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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

0003287

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	**FINAL DECISION AND ORDER WITH VARIANCE**
ZULFIQAR ALI, M.D. **RESPONDENT.**	DHA Case No. SPS-12-0064 DSLC Case No. 11 MED 299

BACKGROUND

On February 21, 2014, Administrative Law Judge Jennifer Nashold, State of Wisconsin, Division of Hearings and Appeals, issued a Proposed Decision and Order (PDO) in the above referenced matter. The PDO was mailed to all parties. Both parties filed Objections. On June 18, 2014, the Medical Examining Board (Board) met to consider the merits of the PDO. The Board voted to approve the PDO with variance. The PDO is attached hereto and incorporated in its entirety into this Final Decision and Order with Variance.

VARIANCE

Pursuant to Wis. Stat. §§ 440.035(1) and 448.02, the Board is the regulatory authority and final decision maker governing disciplinary matters of those credentialed by the Board. The matter at hand is characterized as a class 2 proceeding pursuant to Wis. Stat. § 227.01(3). The Board may make modifications to a PDO, a class 2 proceeding, pursuant to Wis. Stat. § 227.46(2).

In the present case, the Board adopts the PDO in its entirety except for the sections titled, "**Discipline**" and "**ORDER**". Those sections are varied as described below.

Discipline

The Division of Legal Services and Compliance (Division) recommended that Respondent be required to participate in a psychiatric evaluation to determine fitness to practice. The PDO did not include this requirement and the Administrative Law Judge opined that such an

evaluation was not warranted. The Board disagrees with the opinion of the Administrative Law Judge and believes that a psychiatric evaluation is supported by evidence in the record and is consistent with the purposes of professional discipline.

The record reflects an ongoing failure to take steps to ensure an airway despite multiple requests by other professionals and medical evidence indicating an adequate airway had not been established. This ongoing failure was blatant and inexplicable. The disregard of the medical evidence was irrational and the interactions with staff were inappropriate. At the hearing, contrary to all the evidence in the record, the Respondent maintained his opinion that there was no esophageal intubation. Based on the evidence in the record, a psychiatric evaluation is required to ensure fitness to practice and to ensure protection of the public.

ORDER

The Order in the PDO is adopted in its entirety with the addition of the following provision in Paragraph C.:

iv. Respondent shall undergo an evaluation by a mental health care professional who is competent to determine whether or not Respondent currently possesses a mental health condition which renders Respondent unable to practice medicine with reasonable skill and safety to patients.

1. The evaluator must be preapproved by the Board's designee, under the following terms:

    a. Before undergoing the evaluation, Respondent shall submit to the Department Monitor a copy of the evaluator's curriculum vitae, and copies of professional licenses and certifications held.

    b. The evaluator must be a licensed doctorate-level psychologist who is certified in a relevant field of practice by the American Board of Professional Psychology or a licensed psychiatrist who is certified in a relevant field of practice by the American Board of Psychiatry and Neurology. At the discretion of the Board's designee, additional experience in a relevant field of practice may be substituted for Board certification. At the discretion of the Board's designee, alternate Board recognitions, such as fellowships, may also be substituted for Board certification.

c. The evaluator must have had no previous personal or professional relationship with Respondent, and may not have previously evaluated or treated Respondent.

d. The evaluator shall have had a minimum of ten years of experience in the practice of psychology or psychiatry, and may not have been previously disciplined by any credentialing authority.

2. While the evaluator remains responsible for the final evaluation, the evaluator may delegate testing or other components of the evaluation to other mental health professionals who the evaluator deems competent to conduct those tests or perform the delegated task.

3. The exact tests chosen for administration are within the discretion of the evaluator. However, the evaluation must include a comprehensive interview of the individual and the use of rating scales, neuropsychological testing, and personality tests.[1]

4. The evaluation shall include an assessment of Respondent's ability to appropriately manage the triggers, degrees, and effects of an angered emotional state.

5. Any evaluation submitted for the purpose of staying or ending the suspension of Respondent's license to practice medicine and surgery must have been completed no more than 60 days prior to submission to the Board, unless otherwise approved by the Board's designee.

6. The evaluator shall identify restrictions on the nature of practice or practice setting or requirements for supervision of practice, if any, which are necessary to render Respondent able to practice medicine and surgery with reasonable skill and safety.

7. The evaluator shall identify specific mental health treatment goals, if any, which must be met before Respondent is able to practice medicine and surgery with reasonable skill and safety.

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[1] Commonly used tests include the Beck Anxiety Inventory, Beck Depression Inventory-II, Brief Psychiatric Rating Scale (BPRS), Bums Anxiety Inventory, Bums Depression Inventory, Hamilton Anxiety Rating Scale, Hamilton Depression Rating Scale, Inventory to Diagnose Depression, Profile of Mood States (POMS), State-Trait Anxiety Inventory (STAI), Symptom Checklist-90-Revised, Taylor Manifest Anxiety Scale, Yale-Brown Obsessive-Compulsive Scale, Kaufman Adolescent and Adult Intelligence Test, Rorschach, Wechsler Adult Intelligence Scale-III or IV (WAIS-III or WAIS-IV), Wechsler Memory Scale IV (WMS-IV), Category Test, Continuous Performance Test, Halstead-Reitan Neuropsychological Test Battery, MMPI2, NEO Personality Inventory, PAI, and the Thematic Apperception Test.

8. The evaluator's opinions and conclusions must be rendered to a degree of reasonable professional certainty.

9. Respondent must provide the evaluator with a copy of the Medical Examining Board's Final Decision and Order.

10. Respondent shall authorize release directly to the evaluator of records of mental health evaluations, diagnosis, treatment and treatment summaries that Respondent has undergone, and such other records that the evaluator determines are necessary to a competent evaluation.

11. Respondent is responsible for the costs associated with the evaluation.

12. Respondent shall authorize the evaluator to discuss the results of the evaluation with the Board or its designee.

Dated at Madison, Wisconsin this 25TH day of June, 2014.

WISCONSIN MEDICAL EXAMINING BOARD

By: Kenneth Simons MD,
A Member of the Board

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

0003287

In the Matter of Disciplinary Proceedings Against
ZULFIQAR ALI, M.D., Respondent

PROPOSED DECISION AND ORDER
DHA Case No. SPS-12-0064

Division of Legal Services and Compliance Case No. 11 MED 299

The parties to this proceeding for purposes of Wis. Stat. §§ 227.47(1) and 227.53 are:

Zulfiqar Ali, M.D, by

Attorney Nathaniel Cade, Jr.
Cade Law LLC
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Milwaukee, WI 53217

Wisconsin Medical Examining Board
P.O. Box 8366
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Department of Safety and Professional Services, Division of Legal Services and Compliance, by

Attorney Sandra Nowack
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
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PROCEDURAL HISTORY

These proceedings were initiated on August 24, 2012, when the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), served a Complaint on Respondent Zulfiqar Ali, M.D. The Complaint alleged that Dr. Ali engaged in unprofessional conduct as defined in Wis. Admin. Code § Med 10.02(2)(h) and was therefore subject to discipline pursuant to Wis. Stat. § 448.02(3). Specifically, the Division alleged that on March 19, 2011, Dr. Ali removed the cervical collar of a patient ("Patient A") prior to completing primary and secondary trauma assessments, failed to recognize and correct an

improperly placed endotracheal tube he had inserted, and failed to perform an abdominal examination on Patient A.

Dr. Ali, through counsel, filed an Answer to the Complaint on September 13, 2012. On September 14, the undersigned administrative law judge (ALJ) set a prehearing conference for October 2, 2012. Consistent with the prehearing conference, the ALJ issued a Prehearing Conference Report and Scheduling Order on October 2, 2012, which set a hearing date of February 5-6, 2013, a discovery deadline of January 14, 2013, and a deadline of January 21, 2013 for filing and service of proposed exhibits and exhibit and witness lists.

A hearing was held on February 6, 2014, at which three witnesses testified for the Division: Nurse Sharon Kaplon, Dawn Kalies and the Division's expert, Dr. Todd Nelson. Dr. Ali presented no witnesses nor did he offer any exhibits. At the conclusion of the hearing, the Division sought to amend its Complaint to add that Dr. Ali failed to document an abdominal examination. Counsel for Dr. Ali objected based on lack of notice, and the parties were ordered to brief that issue along with their briefing on the merits of the case.

Following receipt of the transcript, on February 20, 2013, a Briefing Order was issued, with the first brief to be submitted April 5, 2013, and last brief to be submitted May 16, 2013. Prior to filing of the first brief, on March 26, 2013, current counsel for Dr. Ali, Attorney Nathaniel Cade, filed a Notice of Appearance and Substitution of Counsel. On April 3, 2013, Attorney Cade filed a Motion to Stay Briefing Schedule and Reopen Proceedings to Allow Zulfiqar Ali, M.D. to Testify. As grounds for the motion, counsel noted that Dr. Ali's former counsel did not submit either a witness or exhibit list or offer any explanation for failing to do so, despite Dr. Ali providing her with names of potential witnesses.

In addition, Attorney Cade noted that Dr. Ali's former counsel did not inform Dr. Ali that at the time he retained her, she was under investigation by the Officer of Lawyer Regulation (OLR), that there had been a hearing before an OLR referee, that a penalty of a two-month suspension had been recommended, and that briefing before the Wisconsin Supreme Court was complete. The motion noted that sixteen days after Dr. Ali engaged former counsel, former counsel's license was suspended for two months, effective June 27, 2012. The motion further noted that former counsel failed to inform Dr. Ali that she was then fighting allegations brought by the OLR that her license be suspended for four months or that she was the subject of a third OLR complaint, which at the time of the motion was pending before a different OLR referee. A May 23, 2013 Wisconsin Supreme Court decision attached to the motion showed that former counsel had engaged in misconduct, including failing to act with reasonable diligence and promptness in representing a client, failing to communicate with clients, failing to take steps to protect a client's interest, and failing to cooperate in an OLR investigation.

