however, the evidence supports that it was unprofessional conduct to miss the clavicle fracture in the x-ray, particularly given the mother's report that she could not pick the child up. Four physicians, including Dr. Sheikh's expert, concluded without question that the x-ray clearly showed a fracture. There is no evidence disputing Dr. Parker's testimony that the fracture was "obvious." Both Dr. Parker and Dr. Dunn agreed that it did not meet the minimal standards of competency to report the x-ray as "normal." While counsel for Dr. Sheikh emphasizes that there were some discrepancies about the scope of the fracture and whether it was a greenstick or some other type, there was no dispute that the x-ray indicated a fracture. Nor does the fact that Dr. Parker occasionally used phrases indicating that the x-ray "suggested" a fracture change the overwhelming evidence that the fracture was clearly shown in the x-ray. Even Dr. Sheikh himself testified at the hearing that the x-ray showed a fracture; however, he argued that the x-ray showing the fracture was not the one he ordered and reviewed on August 22, 2009.

Dr. Sheikh testified that he thought the replacing of the x-ray was part of the fraud committed against him by the group of Caucasian family of physicians and nurses at GRHC:

> *But they implanted an x-ray on a person, and then they blamed me that you have missed the fracture. If this is not hatred, what is it? I want to ask you, you tell me, if it's not hatred . . . intolerance, what is it then?*

(Hrg. Trans. Vol. III, p. 741, line 1 – p. 743, line 7). Dr. Sheikh's testimony that he did not review the x-ray showing the fracture is not credible. The testimony of Ms. Moore and Ms. Wittman clearly demonstrate that the x-ray that Dr. Sheikh reviewed on August 22, 2009 was the

same one that Ms. Wittman took per Dr. Sheikh's order and which everyone agreed showed a fracture. Moreover, as stated, Dr. Sheikh has demonstrated a willingness to be untruthful in these proceedings. Dr. Sheikh's testimony that the x-rays were switched by staff at GRHC is simply not supported by credible evidence. The notion that staff and/or administration conspired to switch the x-rays of a one year-old child so that the child's fracture would go *undiagnosed and untreated* before discharge to home is not plausible.[16]

A preponderance of evidence establishes that Dr. Sheikh reviewed the correct chest x-ray for Patient B.K. on August 22, 2009. He simply missed the fractured clavicle that every other reviewing physician saw, including Dr. Overbeeke, Dr. Duranceau, Dr. Parker and Dr. Dunn.

Discipline

In light of the violations set forth above, Dr. Sheikh is subject to discipline pursuant to Wis. Stat. § 448.02(3)(c), The three purposes of discipline are: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich,* 71 Wis. 2d 206, 237 N.W.2d 689 (1976).

The Division recommends that Dr. Sheikh's license be suspended indefinitely and that prior to petitioning the Board to lift the suspension, Dr. Sheikh undergo an assessment with the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado and that he complete any educational programs recommended by CPEP within 2 years of a report of the assessment results to the Board.

Considering the facts of this case and the factors set forth in *Aldrich*, I conclude that the Division's recommendation is appropriate. Dr. Sheikh's multiple acts of unprofessional conduct

[16] Counsel for Dr. Sheikh suggests that GRHC staff may be motivated to unjustly build a case against Dr. Sheikh because he has sued them. However, presumably any lawsuit would have been filed after Dr. Sheikh was terminated from employment on August 31, 2009 and *after* many of the acts which would have had to be orchestrated against him under Dr. Sheikh's theory.

over a short period of only 12 days involving three separate patients and wide range of deficient conduct demonstrate a strong need for rehabilitation and protection of the public. License suspension will also deter other licensees from engaging in similar conduct by demonstrating the grave repercussions for such serious conduct.

Costs

Pursuant to Wis. Stat. § 440.22, the Board has the authority to assess respondents for costs of the disciplinary proceedings. Factors to consider include: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the cooperation of the respondent; (5) any prior discipline; and (6) the fact that the Department is a program revenue agency, funded by other licensees. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz*, Case No. LS 0802183 CHI (Aug. 14, 2008).

The Division recommends that full costs be imposed on Dr. Sheikh for this proceeding. I do not agree that full costs are warranted. Regarding the first factor, I note that the Division failed to prove the allegations and count with respect to one of the four patients, Patient S.H., a count which took substantial time at hearing. In addition, the Division appears to have abandoned (and did not prove) one of the sub-allegations contained in the Amended Complaint with respect to Patient D.M., namely, that Dr. Sheikh failed to examine him for a potential blood clot or infection even though he was complaining of leg pain. Moreover, although the Division proved the one count of unprofessional conduct alleged with respect to Patient B.K. in that Dr. Sheikh missed the obvious fracture in the x-ray, the Division did not prove the sub-allegations that it was unprofessional conduct for Dr. Sheikh to fail to discover the clavicle fracture in his first and second clinical exams.

