Med Board Newsletter

A publication of the Wisconsin Medical Examining Board **May 2013**

Chair's Corner

By **Sheldon A. Wasserman, MD**

When I was first appointed to the Wisconsin Medical Examining Board in early 2009, one important item signaled a needed change -- the administrative rules governing unprofessional conduct. The regulations were last revised in 1976, and many of them did not cover more modern standards and developments within the practice of medicine.

Dr. Sheldon Wasserman

So when I began my first term as Chair of the Board in January, 2012, I made it a high priority to update the professional conduct rules, which are located in Wis. Admin. Code MED Chapter 10, Unprofessional Conduct. Hundreds

*Please see **Chair,** page 3*

Wisconsin Presciption Drug Monitoring Program

Wisconsin will soon have a powerful new tool for healthcare professionals, the Wisconsin Prescription Drug Monitoring Program (PDMP). The PDMP is a statewide program that collects information about the dispensing of certain controlled substances and Tramadol to patients in Wisconsin. The PDMP database makes the information available to legally authorized individuals, such as physicians, physician assistants, dentists, advanced practice nurse prescribers, pharmacists, and other healthcare professionals. The primary purpose of the PDMP is to improve patient care and to reduce the abuse and diversion of prescription drugs in Wisconsin while still ensuring patients with a legitimate medical need for the drugs are not adversely affected. Studies show that PDMPs are a valuable tool for reducing prescription drug diversion and improving clinical decision-making.

Development of the PDMP began in June 2010, when the Legislature passed a bill directing the Pharmacy Examining Board (PEB) to create the PDMP. Since the law became effective, the Department of Safety and Professional Services (DSPS) has been overseeing the operations of the PDMP under the direction of the PEB.

Beginning on June 1, 2013, users will be able to create accounts with the PDMP. By creating accounts, healthcare professionals and their delegates will be authorized to query the PDMP database in order to gain immediate access to prescription histories for patients in their care, which will help them determine appropriate treatment and referral needs.

*Please see **PDMP**, page 2*

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)
Kenneth Simons, MD, Vice-Chair (Milwaukee)
Jude Genereaux, Secretary, Public Member (Ellison Bay)
James Barr, Public Member (Chetek)
Mary Jo Capodice, DO (Sheboygan)
Greg Collins, Public Member (De Pere)
Rodney Erickson, MD (Tomah)
Suresh Misra, MD (Milwaukee)
Gene Musser, MD, Vice-Chair, (Madison)
Timothy Swan, MD (Marshfield)
Sridhar Vasudevan, MD (Belgium)
Timothy Westlake, MD (Hartland)
Russell Yale, MD (South Milwaukee)

Department of Safety and Professional Services (DSPS) Administrative Staff:
Tom Ryan, Executive Director
Matt Niehaus, Bureau Assistant
Shawn Leatherwood, Advanced Paralegal

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.

Medical Examining Board members. Front row, left to right: Mary Jo Capodice; Suresh Misra; Kenneth Simons; Jude Genereaux; Sridhar Vasudevan, James Barr. Back row, left to right: Russell Yale; Timothy Westlake; Rodney Erickson, Timothy Swan, Gregory Collins; Sheldon Wasserman. Not pictured: Gene Musser.

PDMP

Continued from Page 1

Pharmacies and practitioners who dispense the monitored drugs have been compiling information about each dispensing of monitored drugs since January 1, 2013, the date on which the administrative rules creating the PDMP became effective. The PDMP database will therefore contain six months worth of data when it becomes fully operational on June 1.

By establishing the PDMP, Wisconsin is joining 48 other states that use PDMPs as part of their effort to curb the national prescription drug epidemic. To further enhance the PDMP, the PEB requested that the DSPS join the National Association of Boards of Pharmacy (NABP) PMP InterConnect, which will allow dispensers and practitioners to request data from other state prescription monitoring programs that are participating in the PMP InterConnect. To that end, the DSPS is currently negotiating a memorandum of understanding with the NABP.

For more information about the PDMP, visit the program's website, http://dsps.wi.gov/pdmp or e-mail questions to pdmp@wisconsin.gov.

Chair's Corner

Continued from Page 1

of hours of time were put in by Board members, both physicians and non physicians, as well as staff members of the Department of Safety and Professional Services (DSPS) to revise the rules. Several others were involved in the process. We even invited the Wisconsin Medical Society and the Wisconsin Hospital Association to the table from time to time as the Board discussed the policies underlying the rules and changes that would govern the future of our profession.

As I worked with DSPS staff, more questions arose about rules that were so outdated compared to the current practice of medicine, the specialization of care delivery, and evolving standards of decency. The rule simply has not kept pace with the rapid changes the profession has witnessed in recent times, with new diagnosis, care and treatment methods emerging almost daily. This proposed rule overhauls the present version of the rules, introduces new areas of oversight, deletes outdated language, and augments existing regulations.

The new version of the Unprofessional Conduct Chapter is divided into four sections: 1) Definitions; 2) Physician Dishonesty and Character; 3) Direct Patient Care Violations; 4) Law Violations, Adverse Action and Required Reports to the Board. In these four sections we bring the rule current with contemporary standards. Here are some of the highlights:

1. Improved language relating to sexual misconduct, inappropriate prescribing, and reporting of criminal acts;

2. A provision that specifically addresses wrong site, wrong patient and wrong procedure surgery;

3. New guidance regarding negligent practice reports received by the Board;

4. Further clarification of patient abandonment;

5. More direction about informed consent; and

6. A means to address disruptive behavior.

The current rule draft can be located on line by clicking here.