The Division's attorney agreed to the request to stay briefing and the parties jointly requested that the ALJ schedule a status conference. At the telephone status conference on April 22, 2013, Attorney Cade indicated that he may wish to depose and call witnesses in addition to Dr. Ali. Counsel for the Division indicated that she did not object to Dr. Ali testifying but objected to the testimony of additional witnesses. After two subsequent status conferences held on May 13, 2013 and May 29, 2013, the ALJ issued a Notice of Hearing and Scheduling Order,

setting a date for the continued hearing on August 6, 2013 and setting a deadline of June 25, 2013 to file and serve any supplemental exhibit or witness lists, and setting a telephone conference for July 9, 2013 to address any objections to the proposed supplemental exhibits or witnesses.

On July 8, 2013, the Division filed a Motion to Exclude Testimony of Dr. Ali's proposed witnesses, stating, *inter alia*, that Dr. Ali's original motion was to allow only Dr. Ali's testimony, to which the Division agreed, and that it would prejudice the Division to allow Dr. Ali to present up to six additional witnesses who had not yet been identified, six months after the Division had presented its case and one month prior to the continued hearing date, particularly since discovery had closed.

On July 9, the ALJ held a status conference at which Attorney Cade indicated that he only wished to call two witnesses in addition to Dr. Ali; however, he did not identify the two witnesses. Over the objection of the Division, the ALJ allowed Dr. Ali to call two additional witnesses and ordered that he file and serve a list containing the names of these two witnesses no later than July 16, 2013. In addition, the ALJ set a new deadline of September 16, 2013 for completion of discovery, set a deadline of September 16, 2013 for the Division to file and serve its additional witness list, and reset the continued hearing date from August 6, 2013 to October 1-2, 2013.

On July 16, 2013, counsel for Dr. Ali filed a Second Amended Witness and Exhibit List, identifying Dr. Ali, Dr. Paul Duscher and Nurse Megan Fitzsimmons as potential witnesses. On September 12, 2013, the Division filed its supplemental witness list, identifying Dr. Ali, Dr. Nelson, Paramedic Mark Price, and Dr. Duscher as potential witnesses.

The continued hearing was held on October 1, 2013. The Division presented the testimony of Paramedic Mark Price and Dr. Ali. Dr. Ali did not call any additional witnesses.[1]

[1] Toward the end of the October 1, 2013 continued hearing, Dr. Ali, who was on the witness stand answering questions from his attorney, indicated that he wished to put on the record that his rights had been violated, including that medical records were missing or had been altered. Counsel for the Division interjected, recommending that, in the interest of time, Dr. Ali put his grievances in writing as part of his closing argument. Dr. Ali stated that he was agreeable to putting his grievances in writing and the ALJ stated that whether he did so or not would be between him and his attorney. His attorney did not follow up with questioning regarding Dr. Ali's allegations that documents were altered or that his rights were violated but instead continued where he had left off, questioning Dr. Ali about when a second hospital took over care of Patient A. (Hrg. Trans., pp. 550-552) After Dr. Ali's testimony, this issue was again taken up and it was clarified that no additional exhibits would be received with Dr. Ali's submission because they had not been previously disclosed, but that if Dr. Ali wished to submit a written grievance, he could do so after consulting with his attorney. (Hrg. Trans., pp. 570-72) On December 30, 2013, Dr. Ali himself emailed a document to the ALJ, to his attorney and to the Division's attorney, with the subject heading, "My grievances about investigations procedures." In this document, he appears to mainly take issue with the peer review process that occurred in his employment setting but also argues that the medical records are not complete and that there was collusion between medical staff. The brief filed by Dr. Ali's counsel on January 2, 2014 does not incorporate or refer to Dr. Ali's allegations contained in his December 30, 2013 submission. Dr. Ali's assertions are unsupported by any evidence. To the extent Dr. Ali and his counsel wished these assertions to be part of Dr. Ali's defense, counsel was required to solicit this testimony at hearing from Dr. Ali and/or other witnesses, and if there was other proof of Dr. Ali's assertions, to file proposed exhibits according to the scheduling order in advance of hearing, or, at a minimum, to attempt to have the proposed exhibits introduced at the hearing itself. Because the issues raised in Dr. Ali's submission have not been properly presented at hearing or briefed, they are not considered here.

At the conclusion of the hearing, the Division was asked if it still wished to amend the Complaint to add the allegation of failure to document an abdominal examination. The Division stated that it wished to do so and the ALJ reminded the parties that briefing on the issue was required.

Following receipt of the transcript, a Briefing Order and Order Granting Motion to Admit, With Limitations, Deposition Testimony of Dr. Paul Duscher was issued on October 22, 2013. At the request of counsel for Dr. Ali, an Amended Briefing Order was issued on December 16, 2013, with the final brief reply due on January 10, 2014.[2]

FINDINGS OF FACT

1. Respondent Zulfiqar Ali, M.D. (DOB 9/1/68) is licensed and currently registered by the Wisconsin Medical Examining Board (Board) to practice medicine and surgery in the State of Wisconsin pursuant to license number 4745-20, which was first granted November 1, 2004. (Complaint, ¶ 1, Answer, ¶ 1)

2. Dr. Ali's last address reported to the Department of Safety and Professional Services (Department) is 1601 N. Farwell Avenue, #319, Milwaukee, Wisconsin 53202. (Complaint, ¶ 2, Answer ¶ 2)

3. At the time of the events at issue, Dr. Ali practiced as a physician at Calumet Medical Center (CMC) in Chilton, Wisconsin. Dr. Ali's practice specialty was internal medicine. Dr. Ali was the physician responsible for Patient A during the time she received care at the CMC Emergency Department (ER). (Complaint, ¶ 3; Answer, ¶ 3; Div. Ex. 5, pp. 1, 3-4, 13; Ex. 14, p. 1)

4. Sharon Kaplon is a registered nurse who works as an ER nurse at CMC. She has a Bachelor's degree in nursing from the University of Wisconsin at Oshkosh and is currently pursuing her Ph.D. in nursing. Nurse Kaplon has worked at CMC continuously since March of 2009. (Hrg. Trans., pp. 13-15)

5. On March 19, 2011, Patient A, a 56 year-old female, was involved in a roll-over automobile accident in which she was suspended in water for an undetermined amount of time. First responders who arrived at the scene of the accident noted the patient to be pulseless and unresponsive, in cardiac arrest, but she was successfully revived. Patient A had not been wearing a seatbelt at the time of the accident. (Ex. 5, p. 10; Ex. 10, p. 33; Hrg. Trans., p. 56)

6. Patient A arrived via ambulance at the CMC emergency room at 1528 hours on March 19, 2011. Prior to her arrival, Patient A had been placed on a long board (sometimes referred to as a back board) and a cervical collar had been placed on her. Patient A also had an I-V in her when she arrived and a pulse oximeter was placed on her to measure heart rate and oxygen levels. Medical staff attempted to warm her. (Div. Ex. 5, pp. 6, 10; Hrg. Trans., pp. 57, 62, 64-65)

[2] After inquiry from a legal secretary at the Division of Hearings and Appeals (DHA) on January 17, 2014, counsel for the Division informed DHA that she would not be filing a reply brief. Counsel for Dr. Ali was informed of this fact on January 22, 2014.

7. Nurse Kaplon was the primary nurse assigned to care for Patient A. Therefore, it was Nurse Kaplon's responsibility to ensure that care provided to Patient A went smoothly. Nurse Kaplon assigned another registered nurse, Alison Schneller, to serve as a recorder of events while Patient A was receiving care. The recorder remained in the ER during Patient A's care and called out times and events as she documented them. Rather than providing direct patient care, the recorder documented Patient A's care in real-time. (Div. Ex. 5, p. 13; Div. Ex. 16, p. 6; Hrg. Trans., pp. 21-25)

8. Nurse Kaplon has relied on recorders' notes in the past and has found them to be reliable and accurate. In this case, she relied on the recorder's notes to prepare the trauma record, Exhibit 5, pages 5-11. Nurse Kaplon prepared the trauma record within 10 minutes after Patient A left the ER. To further ensure the accuracy of the trauma record, Nurse Kaplon confirmed any questions she had with colleagues with whom she worked that day, including three registered nurses, two paramedics and an emergency room technician. (Ex. 5, pp. 5-11; Hrg. Trans., pp. 19- 25, 58)

9. At the time of the initial evaluation at CMC, Nurse Kaplon performed a primary assessment of Patient A, meaning that she assessed Patient A's airway, breathing and circulation. In addition to being on a long board and wearing a cervical collar, Patient A had a blood pressure of 191/32 and sinus tachycardia. Patient A was also noted to be cyanotic and responsive to verbal commands. (Div. Ex. 5, pp. 6, 10; Hrg. Trans., pp. 16-17, 31)

10. Nurse Kaplon used the Glasgow Coma Scale to assess Patient A's neurological status. Because Patient A was somewhat confused and did not recall what had happened to her, Nurse Kaplon assessed Patient A at 14 out of 15 points on the Glasow scale. (Ex. 5, p. 6; Hrg. Trans., pp. 17-18)

11. At 1531 hours, Patient A had a pulse ox of 54%, with a second blood pressure reading of 174/92 and heart rate of 94 beats per minute. Patient A was initially placed on a CPAP machine to assist with breathing. (Div. Ex. 14, p. 3,)

12. When Patient A presented to Dr. Ali, he had concerns that she might have had damage to her spine and soft tissue injuries. (Hrg. Trans., p. 444)

13. At 1532 hours, after an initial evaluation during which Patient A denied neck pain, headache or motor sensory loss, Dr. Ali removed the cervical collar and long board. Dr. Ali testified that he did so because it was easier to intubate without the cervical collar on. Dr. Ali's record of the event and the trauma record provide no evidence that Dr. Ali palpated the posterior portion of Patient A's cervical spine before removing the cervical collar. Dr. Ali did not order or review any imaging studies of Patient A's spine before removing the cervical collar. (Div. Ex. 5, pp. 3, 6; Hrg. Trans., pp. 33, 136-144)

14. At 1540 hours, Dr. Ali electively intubated Patient A with a 7.5 mm. endotracheal tube to a depth of 27 cm. Dr. Ali had difficulties with the intubation, requiring a second or third attempt. An Ambu bag was attached to the end of the tube to assist with oxygenating Patient A.

