A publication of the Wisconsin Medical Examining Board

February 2012

Chair's Corner

By **Sheldon A. Wasserman, MD,**

Happy New Year! I am the new chair of the Medical Examining Board (MEB) and I welcome you to the first Newsletter of 2012. I am a practicing OB/GYN physician in Milwaukee. I graduated from the Medical College of Wisconsin and did my residency in Cincinnati, Ohio. I served in the Wisconsin State Legislature for 14 years and have been a member of the Board for the past 3 years.

Dr. Sheldon A. Wasserman

The Medical Examining Board is paid for by your state licensing fees, which support a staff of attorneys, paralegals, and others in the regulation of medicine. We meet in Madison once monthly on the third Wednesday to set policy and to review licensing and disciplinary matters.

Athletic trainers, dietitians, occupational therapists, podiatrists, massage therapists and bodywork therapists are all affiliated with our Board, though they retain rulemaking and disciplinary authority. Perfusionists, physician assistants and respiratory care practitioners comprise separate Councils, which are advisory to our Board.

State law dictates our composition. The MEB is made up of 10 physicians, one of whom is a doctor of osteopathy (DO). There are also three public members on the Board. A variety of specialties are represented, from general surgery to family practice.

Our job is to protect the safety and welfare of Wisconsin residents and to police our profession. We have the responsibility to license and discipline physicians in Wisconsin. It is a job that is not taken lightly, with our decisions at times having dramatic consequences.

During the course of this year, the Board will be revising Wis. Admin. Code Chapter 10, which are the administrative rules relating to professional conduct. This Chapter of the rules has not been revised or updated in decades. Changes to Wis. Admin. Code Chapter 8, which deals with physician assistants, is also underway. One of the most significant changes expected at this time is an increase in the number of PAs a physician may concurrently supervise from two to four. Work on revisions to both rules is still in progress at this time.

If you have any questions, please feel free to contact the Board's Executive Director, Tom Ryan, at thomas.ryan@wisconsin.gov or 608-266-2112.

We are looking forward to a productive and successful year!

Sheldon A. Wasserman, M.D.
Chair, Medical Examining Board

Medical Board Membership and Staff Assignments

The Medical Examining Board (MEB) consists of 13 members. The members are appointed by the Governor and approved by the Senate.

MEB Members:
Sheldon Wasserman, MD, Chair (Milwaukee)
Gene Musser, MD, Vice-Chair (Madison)
Jude Genereaux, Public Member, Secretary (Ellison Bay)
Carolyn Bronston, Public Member (Wausau)
James Conterato, MD (Marshfield)
LaMarr Franklin, Public Member (Glendale)
Sujatha Kailas, MD, MBA, (Fond du Lac)
Raymond Mager, DO (Bayside)
Christopher Magiera, MD (Wausau)
Suresh Misra, MD (Milwaukee)
Sandra Osborn, MD, (Madison)
Ken Simons, MD (Milwaukee)
Timothy Swan, MD (Marshfield)

Department of Safety and Professional Services (DSPS) Administrative Staff:
Tom Ryan, Bureau Director
Sandra Nowack, Legal Counsel
Karen Rude-Evans, Bureau Assistant
Shawn Leatherwood, Advanced Paralegal
David Carlson, Communications & Operations Associate

Executive Staff:
Dave Ross, Secretary
Bill Wendle, Deputy Secretary
Greg Gasper, Executive Assistant

The MEB meets monthly, usually the third Wednesday of the month. Dates and times are announced on the DSPS website at www.dsps.wi.gov. Meeting agendas are posted about one week prior to the meeting and identify open and closed session agenda items.

The Medical Examining Board. Front row: LaMarr Franklin, Sheldon Wasserman, Sujatha Kailas, Sandra Osborn and Gene Musser. Back row: Azita Hamedani (former member), Suresh Misra, Raymond Mager, James Conterato, Christopher Magiera, Carolyn Bronston, Kenneth Simons and Jude Genereaux.

Guidance Available in Archived Med Board Newsletters

Several excellent articles, offering guidance to physicians on a variety of topics, are available for review in archived versions of the Medical Examining Board Newsletter (previously the "Regulatory Digest").

The September 2011 newsletter contains an article entitled "Too Close For Comfort-Practical Tips to Avoid Professional Boundary Issues", by Sandy Nowack, Legal Counsel for the Board.

Dr. Sheldon Wasserman, current Medical Examining Board Chair, authored an article in the March 2011 newsletter entitled "Board Guidance: Sexual Boundaries and Chaperones".