Much of the groundwork for the revised Chapter 10 has been laid. A public hearing took place on March 20, 2013 during the Medical Examining Board's monthly meeting. The Board plans to send the rule to the Governor and Legislature for review and approval after the hearing. When all reviews are complete, the Board will consider the rule for final approval.

I am proud of the work the Board, Department staff, and all the major stakeholders have put into this project. Wisconsin has first rate physicians and we will soon have updated rules that reflect modern practice.

Questions regarding MED 10 may be directed to Medical Examining Board Executive Director Tom Ryan, thomas.ryan@wisconsin.gov or by phone at 608-261-2378.

Sheldon A. Wasserman M.D.
Chair

The Medical Examining Board conducting business at its first "paperless" meeting on March 20, 2013.

Enforcement Actions of the Medical Examining Board

Disciplinary options available to the Board include:

Reprimand–A public warning of the licensee for a violation. This is reported to the National Practitioners Data Bank (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.

Non-disciplinary options available to the Board include:

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 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.

Adminstrative Warnings

From July 2012 to February 2013 the Board issued two administrative warnings. 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

July 2012

Bradley A. Bourkland, Physician, Rhinelander, WI

The Medical Examining Board imposed an **indefinite suspension** on the license of Dr. Bradley Bourkland for reporting to work under the influence of alcohol. Dr. Bourkland's blood alcohol level was 0.274 GM/DL. After 90 days of his suspension, Dr. Bourkland may request a stay of the suspension if he provides proof of compliance with the conditions of the Order including: continuing in drug and alcohol treatment; attending AA/NA meetings; and submitting to drug and alcohol screens.

Dated: July18, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001929-00007604.pdf

Michael E. Brouette, Physician Assistant, Pardeeville, WI

The Medical Examining Board **reprimanded** Mr. Michael Brouette for failing to order a head imaging scan and failing to consult with his supervising physician while treating his patient. The patient initially presented with soreness in the chest, in the knee and numbness in the left hand as a result of a car accident. Later there was some dispute as to whether the patient had a subdural hematoma while in Mr. Brouette's care. The Board also limited Mr. Brouette's license by requiring him to complete 10 hours of continuing education.

Dated: July18, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001927-00007602.pdf

James David Hanna, Physician, La Crosse, WI

The Medical Examining Board **suspended** the license and registration of Dr. James David Hanna for reporting to work under the influence of alcohol. Dr. Hanna's blood alcohol level was 0.212% by weight. The suspension may be stayed and the renewal of the registration may be permitted if Dr. Hanna petitions the Board and provides proof that he is in compliance with the conditions which have been imposed. The conditions include: drug and alcohol treatment; attending AA/NA meetings; and submitting to drug and alcohol screens.

Dated: July18, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001486-00007611.pdf

Terrance Moe, Physician, Eagle River, WI

The Medical Examining Board **reprimanded** Dr. Terrance Moe for treating a patient for back pain by prescribing oxycontin, methadone, Norco and Duragesic patches because he: a) failed to document a physical exam to support the diagnosis; b) prescribed medications for the diagnosis that weren't indicated for the diagnosis; and c) prescribed opiate pain medications even after he became aware that the patient had overdosed on opiates. Dr. Moe acted similarly with at least three other patients. The Board imposed an indefinite limitation on Dr. Moe's license in that he must retain a professional mentor for prescription records. Dr. Moe is also prohibited from prescribing Schedule I and II medications unless he is in the emergency department or on call at the hospital where he works and no other licensed prescriber is available to administer or prescribe the needed medication

Dated: July 18, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001485-00007610.pdf

Marta Muller, Physician, Oconomowoc

The Medical Examining Board **limited the license** of Dr. Marta Muller for failure to record her initial psychiatric intake notes, failure to document meetings with patients, and failure to document communications between herself and the primary care practitioner for her patients. Dr. Muller may not practice clinically until she demonstrates satisfactory completion of a course in medical recordkeeping.

Dated: July18, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001930-00007605.pdf

August 2012

Edwin E. Ferguson, Jr., Physician, Delafield, WI

The Medical Examining Board **reprimanded** Dr. Edwin E. Ferguson, Jr. and ordered a 60-day suspension of his license to practice medicine and surgery. In the summer of 2006, Dr. Ferguson became acquainted with Patient A, who had been diagnosed with inflammatory polyarthritis/reactive arthritis. Over the following three years, Dr. Ferguson prescribed Patient A opioids in an unusual and unjustified amount. He also prescribed benzodiazepines, corticosteroids, anti-inflammatories, antibiotics, sulfa medications and other medications. Dr. Ferguson did not keep patient health care records concerning his prescriptions for Patient A. Dr. Ferguson claimed that he saw Patient A at least monthly at Patient A's home and that on those occasions he took Patient A's blood pressure and performed an appropriate, focused examination. Dr. Ferguson did not keep any patient health care records of those encounters. During the same time period Dr. Ferguson took guitar lessons from Patient A, co-signed a loan for Patient A, and loaned Patient A money. The Board limited Dr. Ferguson's license in that he must complete a class on professional boundaries and he may not order, prescribe, dispense, or administer any controlled substance until he has completed a Board-approved course on appropriate prescribing of controlled substances.