Nurse Kaplon was present when Dr. Ali intubated Patient A. One of Nurse Kaplon's duties in caring for Patient A was to ensure that the patient was properly oxygenated and that the endotracheal tube remained in place as staff provided respirations. (Hrg. Trans., pp. 38, 72, 165)

15. Intubation is a process by which medical professionals help patients breathe when they are unable to do so effectively on their own. An endotracheal tube, often referred to as an "ET tube," is the device used for intubation. An ET tube has markings that indicate how far it descends into the patient's trachea. The ET tube, if inserted correctly, passes through the patient's vocal cords and down the trachea. Oxygen is then provided to the patient's lungs via the endotracheal tube. Proper intubation results in the oxygen being converted to carbon dioxide (CO2), which is evident when the carbon dioxide passes out of the patient's airway. (Hrg. Trans., pp. 28-29, 153-154)

16. An esophageal intubation occurs when, in the course of intubation, the endotracheal tube is inserted in the esophagus rather than the trachea. As a result of an esophageal intubation, oxygen does not go into the patient's lungs as intended by the intubation. (Hrg. Trans., pp. 41-42)

17. There was a CO2 detector attached to the end of the endotracheal tube used to intubate Patient A. Nurse Kaplon explained that the CO2 detectors are white or colorless until they detect carbon dioxide in the airway, at which time they turn purple. A properly placed endotracheal tube would result in production of carbon dioxide, which would be indicated by a color change in the detector. (Hrg. Trans., pp. 30, 153-154)

18. Immediately after Dr. Ali inserted the endotracheal tube, questions arose as to whether the tube was properly placed. Nurse Kaplon observed that when Dr. Ali intubated Patient A, the CO2 detector did not change color as it should have if the endotracheal tube were properly placed. Nurse Kaplon heard the two paramedics immediately tell Dr. Ali that the CO2 detector did not change color and she agreed with them. (Div. Ex. 5, p. 10; Div. Ex. 11, p. 3; Div. Ex. 16, p. 108; Hrg. Trans., pp. 35-36, 84)

19. Nurse Kaplon did a secondary assessment after Dr. Ali inserted the endotracheal tube. In her secondary assessment, Nurse Kaplon noted that Patient A's heart rate was faster than normal and that Patient A's abdomen was firm and distended, which is abnormal. It was during this secondary assessment that Ms. Kaplon noted that she did not hear breath sounds in the lung fields and that she heard gurgling sounds in Patient A's abdomen, which can be indicative that the oxygen intended for the lungs has been diverted to the epigastric area. She also heard Paramedic Mark Price inform Dr. Ali that there were no breath sounds in the lungs. She informed Dr. Ali that she heard gurgling sounds in the abdomen but did not recall whether she informed him that the abdomen was firm and distended, although it was her customary practice to inform the physician of any abnormal findings. (Hrg. Trans., pp. 32-33, 40, 50-51, 78-81, 113, 119)

20. Indications of an esophageal intubation include: visualizing that the ET tube has not gone through the vocal cords, no carbon dioxide detection on the CO2 detector upon placement of the endotracheal tube, lack of rise and fall of the chest, absence of breath sounds in the lung

fields, gurgling sounds in the epigastric region, and a firm and distended abdomen. (Div. Ex. 11, pp. 1-3; Hrg. Trans., pp. 40, 148, 153-154, 232)

21. Mark Price, who was a paramedic working in the ER at the time of the events, has done approximately two hundred intubations during his thirty-year career as a paramedic. After Dr. Ali intubated Patient A, Paramedic Price observed that breath sounds were negative bilaterally over the lung fields and there was no chest rise or fall. There were also sounds in the epigastrium area. When Paramedic Price did not hear breath sounds in the lungs, he informed Dr. Ali of this fact and told Dr. Ali that he did not believe the ET tube was in the right place. (Div. Ex. 5, p. 10; Div. Ex. 16, pp. 90-91, 108; Hrg. Trans., pp. 32, 38, 40, 312, 315-316)

22. The reporter's notes reflect that at approximately 1546 hours, Mr. Price asked Dr. Ali to replace the endotracheal tube. Nurse Kaplon recalled that she heard the paramedic ask Dr. Ali to replace the endotracheal tube. (Div. Ex. 5, pp. 10, 13; Div. Ex. 14, p. 5; Hrg. Trans., p. 43)

23. Dr. Ali declined, saying that it was "okay" that there were not breath sounds, and he wanted to wait for the radiologist's interpretation of the single-view chest x-ray. (Complaint ¶ 19; Answer ¶ 19; Div. Ex. 5, p. 10; Div. Ex. 16, p. 7; Hrg. Trans., p. 43)

24. In Dr. Ali's Emergency Room Report dictated March 23, 2011, four days after the events in question, he states: "X-rays were done to look for the tube location. After intubation, upon auscultation air entry seemed diminished. Staff did show some concerns about placement of tube in airway versus esophagus. Considering that patient had a drowning, it was not unexpected that air entry was not very good." (Div. Ex. 5, pp. 3-4)

25. Mr. Price "begged' Dr. Ali to recheck Patient A for breath sounds but Dr. Ali stated that he wanted to wait for the results of the x-ray. Mr. Price did not recall Dr. Ali ever rechecking the ET tube. (Hrg. Trans., p. 332)

26. On the day of the incident, March 19, 2011, paramedic Jeff Roehrig documented that he personally told Dr. Ali that he did not believe Patient A was properly intubated. Paramedic Roehrig reported that Dr. Ali repeatedly denied requests to let someone even visually confirm the tube's placement. Mr. Roehrig makes the same statements in an March 19, 2011 email to CMC Director of Patient Care Services and someone identified as "Mark," presumably Mark Price, and also states that "Dr. Ali did not listen[] to lung sounds at any time." (Div. Ex. 16, p. 2; Resp. Ex. 115)

27. On the day of the incident, Nurse Schneller documented that she, three nurses and two paramedics requested replacement of the endotracheal tube several times, but that "Dr. Ali refused each time." (Div. Ex. 16, p. 7)

28. According to Nurse Schneller, after Dr. Ali first retracted the endotracheal tube a centimeter:

> Breath sounds were still negative over bilateral lung fields, and positive over the epigastrium as the patient's abdomen was becoming increasingly distended. Dr.

> Ali stated the he had talked to a radiologist and that it was in the right place. However, the patient continued to be more and more hypoxic and became cyanotic. Several more requests over time were made to replace the endotracheal tube. Dr. Ali refused all of these requests, and was adamantly yelling at the staff not to touch the tube. He did eventually remove the tube an additional centimeter or two, and breath sounds were still negative over the lung fields. The patient's vital signs were reflecting increasing instability, and epinephrine and atropine had been given over time. . . . I observed the patient's heart rate go from 90 to 36, oxygen saturation levels down to 20 percent.

Nurse Schneller also indicated, "Watching the patient decline as she did, standard protocol determines the need for an airway first and foremost, and I have never waited for X-Ray placement verification for an airway. This was not needed. Breath sounds being heard or not heard should have been the red flag for the physician." (Div. Ex. 16, pp. 7, 9)

29. Nurse Kaplon similarly testified that the interactions between staff and Dr. Ali became confrontational after the paramedics and nurses voiced concerns that the endotracheal tube was not properly placed and Patient A was not getting proper oxygenation. Dr. Ali was yelling but she did not believe anyone else was yelling. (Hrg. Trans., pp. 52-54, 99-100)

30. Like Nurse Schneller, Nurse Kaplon recalls that in addition to herself and the two paramedics, three other nurses expressed concern about the intubation, although at hearing she could not recall whether or not Dr. Ali was present at the time. (Hrg. Trans., p. 116)

31. Nurse Kaplon had a conversation with Dr. Ali outside of the emergency room to express her concern that, based on the clinical indicators, Patient A was not oxygenating properly. She explained that she approached him outside of the patient's room because: "I felt that there was too much going on in the room that he could potentially feel like, you know, he was being – everyone was coming down on him at once and I just wanted to take it out of the room in a more -- a less anxiety setting and have a conversation with him." (Hrg. Trans., pp. 37, 52, 86, 115, 121)

32. When Nurse Kaplon asked Dr. Ali to check the placement of the endotracheal tube, he told her that based on the x-ray interpretation, the tube was in the correct location but that he was going to retract it a bit. (Hrg. Trans., pp. 52, 86)

33. At 1553 hours, following review of the radiograph, Dr. Ali withdrew the endotracheal tube back approximately 2 cm. but breath sounds were still negative over the lung fields. (Div. Ex. 5, pp. 7-8, 13; Div. Ex. 14, p. 5)

34. The radiologist's report, which was completed after Dr. Ali spoke with the radiologist, states under Findings: "There is an endotracheal tube in place overlying the region of the proximal right mainstem bronchus. This has been retracted 2 cm. as of this dictation." Under Impressions, the report states: "Low lying endotracheal tube which has since been retracted." (Div. Ex. 5, p. 15; Hrg. Trans., pp. 426, 468-472)

35. In Dr. Ali's Emergency Report, he indicates: "We did x-rays. After the x-rays I did reposition the tube and pulled it back approximately 2 cm. I discussed the placement of tube with radiologist. Tube was found to be in the right main bronchus approximately 1-2 cm in right main. Tube was pulled 2 cm after the x-rays. However, to make sure it is in the trachea, I again pulled the tube 2 cm more." (Div. Ex. 5, p. 4)

36. In his response to the Division's Request for Admissions, Dr. Ali admitted "that a single chest x-ray in itself is inadequate to confirm tracheal vs. esophageal intubation." He further admitted that "a minimally competent physician knows that single chest x-ray in itself is inadequate to confirm tracheal vs. esophageal intubation." (Div. Ex. 14, pp. 4-5)