The March 2011 newsletter also has an article written by Board Member, Dr. James Conterato entitled "Board Guidance: Prescribing Opioids".

In the same newsletter, you can find an article written by former Board Member Dr. Jerold Harter, "Board Guidance for Psychiatrists: The Duty to Report".

Dr. Harter's article outlines details of 2009 Wisconsin Act 382 which created a requirement for licensed physicians to report to the MEB if they have knowledge of a colleague who engages in a pattern of unprofessional conduct, creates an immediate or continuing danger to one or more patients or to the public, may be medically incompetent or may be mentally or physically unable to safely engage in the practice of medicine or surgery.

Proposed Solutions for Wrong Site Surgery Under Review by Joint Commission Center for Transforming Healthcare

Introduction by ***Carolyn Bronston, Public Member, Medical Examining Board***

As a public member who has screened well over a thousand medical complaints, I think wrong site, wrong side, wrong procedure/correction, or, the most egregious, wrong patient, are absolutely the worse words a patient can hear.

To have confronted the need for surgery, weighed the options, considered all the risks,and then to have one of these as the result must be unforgivable. The problem has received a thorough analysis in a study run by the Joint Commission Center for Transforming Healthcare.

They found that errors and omissions that contribute to the eventual adverse outcome can start very early in the process with the physician who makes the original diagnosis and referral and can occur at multiple points thereafter. I urge you to use the link in this article to access the discovery process and any necessary corrections that apply to your practice. This is truly one of those times where you can choose to be part of the solution or remain part of the problem.

Health care professionals and patients all agree that wrong site surgery is a serious and preventable adverse event that should never happen. Although reporting is not mandatory in most states, some estimates put the national incidence rate, which includes wrong patient, wrong procedure, wrong site, and wrong side surgeries, as high as 40 per week. Recognizing this as a critical patient safety issue, eight U.S. hospitals and ambulatory surgical centers teamed up with the Joint Commission Center for Transforming Healthcare (JCCTH) to address the problem. Like many health care organizations throughout the United States, these organizations understand that, while wrong site surgery is a relatively rare problem, all facilities and physicians who perform invasive procedures are at some degree of risk. The magnitude of this risk is often unknown or undefined. Providers who ignore this fact, or rely on the absence of such events in the past as a guarantee of future safety, do so at their own peril.

Using Robust Process Improvement™ (RPI) methods such as "Lean Six Sigma" and change management, the hospitals, ambulatory surgical centers and Center worked to discover the causes of and put a stop to these preventable breakdowns in patient care. These organizations found that problems with scheduling and pre-op/holding processes, as well as ineffective communication and distractions in the operating room contributed to increasing the risk of wrong site surgery. In addition, a time out without full participation by all key people in the operating room was identified as another contributing factor that increased risk. These contributing factors vary by organization and by event. This underscores the importance of understanding the specific contributing factors that increase risk in each organization so that appropriate solutions can be targeted to reduce the specific weaknesses in that organization's processes.

By reinforcing quality and measurement, emphasizing a culture of safety, strengthening knowledge about wrong site surgery, and improving consistency in surgical processes and in other processes that lead to surgery, the eight participating health care organizations and the Center found that opportunities for errors or defects could be reduced. For example, addressing documentation and verification issues in the pre-op/holding areas decreased defective cases from a baseline of 52 percent to 19 percent. Defects are the causes of and risks for wrong site surgery. In turn, the incidence of cases containing more than one defect decreased 72 percent.

The tested wrong site surgery solutions are now available to all Joint Commission-accredited organizations through the Targeted Solutions Tool™ (TST), which encapsulates the work of the JCCTH. The Center offers accredited organizations access through a secure extranet site to the framework for a wrong site surgery improvement method that, if implemented well, will contribute

See **Wrong Site,** Page 10

Enforcement Actions of the Medical Examining Board

The MEB has the following options available for discipline of a licensee:

Administrative Warning – Issued if a violation is of a minor nature, a first occurrence and the warning will adequately protect the public. Not reported to the National Practitioners Data Bank (NPDB). The content of the warning is confidential.

Remedial Education Order - Issued when there is reason to believe that the deficiency can be corrected with remedial education, while sufficiently protecting the public. This is not reported to the NPDB.

Reprimand – A public warning of the Licensee for a violation. This is reported to the NPDB.

Limitation of License – Imposes conditions and requirements upon the licensee, imposes restrictions on the scope of the practice, or both. This is reported to the NPDB.