Dated: August 15, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001967-00007672.pdf

Gope Hotchandani, Physician, Green Bay, WI

The Medical Examining Board **reprimanded** Dr. Gope Hotchandani for conduct which fell below the minimum standards in the medical profession when he failed to properly perform facial hair removal by laser procedure on a patient with Fitzpatrick VI skin type resulting in the unacceptable risk of burns to the patient's face on the right side. The Board also **limited** Dr. Hotchandani's license by restricting him from performing any laser hair removal on persons with Fitzpatrick VI skin type.

Dated: August 15, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001966-00007671.pdf

Mark E. Mc Dade, Physician, Janesville, WI

The Medical Examining Board **reprimanded** Dr. Mark E. Mc Dade for his care of a patient presenting with a hernia repair. On June 19, 2008, the patient arrived for surgery as she was recovering from a sinus infection. Dr. Mc Dade wrote in the record that the patient's head, ears, eyes, nose and throat were within normal limits. Dr. Mc Dade performed an incisional hernia repair with mesh as a day surgery. During the course of the patient's recovery the mesh became infected. Dr. Mc Dade removed the mesh. The Board found that moving forward with an elective surgery when the patient had an active infection in her body fell below the minimum standard within the profession; that Dr. Mc Dade should have known that there was an infection; and that it would increase the risk of infection in and around the mesh.

Dated: August 15, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001971-00007676.pdf

Eileen M. Reardon, Physician, Oakdale, MN

The Medical Examining Board **reprimanded** Dr. Eileen M. Reardon for care she provided to two patients during their pregnancies. Specifically, Patient A, a 25 year-old obese female with a history of gestational diabetes, presented to Dr. Reardon at 12 weeks gestation for her first obstetrics and lab exam. Patient A had a history of large babies resulting in difficult deliveries with severe shoulder dystocia. Dr. Reardon failed to perform an amniocentesis on Patient A at anytime during the pregnancy and failed to document that an amniocentesis had been attempted but failed. Dr. Reardon performed an elective cesarean section prior to term of 37 weeks in a patient with a history of diabetes. Dr. Reardon performed a colposcopy examination and biopsy on Patient B, a 29 year-old female. The biopsy showed a high grade dysplasia squamous intraepithelial lesion in the cervical region. The baby was delivered by cesarean section. The Board found that Dr. Reardon failed to monitor Patient B's cervical lesion during her pregnancy and should have evaluated it every trimester and performed repeat colposcopies. The Board also found Dr. Reardon failed to document adequate justification for doing an elective cesarean section.

Dated: August 15, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0001968-00007673.pdf

September 2012

Amjad Butt, Physician, Haverton, PA

The Medical Examining Board **reprimanded** Dr. Amjad Butt for having an adverse action taken against his license to practice medicine and surgery by the Iowa Board of Medicine. On July 7, 2011, the Iowa Board held a hearing and concluded that Dr. Butt had engaged in unprofessional conduct and sexual harassment in the practice of medicine. On August 25, 2011, the Iowa Board issued a Findings of Fact, Conclusions of Law, Final Decision and Order. The Wisconsin Medical Examining Board also imposed **limitations** on Dr. Butt's license, requiring him to maintain compliance with all terms and conditions imposed by the Iowa Board, and if Dr. Butt ever applies for reinstatement of his expired Wisconsin license, he must provide proof that he is in compliance with the Iowa Board's Order. The Wisconsin Medical Examining Board imposed this discipline as a default judgment due to Dr. Butt's failure to answer the underlying complaint, failure to provide a telephone number where he could be reached for the telephonic pre-hearing conference, and failure to appear at the prehearing conference.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002062-00007804.pdf

Rodrigo A. Castillo, Physician, Janesville, WI

The Medical Examining Board **reprimanded** Dr. Rodrigo A. Castillo for prescribing Duragesic patches to his patient for abdominal pain from approximately July 2002 until October 2006 without seeing the patient for reevaluation of her medical condition or determining the continuing need of the medication. Dr. Castillo **voluntarily stopped** providing treatment to chronic pain patients and referred chronic pain patients to other practitioners. The Board recognized Dr. Castillo's 22 hours of education in the area of pain management.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002059-00007801.pdf

Bruce K. Jacobson, Physician, Rhinelander, WI

The Medical Examining Board **accepted the voluntary surrender** of Dr. Bruce K. Jacobson's license to practice medicine and surgery in Wisconsin as a result of his conviction for possessing child pornography.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002056-00007798.pdf

Paul E. Mannino, Physician, Clinton, WI

The Medical Examining Board **reprimanded** Dr. Paul E. Mannino for conduct that fell below the standard of care while treating two patients. Dr. Mannino's physical examinations were insufficient to support his diagnosis in each patient or justify an increase in pain medications prescribed to each patient. Dr. Mannino failed to obtain both patients' medical records and he failed to require that both patients receive pain medication from one medical provider and fill their prescriptions at one pharmacy. The Board recognized Dr. Mannino's completion of 7.25 continuing education credits in initiating, documenting, monitoring, and discontinuing opioid therapy.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002052-00007794.pdf

Behram Pastakia, Physician, Bethesda, MD

The Medical Examining Board **reprimanded** Dr. Behram Pastakia for his review of a barium esophagram. Dr. Pastakia reviewed the radiographs post surgically but did not identify the retained sponge that was left in his patient's left abdomen or the significant abscess in the bowel. By failing to recognize the presence of the retained sponge and the bowel abscess, Dr. Pastakia exposed the patient to the risk that the patient's condition would not be diagnosed and treated in a timely manner. The Board also imposed a **limitation** on Dr. Pastakia's license by requiring him to complete continuing education in CT interpretation and radiographic interpretation.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002058-00007800.pdf

Roger A. Pellmann, Physician, Morgantown, WV

The Medical Examining Board **indefinitely suspended** the license of Dr. Roger A. Pellmann to practice medicine and surgery. Dr. Pellmann was convicted in federal court of ten counts of possession with intent to distribute, distributing fentanyl outside his medical practice and not for a legitimate purpose in violation of 21 U.S.C. § 841 (a)(1), and six counts of knowingly obtaining morphine sulfate by misrepresentation, fraud and deception in violation of 21 U.S.C. §843 (1)(3).