37. During the hearing, Dr. Ali testified that he ordered a chest x-ray to check for depth and that a chest x-ray is used to check for depth, not for proper placement, although it can also sometimes indicate whether the tube is in the airway. He further testified that "usually" a chest x-ray is not a good tool to verify tracheal placement. (Hrg. Trans., pp. 422-423)

38. The recorder's notes and trauma report confirm that, at approximately 1602 hours Paramedic Price asked Dr. Ali to replace the endotracheal tube. The trauma report also indicates that at that same time, a nurse in the ER again asked Dr. Ali if the endotracheal tube could be replaced. (Div. Ex. 5, pp. 10, 13; Div. Ex. 14, p. 5; Hrg. Trans., pp. 43-44, 88)

39. At approximately 1602 hours, Dr. Ali left the ER to contact an intensivist on call and a physician at the ER at St. Elizabeth's Hospital in Appleton, Wisconsin. At 1610 hours, Theda Star, the helicopter transport company, was called. (Complaint ¶ 28; Answer ¶ 28; Div. Ex. 14, p. 6; Hrg. Trans., p. 92)

40. In an effort to get more oxygen to the lungs, at one point Paramedic Roehrig used a mask that went around Patient A's mouth and nose, rather than bagging the end of the ET tube. Paramedic Roehrig's action allowed some oxygen to get to Patient A's lungs through her nose and mouth, without going through the endotracheal tube. (Div. Ex. 16, p. 2; Hrg. Trans., p. 317)

41. Paramedic Roehrig eventually spoke with Mike Kloeser, a certified nurse anesthetist (CRNA), over the telephone to explain what was happening. Nurse anesthetists are trained in anesthesiology and they provide intubations and anesthesia in the operating room. The CRNA then spoke to Dr. Ali on the telephone. After his conversation with the CRNA, Dr. Ali told Paramedic Price to check the placement of the endotracheal tube. (Div. Ex. 16, p. 2; Hrg. Trans., pp. 318-319, 362)

42. At 1612 hours, Mark Price "rechecked visual of tube in mouth." When he checked, Mr. Price could see that Dr. Ali's ET tube was not in the vocal cords. (Div. Ex. 5, p. 13; Div. Ex. 16, p. 108; Hrg. Trans., pp. 45, 88 321-22)

43. At 1614 hours, when Dr. Ali left Patient A's room, Mr. Price placed a second endotracheal tube into Patient A, which was a 7 mm. tube. The first tube was not removed. Mr. Price described his intubation as follows: "I placed a laryngoscope blade in her mouth over her tongue into her – the tip into her vallecula, raised the vallecula to visualize the vocal cords,

placed a tube through the vocal cords." (Div. Ex. 5, p. 13; Div. Ex. 16, p. 108; Hrg. Trans., p. 310)

44. When a person is esophageally intubated, it is medically acceptable to place a second ET tube in the trachea rather than removing the first. Inserting a second tube serves two purposes. First, if the first tube was in the right place, it is not being removed. Alternatively, if the first tube is in the wrong place, the misplaced tube serves as a guide of where not to go. (Hrg. Trans., pp. 162, 236)

45. Mr. Price reintubated based on his understanding that the CRNA had instructed that a paramedic should check the intubation, that checking would include correcting, and that correcting included inserting a second tube when the first was incorrectly placed in the esophagus (Div. Ex. 16, p. 2; Hrg. Trans., pp. 320, 352)

46. Mr. Price observed his ET tube go into the vocal cords. In contrast to the first intubation effort, after Mr. Price inserted a second endotracheal tube, the following clinical indicators of a successful endotracheal intubation were present:

- Patient A had positive breath sounds in the lung fields.
- The CO2 detector changed from colorless to purple.
- There were improvements in Patient A's oxygen levels

(Div. Ex. 5, pp. 11, 13; Div. Ex. 16, pp. 2, 7, 91, 108; Hrg. Trans., pp. 45-47, 325)

47. Following the second intubation, an additional chest x-ray of Patient A was conducted at 1623 hours. The report for this x-ray indicates:

> In the region of the mediastinum there are two ET tubes that are projected, one is more in the midline and its tip is projected just above the carina. This needs to be withdrawn, approximately about 4 to 5 cm. The second ET tube, which is projected just to the left of the first, its tip is at a slightly higher level. I suspect that this is the tube in the proximal esophagus.

(Div. Ex. 5, p. 16; Hrg. Trans., p. 428)

48. 28 minutes passed between 1546 hours – the time the paramedic first asked Dr. Ali to replace the endotracheal tube – and 1614 hours – the time Mr. Price actually reintubated Patient A.

49. At 1624 hours, following a decline in Patient A's condition, CPR was initiated and a Code Blue called. (Div. Ex. 5, pp. 4, 11, 12; Hrg. Trans., pp. 91, 93)

50. Nurse Kaplon was monitoring Patient A's oxygen saturation levels and other vital signs, and those levels were being printed out from a computer in the ER from 1531 hours to 1647 hours. Vital signs are shown in 1-minute increments, although the oxygen saturation levels

are blank for many of the designated 1-minute increments. (Div. Ex. 5, pp. 17-28; Hrg. Trans., p. 42)

51. According to the print-out, during the 34 minutes from when Dr. Ali inserted the ET tube at 1540 hours until 1614 hours, when Paramedic Price inserted the second ET tube, Patient A's oxygen saturation level was generally low. With the exception of brief 1 to 3-minute periods where they reached percentages in the 80s (from 1552-1554, 1603-1605, 1607 and 1613 hours), the percentages were below the 80s range, including percentages in the 20s, 50s, 70s and percentages of 12, 30, 48, and 62. During the 10-minute period from the second intubation at 1614 hours until 1624 hours when Patient A went into cardiac arrest and Code Blue was called, percentages were in the 80s at 1615 and 1623 hours, in the 70s at 1619, 1620 and 1622 hours, and at 47 at 1621 hours. With the exception of the 47 at 1621 hours, after the second intubation, the percentages never went below the 70s, although there were only 6 readings during this time period. (Div. Ex. 5, pp. 18-25; Hrg. Trans., pp. 72-76)

52. The oxygen saturation levels in the print-out described in paragraphs 50-51 was based on readings from a pulse oximeter. A pulse oximeter measures oxygen saturation levels, and the device for measuring is usually placed on the finger or ear. The device can fall off or turn to the side in the ER. Also, the accuracy of the reading can be affected by circulation problems. Circulation can be affected by cold water temperature submersion, which occurred in this case. Also, at various points after Dr. Ali's intubation, medical staff oxygenated Patient A by placing a bag valve mask directly over the patient's mouth with the Ambu bag attached to the mask, rather than using the endotracheal tube. In addition, medications were given at various points which may have affected readings. (Hrg. Trans., pp. 94, 106-109, 172)

53. At 1630 hours, emergency air transportation (Theda Star) arrived from Theda Clark Medical Center Emergency Department. Patient A left CMC at 1639 hours (Div. Ex. 5, pp. 4, 12; Hrg. Trans., pp. 57-58, 62, 92)

54. An end-tidal CO2 monitor, as opposed to an end-tidal CO2 detector, provides a quantitative measure of the carbon dioxide. When Theda Star arrived, its staff used an end-tidal CO2 monitor on the tube placed by Mark Price. Theda Clark's monitor showed an end tidal CO2 level of 42. (Div. Ex. 5, p. 12; Hrg. Trans., pp. 163, 325-26)

55. Upon arrival at Theda Clark Medical Center Emergency Department at 1714 hours, Patient A was unresponsive to verbal and painful stimuli and had no spontaneous movement of extremities. Evaluation at the Theda Clark emergency department revealed apparent anoxic brain injury secondary to near drowning and possible prolonged esophageal intubation. Patient A died on March 22, 2011. (Div. Ex. 10, pp. 17-20; Div. Ex. 14, p. 7)

56. The record does not contain any documentation of an abdominal examination of Patient A performed by Dr. Ali. Dr. Ali testified that he conducted an abdominal examination and documented it. He stated that the abdominal examination was not very detailed and that part of the abdominal examination was performed prior to intubation. He acknowledged that the abdominal examination did not appear in the record but stated that the medical record was "suspicious." (Div. Ex. 5, pp. 3-4; Div. Ex. 11, p. 1; Hrg. Trans., pp. 49-50, 152, 509, 531-533)

57. The Division's expert witness, Dr. Todd Nelson, is a physician licensed to practice medicine and surgery in Wisconsin and is:

- the medical director for emergency and trauma services at Holy Family Memorial Hospital in Manitowoc, Wisconsin
- the associate chief medical officer for the hospital and all clinics within the Holy Family network
- the emergency medical services director for 11 of 13 emergency medical services in Manitowoc County
- an assistant clinical professor in emergency medicine, with a half-time appointment at the University of Wisconsin, Madison, where he works with medical students and residents
- a flight physician with MedFlight, serving 96 hours per month.