Suspension – Completely and absolutely withdraws and withholds for a period of time all rights, privileges and authority previously conferred by the credential. This is reported to the NPDB.

Revocation - To completely and absolutely terminate the credential and all rights, privileges and authority previously conferred by the credential. This is reported to the NPDB.

Adminstrative Warnings
January-June 2011

Between July and December of 2011, the Board issued 8 administrative warnings. Administrative warnings are non-disciplinary and their content is confidential. In the past three years, the conduct most often underlying administrative warnings has included record-keeping violations and minor issues in prescriptive practices. Health care professionals are advised to insure timely, accurate and complete patient health care records are created for every patient contact, and particularly where a prescription order is issued.

Board Orders

August 2011

Clifford Greenbaum, Podiatrist, Oak Brook, IL

The Podiatry Affiliated Credentialing Board accepted the voluntary surrender of Dr. Greenbaum's license to practice podiatric medicine and surgery. Dr. Greenbaum surrendered his license during the pendency of an investigation, but for medical reasons.

Dated: August 9, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001030-00006305.pdf

Avery D. Alexander, Physician, Appleton, WI

The Medical Examining Board reprimanded Dr. Avery D. Alexander for follow-up care of his patient who had undergone bilateral refractive lensectomies. On two of the patient's follow-up visits Dr. Alexander took tactile pressures of his patient's eye instead of specific numeric readings. Dr. Avery admitted that specific numeric readings should have been taken during the patient's subsequent follow-up visits in order to comply with the standard of care. The Board limited Dr. Avery's license by requiring him to complete four hours of education in the appropriate post-surgical care of patients with glaucoma before December 31, 2012.

Dated: August 17, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001042-00006326.pdf

John W. Ingalls, Physician, Webster, WI

The Medical Examining Board reprimanded Dr. John W. Ingalls for failure to respond appropriately to a patient's chemical dependency, failure to document all prescriptions in the patient's health care record, failure to consider opioid treatment options, failure to assess his patient's compliance through toxicology testing, failure to require an opioid use agreement and failure to establish goals of improved functioning for his patients. Dr. Ingalls' conduct created an unacceptable risk that his patient would overdose or use opioid pain medications for reasons other than pain relief. The Board imposed

educational, prescription and practice limitations on Dr. Ingalls' license. Dr. Ingalls must complete remedial education on controlled substance management and patient health care records. He must refrain from prescribing opioids, including tramadol, to any patient for a total of more than 30 days in any 365 day period except as authorized by the Board and he must be supervised by a professional mentor.

Dated: August 17, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001043-00006327.pdf
Jan Rosnow, Physician, Sacramento, CA

The Medical Examining Board reprimanded Dr. Rosnow for having an adverse action taken against her license by the Medical Board of California, Department of Consumer Affairs. Dr. Rosnow was disciplined by the Medical Board of California as a result of administering succinylcholine to a patient that had recently suffered a spinal cord injury. Succinylcholine can be contraindicated for patients with such injuries.

Dated: August 17, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001041-00006325.pdf

September 2011

William J. Alt, Physician, Holland, MI

The Medical Examining Board limited Dr. Alt's license to practice medicine and surgery in Wisconsin for having been subject to an adverse action by the Michigan Board of Medicine Disciplinary Subcommittee in December of 2008. The Michigan Board of Medicine Disciplinary Subcommittee took action against Dr. Alt's license for prescribing controlled substances to a patient in a manner that fell below the minimal standard of care and for incompetence in prescribing controlled substances. The Wisconsin Medical Examining Board limited Dr. Alt's license by ordering that he shall not practice medicine and surgery in Wisconsin until he provides evidence to the Board, that he has complied with all terms and conditions of the Michigan Board of Medicine Disciplinary Subcommittee's 2008 Final Order and his license has been restored with no limitations. In the event Dr. Alt is successful on his appeal of the Michigan Board's 2008 Final Order and he regains an unrestricted license in Michigan, he may petition the Wisconsin Medical Examining Board for removal of all limitations on his license.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001115-00006440.pdf

Leonard L. Go, Physician, Madison, WI

The Medical Examining Board reprimanded Dr. Go for performing a splenectomy on his pediatric patient with the use of a morcellator without having previously used a morcellator or receiving any formal training on its use. During the course of the procedure, an opening in the retrieval bag was discovered causing Dr. Go to immediately convert the procedure into an open laparotomy. The patient developed complications caused by untrained use of the morcellator and another surgeon was called in to assist.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001112-00006437.pdf