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002065-00007807.pdf

Donald Eugene Riemer, Physician, Eau Claire, WI

The Medical Examining Board **reprimanded** Dr. Donald Eugene Riemer for repeatedly prescribing controlled substances over several months for chronic conditions

without adequate medical histories or physical examinations to persons he should have known were not legitimate patients. Dr. Riemer also inappropriately issued prescriptions to himself in order to obtain a supply of zolpidem for general office dispensing. This occurred approximately between the dates of May 2010 until January 2011. The Board imposed several **limitations** on Dr. Riemer's license including but not limited to a neuropsychological evaluation, completion of courses in boundaries, making and keeping health records and professional ethics. The Board also imposed a **permanent limitation** on Dr. Riemer's license in that he may not prescribe, dispense, administer, or order any controlled substances.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002060-00007802.pdf

Anatol Stankevych, Physician, Green Bay, WI

The Medical Examining Board **reprimanded** Dr. Anatol Stankevych for his treatment of two patients. With regard to Patient A, Dr. Stankveych failed to perform and document an adequate physical examination of either of Patient A's eyes via gonioscopy, he failed to adequately describe the lens and cataract in Patient A's eye, and he failed to perform visual field tests on more than one occasion. With regard to Patient B, Dr. Stankevych performed a phachoemulsification procedure and a trabeculectomy procedure which was not indicated based on the patient's intraocular pressures, visual field tests and cup to disc ratios. The Board also imposed two limitations: a) Dr. Stankevych must refrain from performing surgical procedures due to his hand injury until the Board grants permission to resume his surgical practice; and b) he may not apply any of the completed continuing education hours to satisfy the biennial training CE requirement for licensure.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002054-00007796.pdf

Chinelo S. Ude, Physician, Andover, MN

The Medical Examining Board **imposed an indefinite suspension** on Dr. Chinelo S. Ude's license to practice medicine and surgery. On September 10, 2011 the Minnesota Board of Medical Practice suspended Dr. Ude's license to practice medicine and surgery in the state of Minnesota until she complied with the Order for Mental and Physical Examination dated August 22, 2011 and demonstrated the ability to resume the competent practice of medicine with reasonable skill and safety to patients. The Board imposed the discipline as a default judgment due to Dr. Ude's failure to answer the complaint, failure to provide a telephone number where she could be reached for the telephone pre-hearing conference, and failure to appear at the prehearing conference.

Dated: September 19, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002064-00007806.pdf

October 2012

Stephanie Boyer, Physician, Milwaukee, WI

The Medical Examining Board **reprimanded** Dr. Stephanie Boyer for failing to identify that her patient needed a slit lamp examination and an intraocular pressure after the patient presented with symptoms of angle closure glaucoma. By failing to properly identify the patient's condition, Dr. Boyer created the risk that the patient's condition would not be properly diagnosed and treated in a timely manner thereby creating the additional risk of partial or total permanent vision loss.

Dated: October 17, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002092-00007858.pdf

Thomas H. Kowalski, Physician, Greendale WI

The Medical Examining Board **accepted the voluntary surrender** of Dr. Thomas H. Kowalski's license to practice medicine and surgery. On or about 2005, Dr. Kowalski admitted that during the 1970's he had sexual

contact with an adolescent patient. In a separate incident, which occurred in approximately 1987, Dr. Kowalski was suspended from his position as a volunteer camp doctor by the Milwaukee County Council of the Boy Scouts of America for masturbating while fondling the genitals of two junior staff members. The Board further **limited** Dr. Kowalski's license in that he is indefinitely restricted from applying for any credential in Wisconsin.

Dated: October 30, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002111-00007897.pdf

Evan K. Saunders, Physician, Milwaukee, WI

The Medical Examining Board **accepted the voluntary surrender** of Evan K. Saunders' license to practice medicine and surgery following his conviction of four counts of fourth-degree sexual assault and four counts of disorderly conduct in Milwaukee County Case Number 2011CM005751.

Dated: October 17, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0000856-00007861.pdf

November 2012

Donald R. Beaver, Physician, Wauwatosa WI

The Medical Examining Board **reprimanded** Dr. Donald R. Beaver, for conduct which fell below the minimum standards for the profession. While treating patients A, B, C and D, during a time period from July 2010 up to and including March 2012, Dr. Beaver failed to conduct or document physical examinations to support the diagnoses given to each of the patients and failed to justify the medication prescribed. The Board also imposed a **limitation** on Dr. Beaver's license. He is prohibited from prescribing, dispensing, administering, or ordering controlled substances in any schedule; and he must take and complete a multi-day education program addressing controlled substances management.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002140-00007954.pdf