(Div. Ex. 12; Hrg. Trans., p. 128)

58. Dr. Nelson is accustomed to assessing competence of physicians through peer review activities, teaching, and overseeing physicians in the emergency medical department. In addition, he is on faculty at Lakeshore Technical College's critical care paramedic program. (Div. Ex. 12; Hrg. Trans., pp. 129-132)

59. Dr. Nelson reviewed the medical records in this case. All of the medical opinions Dr. Nelson expressed were offered to a reasonable degree of medical certainty. (Hrg. Trans., pp. 128, 135, 177-78, 248)

60. Dr. Nelson's opinion was that because of the risk of intra-abdominal injury due to the circumstances of Patient A's car accident and her overall condition, the standard of minimal competence required Dr. Ali to have conducted an initial examination of Patient A's abdomen and to have documented the examination. (Div. Ex. 11, p. 1; Hrg. Trans., pp. 148-152)

61. Dr. Nelson testified that under the circumstances of this case, where Patient A had scored 14 on the Glasgow Coma Scale because of her confusion, had experienced the trauma of a vehicle roll-over in which she had not been wearing a seatbelt, and had come into the ER on a long board and cervical collar, Dr. Ali should not have relied solely on Patient A's verbal statement that her neck did not hurt as an indication that it was safe to remove the cervical collar. According to Dr. Nelson, in addition to actually palpating Patient A's cervical spine, Dr. Ali should have waited for objective imaging studies to confirm there were no underlying fractures or other spinal injuries, or should have waited until such time as the patient could reliably report what she was experiencing, or both. He stated that Dr. Ali's failure to do so was below the standard of minimal competence. (Hrg. Trans., pp. 136-142, 147)

62. Dr. Nelson further opined that in removing the cervical collar under the circumstances set forth in the previous paragraph, Dr. Ali created an unacceptable risk that an underlying cervical spine injury would go undetected and therefore untreated. An undetected cervical spine injury could lead to paralysis or could leave the patient unable to breathe on her own, or both. (Hrg. Trans., pp. 138, 147)

63. In his 11-year career as an attending physician and working with the University of Wisconsin and Med Flight, Dr. Nelson has performed thousands of intubations. In that time, he has seen esophageal intubations. (Hrg. Trans., pp. 133, 232)

64. Dr. Nelson did not fault Dr. Ali's decision to intubate, nor did he believe the esophageal intubation was, in itself, incompetent practice. Esophageal intubation is a known risk associated with any intubation. (Hrg. Trans., pp. 158, 237)

65. Dr. Nelson's opinion was that Dr. Ali placed the ET tube in the esophagus. This opinion was based on the lack of breath sounds noted in the lung fields, no color change with the CO2 detector and positive sounds in the abdomen with bagging. When asked if these effects could result from the tube either being placed too high or too low rather than in the esophagus, he stated that the only way these symptoms could occur without esophageal intubation is if the ET tube were placed well short of the vocal cords, but that this was not the case because it was placed at 27 cm. and x-rays confirmed that the tube was deep into the patient. He also believed that Paramedic Price's ET tube was correctly placed in the trachea because of the indications of patient improvement following the second intubation. (Hrg. Trans., pp. 174, 157-158, 232-33)

66. Dr. Nelson did not believe it would be possible to insert two ET tubes, a 7.5 mm and a 7 mm., into the trachea without causing major laryngeal damage. (Hrg. Trans., pp. 221, 223)

67. Dr. Nelson's opinion was that Dr. Ali's conduct fell below the standard of minimal competence when he refused to take action to address reliable indicators that the intubation had not been successful, despite multiple requests by his medical team to recheck the tube and to replace it. (Hrg. Trans., pp. 157-158)

68. As a result of this failure, Patient A was unnecessarily deprived of oxygen for more than 30 minutes. (Div. Ex. 11, p. 3)

69. Dr. Nelson indicated that the standard of minimal competence required immediate verification that an endotracheal tube had been placed in the trachea, and not into the esophagus. Following intubation, the standard of minimal competence requires verified presence of CO2, as indicated by a color change of the CO2 detector, rising and falling of the chest, the presence of breath sounds, and no sounds that would indicate oxygen infiltrating the epigastric area. (Div. Ex. 11, p. 3; Hrg. Trans., p. 158)

70. Dr. Nelson stated that a minimally competent physician, the second he notices no bilateral breath sounds, sounds within the abdomen with bagging and no CO2 detection would investigate by looking again with a laryngoscope and reintubate if required, or if unable to do that, put another device in such as a Combitube or an LT King to ensure adequate oxygenation. (Hrg. Trans., pp. 176-77)

71. Dr. Nelson stated that, contrary to Dr. Ali's assertions, the fact that Patient A had been submerged in cold water would have no bearing on these tools for detecting proper ET tube placement. He stated that because Patient A was talking prior to intubation, there was carbon

dioxide exchange going on, a pulse, and good blood pressure. He stated that even where there is lower oxygen due to near drowning and fluid in the lungs, there was still carbon dioxide exchange, which was clearly documented after the second ET tube was inserted. (Hrg. Trans., pp. 159, 170-171)

72. Dr. Nelson indicated that a minimally competent physician would not rely on a single-view chest x-ray to confirm the absence of an esophageal intubation because a single-view chest x-ray would not establish whether or not the endotracheal tube was in the trachea, but would only indicate how far into the body the tube extended. He stated that x-ray only shows a front to back view, and not a side view, and that it cannot be determined from an x-ray if the ET tube is in the trachea or esophagus because one sits directly in front of the other. (Div. Ex. 11, p. 3; Hrg. Trans., pp. 155-158)

73. Failure to conform to the standard of minimal competence in airway management creates an unacceptable risk that the patient will be deprived of oxygen, creating the risk of severe prolonged cerebral hypoxia (low blood oxygen level), which can lead to death. (Div. Ex. 11, p. 5; Hrg. Trans., pp. 161-162, 228)

74. Dr. Nelson testified that following an esophageal intubation, the amount of time it will take a person to go into cardiac arrest will depend on several factors, including whether the person is receiving air from a bag being placed directly over the mouth, as occurred here, and whether he or she is hypothermic. How long someone can go without oxygen before suffering significant injury to the brain is also dependent on multiple factors, including whether the person was adequately oxygenated prior to intubation and whether or not the patient was cold. With near drowning victims, hypothermia can actually have a protective effect which may allow such individuals to go longer than normal without oxygen. (Hrg. Trans., pp. 160-161, 212-13)

75. When asked why approximately 10 minutes after the second tube was placed, Patient A went into cardiac arrest, Dr. Nelson responded that before the second tube was placed, Patient A already had significant problems as indicated, for example, by her receiving epinephrine and atropine. He then stated that after the second tube was placed, "she probably had already suffered from an anoxic brain injury meaning that there was a lack of oxygen getting to the brain and that's what led to her cardiac arrest. . . ." (Hrg. Trans., p. 213)

76. Dr. Nelson's testimony was credible and persuasive.

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)[3] 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).

Whether Dr. Ali engaged in unprofessional conduct by failing to timely recognize and correct an esophageal intubation of Patient A.

The Division asserts that Dr. Ali improperly placed the endotracheal tube into Patient A's esophagus. The Division does not contend that this act in itself constituted unprofessional conduct. As acknowledged by the Division's expert, Dr. Nelson, esophageal intubation is one of the known risks of intubation and does not by itself constitute unprofessional conduct. Rather, the Division's position, as confirmed by Dr. Nelson, is that Dr. Ali engaged in unprofessional conduct by disregarding well-known indications of esophageal intubation, despite repeated statements to him by ER medical staff that Patient A was improperly intubated, and instead waited for and relied on the results of a single view x-ray. As a result, the Division argues, Dr. Ali failed to recognize or correct the improper intubation in a timely manner, leaving Patient A without proper oxygenation for over 30 minutes, thereby creating the risk of severe prolonged cerebral hypoxia, which could result in permanent brain damage or death.

Dr. Ali first argues that he properly intubated Patient A and that there was no evidence that he intubated incorrectly other than the testimony of Paramedic Mark Price. (Respondent's Brief, p. 1) This assertion is contradicted by the record.

In addition to Mr. Price's testimony, which was credible, the record demonstrates that everyone in the ER room, except Dr. Ali, believed that after the first intubation, Patient A continued to decline, that there were signs of incorrect intubation, and that the ET tube should be rechecked and replaced.

Nurse Kaplon personally observed that after Dr. Ali inserted the ET tube, there was no color change on the CO2 detector, and this fact was brought to Dr. Ali's attention. She also personally observed that there were no breath sounds in the lung fields and instead, gurgling sounds in the epigastric area. She heard a paramedic report these abnormal findings to Dr. Ali. She also personally observed that Patient A's chest did not rise and fall after Dr. Ali's intubation and that Patient A's abdomen was firm and distended, indicating that the air from the ET tube intended for the lungs was instead going to the epigastric area. She specifically recalled personally telling Dr. Ali about sounds in the epigastric area. In addition, she observed that unlike after insertion of the ET tube by Dr. Ali, after Mr. Price inserted his ET tube, the CO2

[3] All references to provisions in Chapter Med 10 of the Wisconsin Administrative Code are to the provisions in effect at the time of the alleged conduct in 2011.

detector on that tube immediately changed color, Patient A had positive breath sounds in the lung fields, and there were improvements in Patient A's oxygen levels.

Dr. Nelson, the only medical expert to testify in this case,[4] indicated that the lack of color change in the CO2 detector, the lack of breath sounds in the lung fields, the lack of chest rise and fall, a firm and distended abdomen and sounds heard in the epigastrium are signs of esophageal intubation.

Also, in Nurse Schneller's report which was created on the day of the events, she indicated that she, three nurses, and two paramedics requested replacement of the endotracheal tube several times, but that "Dr. Ali refused each time." She stated that after Dr. Ali first retracted the endotracheal tube a few centimeters, "[t]he patient continued to be more and more hypoxic and became cyanotic," that "breath sounds were still negative over the lung fields," and that "[t]he patient's vital signs were reflecting increasing instability. . . ." She stated, "Watching the patient decline as she did, standard protocol determines the need for an airway first and foremost, and I have never waited for X-Ray placement verification for an airway. This was not needed. Breath sounds being heard or not heard should have been the red flag for the physician."

Paramedic Roehrig believed that the situation following Dr. Ali's intubation was sufficiently dire that he needed to convey the situation to the CRNA and also needed to directly place a ventilation mask over Patient A's mouth instead of attempting to ventilate through Dr. Ali's ET tube.

Also, Dr. Nelson was of the opinion that based on all of the indicators, Patient A was not properly intubated by Dr. Ali but was properly intubated by Mr. Price and that she went into cardiac arrest following the second intubation because she had been deprived of sufficient oxygen for over 30 minutes between the two intubations.