James H. Shropshire, Physician, Monona, WI

The Medical Examining Board ordered Dr. Shropshire to complete six hours of continuing medical education on prescribing oral contraceptives, diagnosing deep vein thrombosis and diagnosing pulmonary emboli as a result of his care of a patient complaining of increased asthma symptoms and menstrual spotting. Dr. Shropshire prescribed his patient prednisone and continued her on other asthma medications including Albuterol. He also prescribed oral contraceptives to address the menstrual spotting. However, deep vein thrombosis is a recognized side effect of these oral contraceptives.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001113-00006438.pdf

Jen C. Sun, Physician, Las Vegas, NV

The Wisconsin Medical Examining Board reprimanded Dr. Sun for having been disciplined by the West Virginia Board of Medicine. The West Virginia Board of

Medicine reprimanded Dr. Sun for providing inaccurate information on his application for licensure.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001114-00006439.pdf

Kevin J. Vaska, Physician, Sioux Falls, SD

The Medical Examining Board reprimanded Dr. Vaska for having been disciplined by the South Dakota Board of Medical and Osteopathic Examiners for making a material misrepresentation on his application for renewal.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001117-00006442.pdf

Michael T. Witkovsky, Physician, Middleton, WI

The Medical Examining Board reprimanded Dr. Witkovsky for failing to maintain adequate medical records, including: incomplete initial evaluations, progress notes, and termination summaries. The Board limited Dr. Witkovsky's license by requiring him to complete a course on medical record keeping and requiring him to participate in a monitoring program from November 1, 2011 to May 1, 2013, under the direction of a monitoring physician pre-approved by the Board.

Dated: September 21, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001116-00006441.pdf

Marilyn K. Kochsiek-Waples, Physical Therapist, Evergreen, CO

The Physical Therapy Examining Board ordered that Ms. Kochsiek-Waples may not reapply for renewal of her license to practice physical therapy in WI at any time in the future. Ms. Kochsiek-Waples was disciplined by the Colorado Board of Physical Therapy for practicing as a physical therapist without a license. Ms. Kochsiek-Waples may not practice physical therapy in Wisconsin when not currently registered.

Dated: September 29, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001124-00006459.pdf

October 2011

Azber A. Ansar, Physician, St Paul, MN

The Medical Examining Board reprimanded Dr. Ansar for having an adverse action taken against his license by the State Medical Board of Ohio. The State Medical Board of Ohio disciplined Dr. Ansar as a result of his conviction of the misdemeanor offense of falsely reporting a crime. Dr. Ansar's license to practice medicine and surgery in Ohio was suspended for six months on the grounds that the conviction involved moral turpitude. Dr. Ansar's Ohio license was restored after the six-month suspension, but remains on inactive status for failure to renew.

Dated: October 19, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001159-00006521.pdf

Sushil A. Sheth, Physician, Burr Ridge, IL

The Medical Examining Board accepted the surrender of Dr. Sushil A. Sheth's license to practice medicine and surgery in Wisconsin as a result of his conviction of health care fraud, a crime substantially related to practice under his medical license, and for having his license to practice medicine disciplined in Illinois. Should Dr. Sheth seek reinstatement of his license or any other credential in Wisconsin, it shall be at the sole discretion of the Board whether to grant a credential and whether to impose any limitation.

Dated: October 19, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001157-00006519.pdf

Robert Stoy, Physician, Hudson, WI

The Medical Examining Board reprimanded Dr. Stoy after finding that on or about November 2007 to January 2009, he refilled a prescription for phentermine for weight loss without recording his patient's weight, treatment plan, reviewing his patient's previous medical records, or having any follow-up visits to record his patient's weight during that time. The Board

limited Dr. Stoy's license requiring him to complete continuing medical education in prescribing weight loss medications.

Date: October 19, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001158-00006520.pdf

November 2011

Adam H. Balin, Physician, Oregon, WI

The Medical Examining Board reprimanded Dr. Balin for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Balin's license requiring him to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001202-00006606.pdf

Mark Beamsley, Physician, Madison, WI

The Medical Examining Board reprimanded Dr. **Beamsley** for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Beamsley's license requiring him to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001204-00006608.pdf

Maria R. Doria, Physician, LaCrosse, WI

The Medical Examining Board reprimanded Dr. Doria for having an adverse action taken against her license by the Georgia Composite Medical Board. The Georgia Composite Medical Board issued a public consent order to Dr. Doria for failing to respond emergently to signals of fetal distress and for inconsistency in her interpretation of the fetal heart rate tracing. The Wisconsin Medical Examining Board recognized 42 hours of continuing medical education credits Dr. Doria earned as a result of the Georgia Composite Medical Board's consent order.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001210-00006614.pdf