George P. Boyum, Physician, Stillwater, MN

The Medical Examining Board **reprimanded** Dr. George P. Boyum for being disciplined by the Minnesota Board of Medical Practice. The Minnesota Board disciplined Dr. Boyum after he admitted that between January 2009 and September 2010, he authorized a series of prescriptions for family members and himself. Dr. Boyum also admitted that he failed to refer family members to other treatment providers for specialized care, failed to provide adequate monitoring, and failed to document the prescriptions in a clinic record. The Board concluded that Dr. Boyum's acts constituted a danger to the health, welfare, or safety of his patients and that he failed to maintain patient health care records in accordance with Wis. Admin Code Chapter Med 21. The Board **limited** Dr. Boyum's license in that he must comply with the terms of the Minnesota Board Order.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002144-00007959.pdf

Mark Fantauzzi, Physician, Circleville, OH

The Medical Examining Board **revoked** Dr. Mark Fantauzzi's license to practice medicine and surgery for being disciplined by the State Medical Board of Ohio. The Ohio Board revoked Dr. Fantauzzi's license as a result of his making a false statement to the Ohio State Board of Pharmacy on his application for registration as a Distributor of Dangerous Drugs. The United States Department of Justice, Drug Enforcement Administration (DEA) subsequently issued an Order to Show Cause and Immediate Suspension of Registration as a practitioner in Schedule II-V based on allegations concerning Dr. Fantauzzi raised by the Ohio Board of Pharmacy. On September 14, 2011, Dr. Fantauzzi voluntarily surrendered his DEA controlled substances privileges. On October 11, 2011, Dr. Fantauzzi entered into an agreement to surrender his license to practice osteopathic medicine and surgery in Ohio with a consent to revocation.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002138-00007952.pdf

John M. Hale, Physician, Green Bay, WI

The Medical Examining Board **indefinitely suspended** the license of Dr. John M. Hale. It may be stayed after 90 days as long as certain conditions are met. Dr. Hale admitted that he had smoked marijuana and ingested morphine. The morphine was obtained from a supply of medications that was intended for a medical mission trip to Haiti. By obtaining a controlled substance other than in the course of legitimate professional practice, Dr. Hale committed unprofessional conduct. The Board may grant a stay of the suspension provided Dr. Hale is in compliance with certain conditions including but not limited to the following: entering into a drug and alcohol treatment program; attending alcoholic and narcotic anonymous meetings; and submitting to urinalysis screens as well as a neuropsychological examination.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002143-00007957.pdf

Gerhard K. Kraske, Physician, Middleton, WI

The Medical Examining Board **reprimanded** Dr. Gerhard K. Kraske for being disciplined by the Virginia Board of Medicine. The Virginia Board disciplined Dr. Kraske for failing to obtain a comprehensive patient history, failing to obtain treatment records from prior physicians before prescribing Tazodone for insomnia and Prozac for anxiety and depression. Dr. Kraske also failed to perform a physical exam, evaluation or assessment and failed to obtain prior records for the patient's shoulder pain prior to prescribing Dilaudid and continued to prescribe Dilaudid in varying strengths for approximately eight months without an examination and without monitoring his patient's pain levels or the medication as prescribed. The Board also imposed a **limitation**. Dr. Kraske must complete a minimum of 12 hours of education on the topic of appropriate prescribing within 9 months of the date of the Board's Order.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002141-00007955.pdf

Kevin D. Krembs, Physician, Munster, IN

The Medical Examining Board **reprimanded** Dr. Kevin Krembs for being disciplined by the Licensing Board of Indiana. The Indiana Board disciplined Dr. Krembs for prescribing medications to patients without a physical examination. During 2007, Dr. Krembs worked for a variety of telemedicine companies. While employed with these companies, Dr. Krembs wrote prescriptions for patients based on a review of medical files and phone conversations with patients and no physical examinations. Dr. Krembs voluntarily discontinued the unprofessional practice.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002142-00007956.pdf

Richard M. Roach, Physician, Minocqua, WI

The Medical Examining Board **reprimanded** Dr. Richard M. Roach for conduct which tended to constitute a danger to the health, welfare, and safety of a patient. In September of 2009, Patient A presented to Dr. Roach for consultation in regard to her bilateral hydronephrosis. Dr. Roach thoroughly explained complications of the surgical procedure. However, Dr. Roach did not obtain or document obtaining informed consent from Patient A regarding the use of contrast dye even though an allergy to contrast was noted in Patient A's allergies and alerts. In October of 2009, Patient A presented to Dr. Roach for surgery. During the procedure Dr. Roach used contrast for high-pressure balloon dilation to correct a stricture. During the procedure, Patient A experienced an anaphylactic reaction secondary to extravasated contrast at the high-pressure balloon dilated UPJ stricture site. Dr. Roach's conduct created an unacceptable risk that Patient A would have an adverse reaction. As a result, the Board imposed an education **limitation** requiring Dr. Roach to take 2 hours of medical education on management of allergic reactions and anaphylactic shock within 4 months of the Board's Order.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002146-00007961.pdf

Edward J. Rosenthal, Physician, Glendale, WI

The Medical Examining Board **reprimanded** and imposed a limitation on Dr. Edward J. Rosenthal based on the following conduct. From approximately March of 2009 until approximately June 2010, Dr. Rosenthal treated a patient for a gross hematuria. On or about May 2009, Dr. Rosenthal performed a cytoscopy on this patient and followed up with the patient on several occasions, closely monitoring the patient's PSA levels. However, he failed to conduct a digital rectal exam or other diagnostics during this time. Dr. Rosenthal also failed to inform the patient of the availability of all alternative, viable medical modes of treatment and about the benefits and risks of the treatment. Lastly, Dr. Rosenthal failed to respond to the Board's request for information. The Board imposed an education **limitation** requiring 4 hours in appropriate monitoring and evaluation including further diagnostics, after an increase in free PSA levels and 2 hours of education in informed consent.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002145-00007960.pdf