Although not argued by counsel for Dr. Ali in briefing, evidence supporting Dr. Ali's contention that he properly intubated Patient A was his testimony that he visualized the vocal cords before inserting the tube and that following his intubation, he saw Patient A's chest rise and fall. (Hrg. Trans., pp. 519, 553) He stated that he listened to the lungs and heard more breath sounds on the right side than the left side, which indicated to him that he had the ET tube too far down into the right side. (Hrg. Trans., pp. 483-85) He stated that he believed that the sounds in the lungs were weak because Patient A had edema and was obese. (Hrg. Trans., p. 486)

Dr. Ali also testified that he listened to the epigastrium area and heard noise there but believed this was also caused by the tube being too far down. (Hrg. Trans., p. 485) He also acknowledged that the pulse oximeter was not giving good oxygen saturation levels but believed that this was due to circulation problems in the patient. (Hrg. Trans., p. 486)

Dr. Ali's statements regarding the oxygen saturation levels may be correct. Dr. Nelson likewise testified that the oxygen saturation levels taken from the oximeter could be affected by

[4] Counsel for Dr. Ali asserts that it was due to Dr. Ali's prior counsel's failures that no expert was presented on behalf of Dr. Ali. (Respondent's Brief, p. 3) I note that current counsel did not request, and was not precluded from, presenting an expert at the continued hearing.

circulation issues. However, Dr. Ali's other assertions are not persuasive. His testimony regarding chest rise and fall and air being heard in the lungs is contradicted by the more credible testimony of Nurse Kaplan and others who were in the room and who observed that this did not occur. With respect to his claim that he visualized the vocal cords before placing the ET tube, the record supports the conclusion that Dr. Ali was mistaken in believing that his ET tube had gone into the trachea. Regarding the noise from the epigastrium area, the expert witness and other witnesses familiar with intubation testified that this is one of the classic indicators of an esophageal intubation.

Also credible are the written statements and testimony of medical personnel who stated that Dr. Ali refused to let other people check his intubation and Nurse Kaplon's testimony that she asked Dr. Ali to re-check the intubation but he declined, stating that the results of the x-ray confirmed that it was properly placed but needed to be pulled back a few centimeters.

Dr. Ali also testified that the radiologist had verbally confirmed that the x-ray showed a tracheal rather than an esophageal intubation. The radiologist's report states: "There is an endotracheal tube in place overlying the region of the proximal right mainstem bronchus. This has been retracted 2 cm. as of this dictation." The information regarding the right mainstem bronchus was conveyed to Dr. Ali and his interpretation was that the tube was inside of the right bronchus, which resulted in his retracting the tube a few centimeters. To a layperson at least, this interpretation of the radiologist's information seems sound. It is difficult to discern how the ET tube could be either in or "overlaying" the region of the proximal right mainstem bronchus if the tube had been placed in the esophagus, because the esophagus presumably goes straight down toward the stomach and would be more in the middle of the chest area rather than on the right side. The report further states: "Low lying endotracheal tube which has since been retracted." This too suggests (though far less so than the prior statement) that the radiologist believed the tube was laying too low into the bronchus, rather than in the esophagus, and needed to be retracted.

However, there was no expert testimony suggesting that Dr. Ali's (or a layperson's) interpretation of the radiologist's report is correct. Without additional testimony from an expert explaining the meaning or significance of the language in the report, and with the overwhelming evidence demonstrating that an x-ray is not a proper tool for determining esophageal versus tracheal placement, I cannot conclude based on this record that the report means Dr. Ali properly inserted the ET tube into the trachea. I also note that counsel for Dr. Ali does not refer to the results of the radiologist's report in his brief.

The only medical expert testimony in this case was that this type of x-ray is not a legitimate tool for determining whether the tube was in the esophagus or trachea and that the other indicators, all of which pointed to an endotracheal intubation, were the indicators upon which competent physicians rely. Dr. Nelson unequivocally stated, "X-rays are used in order to identify the depth of the endotracheal tube, not whether or not it's within the trachea or another place." (Hrg. Trans., p. 155) Dr. Nelson indicated that for this reason, a minimally competent physician would not rely on a single-view chest x-ray to confirm the absence of an esophageal intubation. He stated that x-ray only shows a front to back view, and not a side view, and that it

cannot be determined from an x-ray if the ET tube is in the trachea or esophagus because one sits directly in front of the other.

In addition, although Dr. Ali appears to have changed his position in briefing, Dr. Ali himself acknowledged both at hearing and in the discovery process that an x-ray is not used in checking for esophageal intubation. In his response to the Division's Request for Admissions, Dr. Ali admitted that "a single chest x-ray in itself is inadequate to confirm tracheal vs. esophageal intubation." He further admitted that "a minimally competent physician knows that single chest x-ray in itself is inadequate to confirm tracheal vs. esophageal intubation." (Div. Ex. 14, pp. 4-5) At hearing, when Dr. Ali was asked why he requested the x-ray, the following colloquy occurred:

> A That is what we routinely do to check the position, depth of the tube. And also sometimes it can tell us indirectly that our tube is in the airway or not.
>
> Q Do you generally agree with the previous testimony that you cannot tell whether or not the chest x-ray is a good tool to verify endotracheal placement? [sic]
>
> A This is not universal truth.
>
> Q Generally speaking.
>
> A Allow me to explain.
>
> Q Well, sir, I'm asking if you generally agree.
>
> A Yes. Usually, yes.
>
> . . .
>
> Q Now, you ordered the chest x-ray for determining placement of your intubation; is that correct?
>
> A It includes the depth. *It does not confirm the placement. We don't do it for that.* But it did in this case.
>
> Q *But you were doing it, and I understand you did it to look at the depth of the tube; correct?*
>
> A *Yes.*

(Hrg. Trans., pp. 422-423) (emphasis added) Thus, Dr. Ali himself has acknowledged as recently as the October 1, 2013 hearing, that an x-ray does not confirm placement of the ET tube and that his purpose in ordering the x-ray was to check on the depth of the ET tube, not whether it was in the trachea or esophagus, although in this instance he believed it could also indirectly indicate whether the ET tube was incorrectly placed.

In further support of his position that Dr. Ali properly intubated Patient A, counsel for Dr. Ali notes that Patient A went into cardiac arrest shortly after Mr. Price reintubated her, in contrast to Patient A's heart beating and blood pressure being maintained for more than 30 minutes after Dr. Ali's intubation. (Respondent's Brief, p. 2). As noted, however, after Dr. Ali's intubation, there were times when ER medical staff placed the mask directly over Patient A's mouth to oxygenate her rather than using the ET tube and also that individuals suffering from hypothermia, which appears to have been the situation with Patient A, may be able to go longer than normal without sufficient oxygen. Such factors would provide a reasonable explanation for Patient A being able to survive for as long as she did despite an improperly placed ET tube. In addition, Dr. Nelson stated his opinion that Patient A died following placement of the second tube because of the prolonged oxygen deprivation during the time period between placement of the first and second ET tubes. Finally, the classic indicators of tracheal intubation, including color change in the CO2 detector and positive breath sounds in the lungs, were present after insertion of the second tube and absent after insertion of the first tube.

Dr. Ali has also failed to explain why, if his ET tube was inserted correctly into the trachea, there would have been any detrimental impact on Patient A for the paramedic to insert a subsequent ET tube incorrectly. As stated by Dr. Nelson, there is no risk to having two ET tubes in place and one of the purposes of leaving the first tube in place when suspicious that it was improperly placed is so that if the first tube was in fact properly inserted, it remains in place. If Dr. Ali's ET tube was correctly inserted, presumably, it would have kept working properly even after placement of the second tube.

I conclude that a preponderance of evidence supports that Patient A was esophageally intubated by Dr. Ali. As stated, however, it was not unprofessional conduct to esophageally intubate Patient A. Rather, the question in this case is whether, given the indications of esophageal intubation, it was unprofessional conduct for Dr. Ali to fail to recognize and esophageal intubation and reintubate or take other action to get oxygen into Patient A and to instead wait for, and then rely on, the results of an x-ray. Despite his prior statements regarding the limited use of x-rays, Dr. Ali now argues in his response brief that the use of a single chest x-ray to confirm placement of a tube is something that a minimally competent doctor would use. (Respondent's Brief, pp. 3-4)

Dr. Ali points to a previous decision by the Medical Examining Board, and the testimony of expert physicians called in that case, which suggest that x-rays do in fact assist in determining whether an endotracheal tube was improperly placed in the esophagus. In *In the Matter of Disciplinary Proceedings Against Walter R. Boisvert, M.D.*, 2009 WL 3246633 (Wis. Med. Exam. Bd. August 19, 2009) (attached to Respondent's Brief), one of the issues was whether a nurse had improperly placed an endotracheal tube in the esophagus of patient M.S., a newborn child, or whether the tube was originally properly placed but prior to the x-ray had become dislodged from the trachea into the esophagus when the patient was moved. As indicated in the *Boisvert* decision, the radiologist who reviewed the x-ray stated, "There is a tube which extends to about the level of the diaphragm which is *probably* in the esophagus." *Id.* at 6. (emphasis added). Five physicians called as experts and Dr. Boisvert himself testified at hearing that they agreed with the radiologist's interpretation of the x-ray. Neither the administrative law judge,

Medical Examining Board nor the witnesses indicated that a chest x-ray could not be used to assist in determining whether the ET tube was in the esophagus or the trachea.

However, contrary to Dr. Ali's assertion, the *Boisvert* decision does not stand for the proposition that "the use of an x-ray, standing alone, can serve as a basis to determine if an endotracheal tube is properly placed." (Respondent's Brief, p. 4) The decision emphasized that the radiologist could only say that the ET tube was "probably" in the esophagus and that the same was true of the other witnesses. *Boisvert*, at 12. Moreover, the decision notes other factors that are significant in determining whether proper intubation occurred. Following the intubation, Dr. Boisvert's progress notes state: "ET tube confirmation was obtained with good bilateral breath sounds, symmetric expansion of the chest and no breath sounds auscultated over the stomach, no movement of the stomach with bagging respirations." *Id.* at 5. The hearing examiner likewise relied on these indicators in concluding that there was insufficient evidence to conclude that the tube was originally in the esophagus rather than the trachea, noting "the lung sounds, the lack of stomach sounds or distension, and the improvements in O2 level, respiration, pulse, blood pressure and color." *Id.* at 8-9. It was only after these indicators changed that Dr. Boisvert ordered an x-ray, and he ordered the x-ray primarily to check for various other problems. Thus, it is clear that these other indicators are significant in determining whether an ET tube is improperly placed in the esophagus.