Other facts, however, such as the nature and severity of the conduct and the level of

discipline sought, militate in favor of imposition of costs. Based on the facts of this case, and considering all of the other factors set forth in *Buenzli-Fritz*, I conclude that imposing 75 percent of the costs of these proceedings on Dr. Sheikh is warranted.

CONCLUSIONS OF LAW

1. The Medical Examining Board (Board) has jurisdiction to act in this matter, pursuant to Wis. Stat. § 448.02(3).

2. Pursuant to Wis. Stat. § 448.02(3), the Board has the authority to make investigations and hold hearings to determine whether a violation of Wis. Stat. § 448.02(3) or any rule promulgated under Wis. Stat. § 448.02(3) has occurred.

3. Pursuant to Wis. Stat. § 448.02(3)(c), the Board may warn or reprimand a licensee or may limit, suspend or revoke a license if it finds that the licensee has engaged in unprofessional conduct or negligence in treatment of a patient.

4. The Division has not shown by a preponderance of the evidence that Dr. Sheikh failed to document a skin examination of Patient S.H. on August 19, 2009 or that he engaged in unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(h) with respect to Patient S.H.

5. The Division has established by a preponderance of evidence that Dr. Sheikh has engaged in unprofessional conduct in violation of Wisconsin Admin. Code § Med 10.02(2)(h) by failing to examine Patient D.M. prior to ordering Haldol when there were no reports from other medical staff that Patient D.M. was potentially violent on that date, and by diagnosing Patient D.M. with mania on August 23, 2009 without any supporting findings.

6. The Division has established by a preponderance of evidence that Dr. Sheikh failed to create medical records regarding his involvement in Patient H.M.'s care, failed to order additional x-ray views to fully evaluate the cervical spine, and discharged Patient H.M. to home

with elevated cardiac enzymes on August 31, 2009 and that this conduct constituted unprofessional conduct in violation of Wisconsin Administrative Code § Med 10.02(2)(h).

7. The Division has established by a preponderance of evidence that Dr. Sheikh failed to create medical records regarding his involvement in Patient H.M.'s care on August 31, 2009, thereby engaging in unprofessional conduct, in violation of Wisconsin Administrative Code § Med 10.02(2)(za).

8. The Division has not established by a preponderance of the evidence that Dr. Sheikh engaged in unprofessional conduct by failing to diagnose a clavicle fracture during the initial and second clinical examinations of Patient B.K., but has established that it was unprofessional conduct for Dr. Sheikh to miss an obvious acute clavicle fracture on the x-ray taken during the second admission on August 22, 2009, in violation of Wis. Admin. Code § Med 10.02(2)(h).

9. Dr. Sheikh's conduct, as described in paragraphs 5-8 above, constitutes violations of Wis. Stat. § 448.02(3), Wisconsin Admin. Code § Med 10.02(2)(h) and (za), and thus subjects Dr. Sheikh to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

For the reasons set forth above, IT IS ORDERED that:

1. The medical license of Dr. Bashir A. Sheikh is indefinitely suspended. Prior to petitioning the Medical Examining Board to lift the suspension on his license, Dr. Sheikh shall undergo an assessment to evaluate Dr. Sheikh's current abilities to practice medicine.

(a) The assessment shall be performed under the direction of The Center for Personalized Education for Physicians (CPEP) in Denver, Colorado (cpepdoc.org).

(b) If the results of this assessment process show a deficiency in Dr. Sheikh's abilities, Dr. Sheikh shall participate in and successfully complete an

educational program established through the program and based upon the results of the assessment. Dr. Sheikh shall complete this program within the time parameters established by the program, but no later than two years from the date of the report to the Board of the results of the assessment process. The Board may consider an extension on request of the program.

(c) In the event that the program states that it is unable to develop an educational program which adequately addresses the issues identified in the assessment, the program shall notify the Board of this fact, and the matter shall be returned to the Division of Legal Services and Compliance for further action. The results of the assessment shall be admissible as evidence in any subsequent proceedings in this action.

(d) Dr. Sheikh shall be responsible for 100 percent of the costs incurred for the assessment and training under the terms of this Order, and shall timely pay all fees when due.

2. Dr. Sheikh shall pay 75% of recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

Department Monitor
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708-8935

3. The terms of this Order are effective the date the Final Decision and Order is signed by the Board.

IT IS FURTHER ORDERED that the above-captioned matter is hereby closed as to Respondent Bashir A. Sheikh.

Dated at Madison, Wisconsin on September 12, 2013.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: _____
Jennifer E. Nashold
Administrative Law Judge