Alan C. Schold, Physician, Glendale, AZ

The Medical Examining Board **reprimanded** Dr. Alan C. Schold for being disciplined by the Commonwealth of Kentucky Examining Board of Medical Licensure. Dr. Schold and the Kentucky Board entered into an Agreed Order of Indefinite Restriction limiting his license for inappropriate prescribing practices while working for Central Kentucky Bariatric and Pain Management. The Board imposed the following **limitations**: he may practice medicine in the specialty of anesthesiology in a perioperative practice environment only; he may only dispense or otherwise professionally utilize controlled substances on patients undergoing surgical or diagnostic procedures; he must maintain compliance with the requirements of the Kentucky Order; and he must provide the Board with any documents issued by the Kentucky Board.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002137-00007951.pdf

David A. Van De Loo, Physician, Eau Claire, WI

The Medical Examining Board issued an interim order **suspending** Dr. David A. Van De Loo's license to practice medicine and surgery while the Board continues to investigate allegations that on or about August 30, 2012, Dr. Van De Loo inappropriately touched his 16-year-old patient's genitals while conducting a physical examination. The Board has not made a final determination as to the validity of the above allegations. The suspension shall remain in effect until the Board issues a Final Decision and Order.

Dated: November 14, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002093-00007958.pdf

December 2012

Floyd O. Anderson, Physician, Golden Valley, MN

The Medical Examining Board indefinitely **suspended** the license to practice medicine and surgery of Dr. Floyd O. Anderson for having his license to practice medicine and surgery suspended by the Minnesota Board of Medical Practice. The Minnesota Board took action against Dr. Anderson's license due to his repeated arrests related to driving under the influence of alcohol and marihuana and his initial refusal to participate in a voluntary monitoring program. The Board stayed the indefinite suspension and imposed the **limitation** that Dr. Anderson must remain in compliance with the Minnesota Board Order.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002202-00008037.pdf

Sean M. Cashin, Physician, Wisconsin Rapids,WI

The Medical Examining Board **reprimanded** Dr. Sean M. Cashin's license for conduct that fell below the minimum standards of competence within the profession. During a laparoscopic cholecystectomy for acute acaculous cholecystits, Dr. Cashin failed to properly identify the cystic duct, consequently leaving part of

the gall bladder in the patient. The patient continuously complained of pain after the surgery but Dr. Cashin did not order a HIDA scan or ultrasound in order to identify the source of the pain in a timely manner. The Board also imposed a **limitation** requiring Dr. Cashin to complete 4 hours of education on laparoscopic gallbladder surgery.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002205-00008040.pdf

Susan J. Carson, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Susan J. Carson for providing work excuse notes to patients without adequately documenting the interaction in a health care record that would meet the requirements of Wis. Admin. Code § Med 21.03. The Board **limited** Dr. Carson's license by requiring her to complete 4 hours of education in medical recordkeeping.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002200-00008035.pdf

Jennifer Y. Edgoose, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Jennifer Y. Edgoose for providing work excuse notes to patients without adequately documenting the interaction in a health care record that would meet the requirements of Wis. Admin. Code § Med 21.03. The Board **limited** Dr. Edgoose's license by requiring her to complete 4 hours of education in medical record keeping.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002199-00008034.pdf

Tilok Ghose, Physician, Eden Prairie, MN

The Medical Examining Board **reprimanded** Dr. Tilok Ghose for having his license to practice medicine and surgery conditioned and restricted by the Minnesota Board of Medical practice. The Minnesota Board's action was based, in part, on Dr. Ghose's failure to appropriately diagnose compartment syndrome and failing to perform orthopedic surgery in an emergent manner on his patient.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002195-00008030.pdf

Peter S. Jerome, Physician, Frisco, TX

The Medical Examining Board **reprimanded** Dr. Peter S. Jerome due to an adverse action taken against his license to practice medicine and surgery in Texas. Dr. Jerome submitted a false or misleading statement on his license application. At the time Dr. Jerome applied for Texas licensure, he failed to report that between 2003 and 2007, his clinical privileges had been suspended four times at two different hospitals due to delinquent medical records.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002207-00008042.pdf

Gloria Lopez, Physician, Orlando, FL

The Medical Examining Board **accepted the voluntary surrender** of Dr. Gloria Lopez's license to practice medicine and surgery. The Board based its action on the Minnesota Board of Medical Practice indefinitely suspending Dr. Lopez's license to practice medicine and surgery in that state. Dr. Lopez **may not reapply** for licensure to practice medicine and surgery in Wisconsin at any time in the future and the Department of Safety and Professional Services will not process any future application for renewal of her license.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002206-00008041.pdf

Michael C. Macatol, Physician, Marietta, OH

The Medical Examining Board imposed an **indefinite suspension** of Dr. Michael C. Macatol's license to practice medicine and surgery in Wisconsin due to the Kentucky Board of Medical Licensure issuing a default order of revocation against his medical license in Kentucky. The Kentucky Board issued its order due to Dr. Macatol reporting to work under the influence of alcohol with a blood level of .13%. As a result of the Kentucky Order, Dr. Macatol also entered into a consent order with the Medical Board of Ohio which provided for monitored treatment. The Board's indefinite suspension is stayed provided Dr. Macatol remains in compliance with the Ohio Board's consent order.