Dr. Ali also attaches two appellate decisions to his brief which mention the use of x-rays in determining tube placement. However, those cases are inapplicable as they did not involve the issue of whether a tube had been improperly placed in the esophagus versus the trachea.[5]

A preponderance of the evidence supports the conclusion that for over 30 minutes, Dr. Ali failed to reintubate Patient A or otherwise provide her with sufficient oxygen under circumstances where the well-established indicators showed an esophageal intubation. Such conduct "tend[ed] to constitute a danger to the health, welfare, or safety" of Patient A and did not meet the level of minimal competence using accepted medical standards. His decision to wait for, and then place great reliance on, the results of the x-ray rather than reintubate or provide oxygen through some other means was compounded by the fact that there would not have been any risk to the patient to do a second intubation. Dr. Ali's conduct posed an unacceptable risk to the health, welfare and safety of Patient A in that it created the risk of cerebral hypoxia, which could lead to physical harm, including death.

Whether Dr. Ali engaged in unprofessional conduct by removing Patient A's cervical collar before adequately assessing Patient A's cervical spine.

Patient A was the victim of a traumatic event – a roll-over car accident in which she was not wearing a seatbelt. When she presented at the emergency room, she could not explain what happened to her. Accordingly, Nurse Kaplon gave her a score of 14 on the Glasgow Coma Scale, with one point off for confusion. At the time Dr. Ali removed the cervical collar, no

[5] The ALJ's further research uncovered an appellate decision involving an alleged esophageal intubation in which two physicians "examined the x-ray and determined that it established that the intubation was in the correct place, the trachea." *Jackson County Hospital Corp. v. Aldrich*, 835 So.2d 318, 323 (2002). However, a subsequent autopsy revealed that the tube was in the esophagus, *id.* at 324, which supports Dr. Nelson's conclusion that an x-ray is not a good tool for determining esophageal intubation.

imaging studies had been done and his records do not indicate that he did any palpation of the cervical spine to check for tenderness.

Dr. Ali documented that he removed the cervical collar after Patient A denied neck pain, headache, or any motor sensory loss. However, the health care record indicates that Patient A was confused and could not remember what had happened to her. Dr. Nelson's uncontroverted testimony was that under the circumstances of this case, Dr. Ali should not have relied solely on Patient A's verbal statement that she was not experiencing neck pain as an indication that it was safe to remove the cervical collar. Rather, the standard of minimal competence required that in addition to actually palpating Patient A's cervical spine, Dr. Ali should have waited for objective imaging studies to confirm there were no underlying spinal injuries, or should have waited until such time as the patient could reliably report what she was experiencing, or both.

In removing Patient A's cervical collar without taking these steps, Dr. Nelson indicated that Dr. Ali created an unacceptable risk that an underlying cervical spine injury would go undetected and therefore untreated. An undetected cervical spine injury could lead to paralysis or could leave the patient unable to breathe on her own, or both.

In briefing, Dr. Ali argues that a score of 14 on the Glasgow Coma Scale is equivalent to being intoxicated and does not mean that the patient would not be able to communicate or identify pain. Even if he is correct that a person who is intoxicated would score a 14, Dr. Ali does not indicate what degree of intoxication a score of 14 would be nor does he provide any support for the assertion that an intoxicated person's ability to feel or express pain might be compromised. Indeed, Dr. Nelson indicated that a patient's intoxication could be a barrier to a medical provider obtaining an accurate report of pain. (Hrg. Trans. pp. 138-139,141, 145)

Dr. Ali also suggests that a score of 14 can have a variance from facility to facility and states that Dr. Nelson "conceded that he has 'no idea what they do at their facility' and "can't speak to that." (Respondent's Brief, p. 6) Dr. Nelson's statement is taken out of context. Although the questions and answers were somewhat confusing, Dr. Nelson was referring not to a score of 14 meaning different things at different facilities, but to the fact that at some facilities, the provider will say aloud what is going on with the patient and the nurse will document it. (Hrg. Trans., pp. 190-191)

Dr. Ali also suggests that Dr. Nelson's testimony was invalid because it was based on a belief that CMC is a high level trauma center when in fact it is only a Level IV center, which means that it would not have the type of staff or training that Dr. Nelson would have expected to see there. (Respondent's Brief, p. 6) However, Dr. Nelson acknowledged that CMC was not a Level I or Level II trauma center. (Hrg. Trans., pp. 182-183) Moreover, it is clear from the entirety of Dr. Nelson's testimony that his opinions were not based on any assumption that CMC was a higher level trauma center than it was. Rather, Dr. Nelson's views regarding what the standards of minimal competence required were based, in part, on the fact that Patient A had undergone a highly traumatic event, one which could have caused spinal injuries and could have affected her ability to feel or report pain. (Hrg. Trans., pp. 136-147, 220-221, 213-232h)

Dr. Nelson's testimony with respect to removal of the cervical collar was not effectively contradicted by any persuasive evidence, including the testimony of Dr. Ali. Dr. Ali testified that he removed the cervical collar while he was intubating Patient A because it is easier. He

also testified that at the time he removed the cervical collar, someone was stabilizing Patient A's neck so she was not put at additional risk and that when the patient was intubated, the collar was put back on. (Hrg. Trans., p. 448) Dr. Ali further stated that he knew it was safe to take the cervical collar off because he somehow knew she would be getting a CT scan at another facility in approximately a half-hour to an hour. (Hrg. Trans., pp. 451-453)

Not only are these points not developed in briefing, but this testimony is outweighed by the medical expert's credible testimony that it was not within minimal standards to remove the cervical collar under the circumstances present here and that to do so created an unacceptable risk to Patient A.

Whether Dr. Ali engaged in unprofessional conduct in failing to conduct or document an abdominal examination.

The Division asserts that Dr. Ali failed to perform an abdominal examination on Patient A. In the alternative, the Division asserts that if Dr. Ali did so, he failed to document the examination. The Division argues that, under the circumstances here, involving a vehicular roll-over in which abdominal injuries could have occurred and where the nurse reported that the abdomen was firm and distended, failure to conduct an abdominal examination constitutes unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(h) because it was "any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public."

The Division further argues that if this tribunal concludes that Dr. Ali did in fact conduct the abdominal examination, then his failure to document the examination would constitute unprofessional conduct under Wis. Admin. Code §§ Med 10.02(2)(za) and 21.03. 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.

I note that the Division's Complaint only alleged that Dr. Ali's failure to conduct an abdominal examination constituted unprofessional conduct; it did not allege that failure to document the examination was unprofessional conduct. At the close of the first day of hearing on February 6, 2013, the Division moved to amend its Complaint to conform to the evidence presented at hearing, namely, that if Dr. Ali performed an abdominal examination, then he engaged in unprofessional conduct under Wis. Admin. Code. § Med 21.03 by failing to document it. Counsel for Dr. Ali objected based on lack of notice and stated that counsel for the Division knew from the time of Dr. Nelson's report that there was no documentation of an abdominal examination and should have moved to amend the Complaint well in advance of the

hearing date. The ALJ stated that because the parties were submitting briefs, the ALJ "would like this issue briefed as well," meaning the issue of whether an amendment to the Complaint was permissible. As stated in the procedural history above, briefs were not submitted following the first day of hearing due to the unusual circumstances involving Dr. Ali's prior counsel and Dr. Ali's retention of new counsel, and instead, the hearing was reopened and a second day of hearing was ultimately scheduled.

Eight months later, at the second day of hearing on October 1, 2013 during which Dr. Ali had new counsel, the issue of documentation of the abdominal exam was explored by both parties in questioning Dr. Ali. At the close of the hearing, the Division's counsel was asked, "And does the [Division] still intend to argue the issue of amending the complaint to add this new documentation allegation?" Counsel for the Division replied, "I do, particularly since they've now had notice of it since February," to which the ALJ responded, "So that issue will be briefed as well." (Hrg. Trans., pp. 572-73) Counsel for Dr. Ali did not renew the objection made eight months prior on the first day of hearing.

Contrary to the ALJ's intention, the parties did not brief the issue of whether it was permissible to amend the Complaint to add the documentation allegation but did brief the issue of failure to document the abdominal examination.[6]

Rather than re-ordering the parties to brief the issue of whether it is permissible to amend the Complaint to include the issue of documentation or refusing to address the issue because it was not briefed, the ALJ will give the parties the benefit of the doubt and decide the issue of amending the Complaint, under the assumption that the parties misconstrued the ALJ's request to "brief the issue" to mean that they should brief the issue of documentation rather than the issue of whether amending the Complaint was permissible.

I grant the motion to amend the Complaint to conform to the evidence at hearing. Although it would have been far preferable for the Division to move to amend the Complaint prior to hearing, I conclude that counsel for Dr. Ali was not prejudiced under the circumstances in these proceedings. First, the Complaint alleged that Dr. Ali had not conducted an abdominal examination, an allegation similar to failing to document an abdominal examination. Moreover, Dr. Nelson's report, which was provided to Dr. Ali's attorney at the latest on January 22, 2013, at least two weeks before the original hearing date, stated that there was no documentation of the exam. (Ex. 11, p. 1) At hearing, Dr. Nelson likewise testified that the standard of minimal competence required Dr. Ali to have conducted an initial examination of Patient A's abdomen and to have documented it. Dr. Ali's counsel had the opportunity to cross-examine Dr. Nelson on these points.