Hannah M. Keevil, Physician, Madison, WI

The Medical Examining Board reprimanded Dr. Keevil for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Keevil's license requiring her to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001205-00006609.pdf

Bernard F. Micke, Physician, Madison, WI

The Medical Examining Board reprimanded Dr. Micke for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Micke's license requiring him to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001211-00006616.pdf

Kathleen A. Oriel, Physician, Madison WI

The Medical Examining Board reprimanded Dr. Oriel for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Oriel's license requiring her to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001207-00006611.pdf

Louis A. Sanner, Physician, Madison, WI

The Medical Examining Board reprimanded Dr. Sanner for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Sanner's license requiring him to complete four hours of continuing education in medical record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001209-00006613.pdf

James H. Shropshire, Physician, Monona WI

The Medical Examining Board reprimanded Dr. Shropshire for providing a medical evaluation and excuse from work without adequately documenting the interaction in a health care record meeting the requirements of Wis. Admin. Code Med § 21.03. The Board also limited Dr. Shropshire's license requiring him to complete four hours of continuing education in medial record keeping.

Dated: November 16, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001206-00006610.pdf

December 2011

Michael V. Baich, Physician, Coleraine, MN

The Medical Examining Board reprimanded Dr. Michael Baich for having had an adverse action taken against his license in Minnesota. The Minnesota Board of Medical Practice disciplined Dr. Baich for engaging in unethical and unprofessional conduct, improper management of medical records, and prescribing a drug or device for other than medically accepted purposes. The Wisconsin Medical Examining Board further limited Dr. Baich's license requiring that he may not practice in Wisconsin until he appears before the Board and provides proof that his Minnesota license is no longer restricted. In the alternative he may provide proof that his Minnesota license remains restricted but he is in full compliance with the Minnesota Board's order. Dr. Baich must also provide proof that he has the necessary knowledge of Wisconsin's legal requirements for health care records and the necessary knowledge to prescribe opioid analgesics competently.

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001280-00006703.pdf

Katherine M. Kaplan, Physician, Marshfield, WI

The Medical Examining Board reprimanded Dr. Katherine Kaplan for having an adverse action taken against her license to practice medicine in North Carolina. The North Carolina Medical Board issued a Public Letter of Concern to Dr. Kaplan for failing to detect a non- reassuring fetal heart tracing and other signs of fetal compromise. The Wisconsin Medical Examining Board recognized the 20 hours of continuing education ordered by the North Carolina Board.

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001278-00006701.pdf

Enrique W. Luy, Physician, New Berlin, WI

The Medical Examining Board reprimanded Dr. Enrique W. Luy for his treatment of a patient's rash. The Board found that by performing an excisional biopsy of the rash instead of obtaining dermatology consult, Dr. Luy had engaged in conduct that tends to constitute a danger to the health, welfare or safety of his patient. The Board imposed a limitation upon Dr. Luy's license requiring him to complete the course "Skin Problems and Diseases".

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001281-00006704.pdf

Michael R. Major, Physician, St. George, UT

The Medical Examining Board ordered that prior to renewing his registration in Wisconsin, Dr. Michael R. Major must obtain four hours of continuing education in preoperative and intra-operative methods of determining the appropriate site for surgical intervention for spinal surgeries and two hours of continuing education in informed consent. The Board imposed the restriction in

order to resolve allegations that in 2004, while practicing in Wisconsin, that Dr. Major performed a three level anterior and posterior spinal fusion rather than the planned two level procedure on his patient. Further, the procedure was performed at the incorrect site, and the patient was not informed of the error. It is further alleged that the error required a second operation to complete the procedure at the correct site and the patient ultimately suffered cauda equina syndrome as a result of complications from surgery. Dr. Major's Wisconsin license is currently expired. He is practicing in Utah, but intends to retire soon. He will not resume practicing medicine in Wisconsin.

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001277-00006700.pdf

Lyndon Steinhaus, Physician, Milwaukee, WI

The Medical Examining Board reprimanded Dr. Lyndon Steinhaus for having an adverse action taken against his medical license in Wyoming. The Wyoming Board of Medicine accepted the voluntary relinquishment of Dr. Steinhaus' license because Dr. Steinhuas pre-signed blank prescription forms and had willfully and consistently utilized medical services of treatment that were inappropriate or unnecessary. According to records, Dr. Steinhaus prescribed excessive amounts of methylin and methylphenidate hydrochloride. The Wisconsin Medical Examining Board limited Dr. Steinhaus' license requiring him to complete four hours of continuing education in professional ethics and continue to attend weekly meetings of Alcoholics Anonymous.