Dated : December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002204-00008039.pdf

Laurel B. Mark, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Laurel B. Mark for providing work excuse notes to patients without adequately documenting the interaction in a health care record that would meet the requirements of Wis. Admin. Code § Med 21.03. The Board **limited** Dr. Mark's license by requiring her to complete 4 hours of education in medical record keeping.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002211-00008046.pdf

Heath J. Meyer, Physician, Minocqua, WI

The Medical Examining Board **indefinitely suspended** Dr. Heath J. Meyer's license to practice medicine and surgery due to forging prescriptions for schedule III controlled substances under another provider's name from approximately February 2011 through December 2011 and January 2012 through June 2012. The Board stayed the suspension provided Dr. Meyer complies with certain conditions of the Board's order including but not limited to individual or group therapy sessions as determined by his therapist, attendance at AA/NA meetings, and drug and alcohol screens.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002196-00008031.pdf

Dipesh Navsaria, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Dipesh Navsaria for providing work excuse notes to patients without adequately documenting the interaction in a health care record that would meet the requirements of Wis. Admin. Code § Med 21.03. The Board **limited** Dr. Navsaria's license by requiring him to complete 4 hours of education in medical record keeping.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002210-00008045.pdf

Sami A. Roumani, Physician, Milwaukee, WI

The Medical Examining Board **reprimanded** Dr. Sami A. Roumani for his conduct during the care of his patient's pregnancy. Over the course of several prenatal visits Dr. Roumani failed to properly advise his patient of the risks caused by high blood pressure during pregnancy. At one visit the patient's blood pressure was 158/120. Dr. Roumani charted the possibility of pre-eclampsia. However the chart did not reflect whether the patient had been advised about the risk of death. The Board also imposed a **limitation** requiring Dr. Roumani to complete 6 hours of category I continuing medical education in recognizing and managing preeclampsia and obstetrical emergencies.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002197-00008032.pdf

Hans P. Schlecht, Physician, Fond du Lac, WI

The Medical Examining Board **reprimanded** Dr. Hans P. Schlect. From approximately 2009 to 2010 Dr. Schlecht dispensed clonazepam, a schedule IV controlled

substance, to his wife, without keeping a proper medical record. Dr. Schlecht claimed that the clonazepam was prescribed to his wife by her authorized prescriber. However, a review of his wife's medical record revealed no prescription was documented after 2001.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002198-00008033.pdf

Richard G. Schmelzer, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Richard G. Schmelzer for providing work excuse notes to individuals without an adequate examination. The Board **limited** Dr. Schmelzer's license by requiring him to complete a 1 hour face-to-face ethics consultation with an expert in the area of medical ethics.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002209-00008044.pdf

Melissa M. Stiles, Physician, Madison, WI

The Medical Examining Board **reprimanded** Dr. Melissa M. Stiles for providing work excuse notes to patients without adequately documenting the interaction in a health care record that would meet the requirements of Wis. Admin. Code § Med 21.03. The Board **limited** Dr. Stiles' license by requiring her to complete 4 hours of education in medical record keeping.

Dated: December 12, 2012
http://online.drl.wi.gov/decisions/2012/ORDER0002201-00008036.pdf

January 2013

Paul K. Awa, Physician, Inglis, FL

The Medical Examining Board **reprimanded** Dr. Paul K. Awa for being disciplined by the State of Florida Board of Medicine. The Florida Board of Medicine issued a Final Order adopting the Settlement agreement due to allegations concerning deficiencies in Dr. Awa's care of a patient.

Dated: January 16, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002257-00008126.pdf

Stephen R. Kreuser, Physician, Washburn, WI

The Medical Examining Board **reprimanded** Dr. Stephen R. Kreuser for treatment of his patient from approximately June of 2010 until October of 2010. Dr. Kreuser treated his patient for stable chronic renal insufficiency, atrial fibrillation hypertension, hypothyroidism, and pneumonia. During the course of treatment, Dr. Kreuser's care fell below the standards in the profession when he charted notes that were illegible, failed to chart vital signs, inadequately charted the basis for continuing diagnosis of pneumonia, ordered excessive x-rays and failed to closely monitor the patient's INR after new medications were prescribed. The Board **limited** Dr. Kreuser's license by requiring him to pass the Special Purpose Examination (SPEX) and undergo an assessment to evaluate his current ability to practice.

Dated: January 16, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002255-00008124.pdf

Edward J. Muellerleile, Physician, Waukesha, WI

The Medical Examining Board **indefinitely suspended** Dr. Edward J. Muellerleile's license to practice medicine and surgery. The Board found that Dr. Muellerleile practiced medicine while suffering from alcohol and cannabis dependence without being in treatment. Dr. Muellerleile may ask the Board to impose a stay of the suspension as long as he is in compliance with the Board's conditions.

Dated: January 16, 2013
https://online.drl.wi.gov/decisions/2013/ORDER0002256-00008125.pdf

February 2013

Eric Brekke, Physician, La Crosse, WI

The Medical Examining Board **reprimanded** Dr. Eric Brekke for failing to timely diagnose and treat a patient's left renal mass. Dr. Brekke saw a patient in the emergency room in July of 2007. The patient had complained of abdominal pain for six days. The patient was admitted with a diagnosis of subacute appendicitis. Dr. Brekke ordered a CT scan of the abdomen and pelvis. The abdominal CT revealed an incidental finding of a left renal mass. Later, in April of 2011, the patient was admitted to the hospital again complaining of lower back pain, and the patient was diagnosed with metastatic clear cell carcinoma of the kidney.