Most importantly, however, there was a period of 8 months between the first day of hearing, at which counsel for the Division first indicated it would seek to amend the Complaint, and the second day of hearing, at which Dr. Ali was provided wide latitude in presenting additional witnesses and at which he himself testified regarding the issue of documentation,

[6] The only reference to the proposed amendment in Dr. Ali's post-hearing brief is the following, contained in the section of the brief addressing discipline: "Especially disconcerting is the fact that the Division, after having the luxury of gathering evidence against Dr. Ali, changes course during the actual hearing and moves to amend the pleadings because it realizes that it likely cannot sustain the original charges against Dr. Ali." (Respondent's Brief, p. 11)

stating that he believed he had documented the examination and suggesting that the records had been altered or destroyed. Thus, both allegations of unprofessional conduct involving the abdominal examination will be addressed, namely, whether the Division proved that Dr. Ali failed to conduct the examination and whether it proved that if he conducted the examination, he failed to document it.

Dr. Ali testified that, despite no documentation of it in the medical record, he conducted an abdominal examination. However, when questioned during cross-examination, Dr. Ali was evasive and not credible:

Q When did you perform the abdominal examination of [Patient A]?

A When we exposed her.

Q When in conjunction with the intubation?

A It should have been before the intubation.

Q Was it before the intubation?

A It has to be because she was – we exposed her, and that's when we removed when we intubated her, she was not on the back board. And I – there's some indication that I noticed that she was incontinent. Not only that, but I remember she had a big, long scar. . . .

Q So it's your testimony that with this patient who came in and was having this difficulty breathing, so difficult that you needed to intubate her, and yet you performed an abdominal examination before taking care of the airway?

A No, when we exposed – it doesn't take one second. So in that sense I mean exam. I did not do a detailed examination.

Q Doctor, is the answer to my question yes?

A It depends on what you mean by detailed examination. If you mean detailed examination, no.

Q The abdominal examination that you've testified that you performed before you did the intubation, that's the examination to which I refer. Are we clear on that?

A No. Examination is not just one yes or no –

Q Doctor, that is a whole 'nother question. I'm trying to keep things focused so that we can move along more quickly. The question is: Do I understand you correctly to say that the abdominal examination that you conducted of this patient who was gasping for breath and who needed to be intubated, that that took place before the intubation?

A Some of it.

Q And you didn't document it, did you?

A I did.

Q You documented the abdominal examination?

A I dictated.

Q Is it in the document that's in the medical record?

A This document is very suspicious. No, it is not.

Q So you are saying that you have issues with the report that's attributed to you that's in the record?

A Yes.

(Hrg. Trans., pp. 531-533) Moreover, Dr. Ali's report completed 4 days after the incident, contains findings under headings such as "NECK," "HEART," "CHEST" and "BACK," but contains no heading for "ABDOMEN," nor does it contain any reference to an abdominal examination anywhere in the report. Based on the fact that there are no records of the abdominal examination and given Dr. Ali's evasiveness during questioning, I do not credit Dr. Ali's testimony that he conducted or documented an abdominal examination of Patient A and instead conclude that neither an abdominal examination nor documentation of such occurred.

The undisputed expert testimony was that it was not within the standards of minimal competency under the circumstances of this case to either fail to perform an abdominal examination or to fail to document it. Failure to conduct the abdominal examination created the unreasonable risk that an intra-abdominal injury would be missed.

Dr. Ali's failure to document the examination constitutes unprofessional conduct under a separate subsection, Wis. Admin. Code §§ Med 10.02(2)(za), which 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, in turn, provides that a physician "shall maintain patient health care records on every patient administered to" and that the patient health care record shall contain, *inter alia*, "[p]ertinent objective findings related to examination and test results" and "[a]ssessment or diagnosis." Wis. Admin. Code § Med 21.03(b) and (c), respsectively. Under these provisions, if Dr. Ali conducted the examination and did not document it, he engaged in unprofessional conduct.

Discipline

In light of the violations set forth above, Dr. Ali 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 requests that Dr. Ali's license to practice medicine and surgery be

suspended indefinitely, until such time that he demonstrates in a manner satisfactory to the Board that the need for the indefinite suspension no longer exists. The Division proposes that Dr. Ali be permitted to petition the Board for a stay or removal of the suspension if he complies with certain specified conditions guaranteeing he is safe to practice. I agree with the recommendation of the Division, with the exception of those conditions that require that Dr. Ali undergo a psychiatric evaluation. Although Dr. Ali admits that he yelled at certain medical staff in the ER when he believed that they were unjustly accusing him of having improperly inserted the ET tube, I do not believe the record contains sufficient evidence that Dr. Ali is in need of a psychiatric evaluation.

I also find unwarranted some of the Division's characterizations regarding Dr. Ali's alleged "ego" and "hubris" in "ignoring" medical staff. (Division's Brief, p. 11, 17) Dr. Ali mistakenly believed, and perhaps still believes, that he properly inserted the ET tube. While this is a serious error, particularly in light of the traditional indicators of esophageal intubation which were present and pointed out to him, he did not completely ignore staff but instead erroneously ordered an x-ray to confirm placement, an action which, although not within the standard of care under the circumstances here, a prior Board decision suggests can provide some indication of whether a tube is improperly placed.

Nevertheless, the protection of the public and need for deterrence require that Dr. Ali's license be suspended unless and until it can be confirmed that he can safely practice. Within a very short period of time, Dr Ali failed to meet the minimal standards of his profession in three very distinct and separate ways, all of which jeopardized the patient's health. Moreover, the record overwhelmingly supports that his actions regarding the ET tube fell below minimal standards and could result in grave consequences, as recognized by everyone in the ER room except him. Also, as previously stated, Dr. Ali's misjudgment was compounded by the fact that there was no risk to the patient in inserting a second tube, even assuming the first was correctly placed. The steps Dr. Ali will have to take in order to have the suspension stayed or removed are essential to the protection of the public and to Dr. Ali's rehabilitation. Thus, with the exception noted above, the Division's recommendation, with the conditions outlined in the Order section below, are adopted.

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 asserts that all of the costs of these disciplinary proceedings should be borne by Dr. Ali. In applying the *Aldrich* factors, I note that the following unequivocally support imposition of costs on Dr. Ali: there were three counts charged, all of which involved separate instances of unprofessional conduct and all of which were proven; the level of discipline sought

by the Division, indefinite suspension, is severe; and any costs not borne by Dr. Ali will have to be borne by his fellow licensees who have presumably not engaged in unprofessional conduct. In support of Dr. Ali not bearing the entirety of the costs is that he has been cooperative throughout these proceedings and has had no prior discipline. With regard to the nature and seriousness of the misconduct, I note that the conduct was serious though unintentional.

In view of the foregoing, it is appropriate to impose 70 percent of the costs on Dr. Ali.

CONCLUSIONS OF LAW

1. Dr. Ali engaged in unprofessional conduct as defined in Wis. Admin. Code § Med 10.02(2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3) by removing Patient A's cervical collar prior to determining whether she had spinal injuries, by failing to recognize and correct an improperly inserted endotracheal tube he had inserted, and by failing to perform an abdominal examination on Patient A.

2. Had Dr. Ali performed an abdominal examination, his failing to document the examination would constitute unprofessional conduct as defined in Wis. Admin. Code §§ Med 10.02(2)(za) and 21.03 and would be subject to discipline pursuant to Wis. Stat. § 448.02(3).

3. Applying the factors articulated in *Aldrich*, indefinite suspension of Dr. Ali's medical license is appropriate, as are the conditions for a stay or removal of the suspension set forth in the Order section below.

4. Pursuant to the factors delineated in *Buenzli-Fritz,* imposition of 70 percent of the costs of this proceeding is warranted.

ORDER

Based on the foregoing, it is hereby ORDERED that:

1. Dr. Ali's license to practice medicine and surgery in Wisconsin is SUSPENDED indefinitely, with the following conditions:

A. Respondent shall mail or physically deliver all indicia of Wisconsin licensure to practice medicine and surgery to the Department Monitor within 14 days of the effective date of this order.

B. Upon a showing by Dr. Ali of continuous, successful compliance for a period of at least 5 years with the terms of this Order, including at least 600 hours of active practice of medicine and surgery for every year the suspension is stayed, the Board may grant a petition by Dr. Ali to remove the suspension of his license to practice medicine and surgery. The Board may, on its own motion or at the request of the Department Monitor, grant full Wisconsin licensure at any time.

C. Dr. Ali may petition the Board for a stay of the suspension. The petition shall include proof that Dr. Ali has complied with the following:

i. Within 60 days of the date of the petition, or as otherwise approved by the Board's designee, Dr. Ali shall have undergone and fully cooperated with an assessment establishing his competence to practice medicine and surgery by an assessment program acknowledged by the Federation of State Medical Boards and preapproved by the Board's credentialing liaison.

ii. Dr. Ali shall have provided the assessment program with a copy of this Order, and shall have executed authorizations for release(s) of information such that the Board's credentialing liaison or other designee may communicate freely with the assessment program staff and may use the resulting final assessment report for the Board's purposes.

iii. Dr. Ali shall have completed, to the satisfaction of the Board's credentialing liaison, all education and training recommended by the competence evaluator, or Dr. Ali shall have a written plan for remediation that will not create an unacceptable risk of harm to patients.

D. Whether or not to stay the suspension of Dr. Ali's license to practice medicine and surgery is entirely within the discretion of the Board or its designee. The prerequisites to a petition to stay the suspension should not be interpreted to be an indication that the stay will be granted.

E. If the Board agrees to stay or remove the suspension of Dr. Ali's license, the Board may limit the license in any manner the Board deems appropriate for reasons consistent with the purposes of professional discipline.

2. Dr. Ali shall pay 70 percent of the costs of this investigation and proceeding in accordance with Wis. Stat. § 440.22 and Wis. Admin. Code § SPS 2.18.

3. Payment of costs shall be made payable to the Wisconsin Department of Safety and Professional Services and sent to the Department Monitor at the address below:

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

4. 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 Zulfiqar Ali.

Dated at Madison, Wisconsin on February 21, 2014.

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 H. Nashold
Administrative Law Judge