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001276-00006699.pdf

Phillip R. Tolentino, Physician, Union Grove, WI

The Medical Examining Board reprimanded Dr. Tolentino for engaging in conduct that constitutes a danger to his patient when he attempted to relieve the pain of a hematoma under his patient's fingernail. While preparing the hand for the procedure, Dr. Tolentino inadvertently caused the chuz pad on which his patient's hand was resting to catch fire. The patient sustained first degree burns to her left arm and hand, and a blister on a finger.

December 14, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001279-00006702.pdf

Nicholas A. Batson, Physical Therapist, Genoa City, WI

The Physical Therapy Examining Board reprimanded Mr. Batson for having been convicted of a crime substantially related to the practice of physical therapy and for having disciplinary action taken against his Illinois license to practice physical therapy. Mr. Batson was convicted of domestic battery involving a former patient. The Board also limited Mr. Batson's license requiring him to maintain compliance with all of the terms imposed against his license to practice physical therapy by the Illinois State Board of Physical Therapy. Mr. Batson must provide the Wisconsin Physical Therapy Examining Board a copy of any document issued by the Illinois State Board of Physical Therapy which alters the condition of Mr. Batson's practice in Illinois.

December 8, 2011
http://online.drl.wi.gov/decisions/2011/ORDER0001272-00006692.pdf

Wrong Site

Continued from Page 3

substantially to its efforts to reduce the risk of wrong site surgery. (Note: Solutions are also available publicly on the Center's website.) The TST is an application that guides health care organizations through a step-by-step process to accurately measure organization performance, identify barriers to excellent performance, and provide proven solutions that are customized to address the identified barriers. RPI expertise or experience is not required, and there is no requirement to complete additional Center projects. The TST is voluntary, self-paced, and is accessed at no additional cost.

As issues such as surgical site infections, hand-off communications, and other safety challenges are tackled through the Center, the solutions developed through the projects will be incorporated into the TST. Hand hygiene solutions for hospitals are currently available through the TST. For more information and other projects related to the Center for Transforming Healthcare, visit *http://www.centerfortransforminghealthcare.org*.

For more information about wrong site surgery contributions factors and solutions, please visit http://www.centerfortransforminghealthcare.org/assets/4/6/CTH_WSS_Storyboard_final_2011.pdf

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A wealth of useful information is available on the Department of Safety and Professional Services website at: www.dsps.wi.gov

Do you have a change of name or address?
Please send changes to the Department. Confirmation of change is not automatically provided. Legal notices will be sent to a licensee's address of record with the Department.

Med Board Newsletter distribution:
If you know someone who would like to receive a copy of the Med Board Newsletter, send their e-mail address(es) to: web@dsps.state.wi.us

Telephone Directory:
Call the Department of Safety and Professional Services toll-free (877) 617-1565 or (608) 266-2112 if you are in Madison, then follow the instructions for the service you need:
For renewal questions, say **renewal.**
For a new license including exam and education requirements, say **licensing.**
For complaint information, say **complaint.**
For legal questions or interpretations, say **legal.**
For exam administration, say **exam.**
For continuing education, say **education.**
For your pin #, say **pin.**
For license verifications, say **verify.**
For the agency staff directory, say **directory.**
For all other questions, say **operator**.

Verifications:
Verifications are available on our website by clicking "Lookup a License" from our home page.

Verifications:
Verifications are available on our website by clicking "Lookup a License" from our home page.

Verifications to Another State Board:
To verify your credential to another state board, submit $10.00 for each verification. A separate $10.00 fee is required for each credential you are verifying and for each state where a verification is to be sent. Make check payable to: Wisconsin Department of Safety and Professional Services. Please provide:

- Your name.
- Profession.
- License number.
- Daytime phone number.
- Mailing address where verification is to be sent.
- If you are requesting verification of exam scores only, please indicate the approximate date you took the exam(s).
- Your signature.

Mail your request to:
Department of Safety and Professional Services
PO Box 8935
Madison WI 53708-8935

If using a priority delivery service (UPS, FedEx, etc.) send to:
Department of Safety and Professional Services
1400 East Washington Ave
Madison WI 53703

The verification will be mailed within 5-7 business days from the date your request is received.