Dated: February 20, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002306-00008239.pdf

Thomas A. Londergan, Physician, La Crosse, WI

The Medical Examining Board **reprimanded** Dr. Thomas A. Londergan for failing to timely diagnose and treat a renal mass found in his patient. In April 2008 the patient presented to Dr. Londergan with pain in the left flank and hematuria. A CT scan of the patient's abdomen and pelvis was performed without intravenous contrast. The radiologist report indicated a 4.8 cm. left renal mass and blood in the left renal pelvis. Without reviewing the radiology report, Dr. Londergan sent the patient home with a prescription of Potassium Citrate suspecting the patient had a left kidney stone. After reviewing the radiology report on the next day, Dr. Londgeran added Allopurinol in addition to the Potassium Citrate and ordered a one month follow up with the patient. Dr. Londergan did not discuss the renal mass indicated in the radiology report at any of the successive follow-up appointments. In April 2011, the patient was admitted to the hospital for lower back pain. At that time the kidney tumor was identified and the patient was diagnosed with metastatic clear cell carcinoma of the kidney.

Dated: February 20, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002305-00008238.pdf

Victoria Mondloch, Physician, Waukesha, WI

The Medical Examining Board **permanently banned** Dr. Victoria Mondloch from the practice of obstetrics and from practice of gynecology except for conducting pap smears. The Board's Order was based on Dr. Mondloch's obstetrical and gynecological surgical treatment of five of her patients. The treatment included failure to properly and timely evaluate a patient for a possible ectopic pregnancy, failure to properly diagnose a patient's condition as a molar pregnancy, failure to properly diagnose a patient with Polycystic Ovary Syndrome (PCOS) and performing an ovarian drilling for treatment of metabolic abnormalities caused by PCOS or hormone imbalance when such treatment was not indicated by those conditions. The Board's **limitation** requires Dr. Mondloch to refer all patients that are pregnant to another obstetrician. She must refer all patients with abnormal bleeding or cramping where there is a possible pregnancy of any type including but not limited to uterine, ectopic, or molar; she must not perform any surgical or gynecological procedure on any patient with the exception of pelvic examinations and pap smears; she must transfer all patients requiring all other gynecological procedures to another gynecologist; and she may not perform ultrasounds. Dr. Mondloch is **permanently banned** from performing any gynecological procedure or seeing any patient for any gynecological reason except for pap smears. The Board also **reprimanded** Dr. Mondloch for her conduct.

Dated: February 20, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002309-00008242.pdf

Charles D. Pratt, Physician, Bayside, WI

The Medical Examining Board **reprimanded** Dr. Charles D. Pratt for failure to timely diagnose the signs of a stroke in a patient during an emergency room visit. The patient presented with shortness of breath and difficulty speaking. When Dr. Pratt evaluated the patient he noted that there were no focal neurological deficits and that the patient's sensory exam, motor exam, speech and coordination, were normal. His impression was dyspnea and the patient was treated for it. When Dr. Pratt later reevaluated the patient he noticed a right facial

droop and tongue protrusion, he also noted pronounced right arm and leg ataxia and weakness. At that time Dr. Pratt diagnosed that the patient had a stroke and a CT scan was performed. The Board **limited** Dr. Pratt's license to practice medicine and surgery by requiring him to complete 4 hours of medical education on the topic of diagnosis and management of strokes.

Dated: February 20, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002304-00008237.pdf

James J. Young, Physician, Weston, WI

The Medical Examining Board **reprimanded** Dr. James J. Young due to his failure to conduct a competent examination and evaluation of his patient and failure to detect necrotic tissue resulting in his failure to properly diagnose the patient's condition. The patient presented to Dr. Young complaining of persistent sinusitis. Her blood pressure was 180/100, pulse 135, temperature 98.9. No respiratory rate was charted. After Dr. Young's examination, the patient was given moxifloxacin and prescriptions for prednisone and hydrocodone. The patient was later seen by another health care practitioner who diagnosed the patient with severe metabolic acidosis from diabetic ketoacidosis, maxillary sinusitis, and acute necrotizing ulcerative gingivostomatitis. The patient was admitted to an intensive care unit where she recovered. The Board found that Dr. Young failed to detect necrotic tissue which resulted in his failure to properly diagnose the patient's condition.

Dated: February 20, 2013
http://online.drl.wi.gov/decisions/2013/ORDER0002307-00008240.pdf

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.

On-line Verifications:
The Wisconsin Medical Examining Board is now able to officially verify licenses and exam scores electronically. By completing a Verification Request online, a licensee can request official verifications of his or her license and exam scores to be sent to state boards, employers, insurance companies and other interested parties. Upon receiving a request, the Wisconsin Medical Examining Board will send a secured link to the verification website to the recipient that the licensee designates.

The real-time information displayed on the verification website is primary source information of the Wisconsin Medical Examining Board. Further, it is consistent with JCAHO and NCQA standards for primary source verification and is as it appears in the database of the Wisconsin Medical Examining Board as of the moment it is viewed.

The fee for licensure verifications has not changed. It is still $10.00 per verification.

The verification website constitutes official certification of licensure information and should be accepted just like a paper verification. However, should a recipient of an online licensure verification question its authenticity, please contact the Wisconsin Medical Examining Board directly.