It was a routine procedure.

Dr. David Almasy used an electrified wire to remove abnormal tissue from the cervix of Nicole Johnston, a 35-year-old mother of four. To reduce bleeding, he injected epinephrine.

The consequences were anything but routine. Johnston's heart started racing, her blood pressure soared and her lungs filled with fluid, causing her to suffocate and die.

During the procedure at Upland Hills Health in Dodgeville in 2010, Almasy gave her at least 100 times too much epinephrine, records show.

The Wisconsin Medical Examining Board in 2011 reprimanded Almasy, required him to take two classes and fined him $1,200.

"He destroyed my family," said Jaimie Barnes, 18, of Madison, Johnston's daughter. "He should have had his license suspended. I'm baffled he didn't get a higher punishment to fit the crime."

But the medical board's reprimand of Almasy is typical, a State Journal analysis found. The newspaper reviewed all 218 cases leading to medical board discipline from 2010 to 2012, along with dozens of cases in which the board didn't take action.

More than half of the doctors disciplined received reprimands, warnings that go on their records but don't limit their practices.

In at least 50 of the cases involving reprimands, patients died or were harmed, leaving some to wonder why the board didn't order harsher penalties.

The board used the same discipline for doctors who wrote questionable sick notes for protesters at the state Capitol in 2011.

Medical board leaders defended their actions, saying they prefer to rehabilitate doctors rather than punish them, especially for mistakes.

But they also said limited money and authority sometimes prevent the board from taking more serious disciplinary action

"It would be nice to have revocations. It would be nice to have stronger suspensions," said Dr. Sheldon Wasserman, board chairman. "But that comes at a cost. We don't have the resources."

State ranks near bottom
Wisconsin has long ranked near the bottom of states in taking serious actions against doctors, according to the consumer watchdog group Public Citizen.

In the group's latest annual report, in May, the state ranked 46th, up from 49th the previous three years.

Wisconsin's medical board ordered 1.90 serious actions per 1,000 doctors from 2009 to 2011, the latest report found. That's about a third less than top-ranked states.

Wasserman and others say Wisconsin might have better doctors than most states. But Public Citizen said there's no evidence the prevalence of doctors deserving discipline varies substantially among states.

"It's a dysfunctional process," Dan Rottier, a medical malpractice attorney from Madison, said of Wisconsin's medical board. "We tell people never to expect them to do anything."

Rottier's lawsuit against Dr. Leonard Go on behalf of Shelby Bomkamp led to a $17.3 million settlement in 2009.

Bomkamp — of Highland, northwest of Dodgeville — suffered a permanent brain injury at age 6 during surgery to remove her spleen, according to the lawsuit and medical board records.

During the surgery in 2007 at St. Mary's Hospital in Madison, Go used a blender-like device to chop up her spleen. He accidentally cut major blood vessels and her bowel, records show.

Go, of Dean Clinic, hadn't used the device before, nor had he been trained how to use it.

The medical board reprimanded him in 2011 and fined him $1,800. The fines are based on investigation costs.

Go declined to comment to the State Journal. In a letter to the medical board, he said he expected to "bear lifelong personal remorse" for what happened.

"I firmly believed the technique I was using in this procedure represented a safer option for the patient," he wrote.

But Rottier said the medical board's discipline wasn't enough.

"A child is permanently brain damaged, and he gets a reprimand? It's pathetic," he said.

Slaps on the wrist?

Wasserman said the board's limited budget makes it hard to fight doctors willing to spend large sums to defend themselves. The board is part of the Wisconsin Department of Safety and Professional Services.

The budget was increased to $1.8 million in 2009 through a 33 percent increase in doctor license fees.
This year, the budget is $1.9 million. A $1.25 million transfer of reserve funds by the state to the general fund last year reduced money available for future years, according to the Legislative Fiscal Bureau.

"There's a push to just get it done with, get the plea bargain accepted and approved, rather than sometimes a harder line," Wasserman said.

The state Supreme Court has ruled the board is supposed to protect the public, deter wrongdoing and rehabilitate doctors — but not punish them, said Dr. Gene Musser, a board member and former board chairman.

State statutes say the board should investigate complaints of unprofessional conduct but don't authorize the board to launch its own probes of suspected wrongdoing, Musser said.

Also, Wisconsin doesn't routinely do criminal background checks when doctors apply for licenses, as most states do.

But a major reason Wisconsin ranks low is the medical board's frequent use of reprimands instead of harsher penalties. Public Citizen doesn't consider reprimands to be serious discipline.

"They are slaps on the wrist," said Dr. Sidney Wolfe, director of Public Citizen's health research group. "They don't have any effect on the doctor's practice."

But Musser said when doctors are reprimanded, the state's 23,000 licensed doctors are notified through a newsletter. Prospective employers find out. So can the public, by searching the medical board's website.

"The process a physician goes through to be reprimanded really wakes them up," Musser said. "It is a gigantic event."

Almasy "showed tremendous remorse" for the epinephrine overdose that killed Johnston, Wasserman said. In a letter to the board from his attorney, Almasy said he was "devastated" by what happened. He declined to comment to the State Journal.

Formerly with Dean Clinic, Almasy lost his privileges at the Dodgeville hospital for nine months and now practices in Sterling, Ill.

He said a nurse gave him the wrong concentration of epinephrine, according to medical board records.

But the nurse, in a deposition, said Almasy confirmed the concentration and dosage before injecting the drug. A surgical tech backed up the nurse's account.

An assessment ordered by the medical board said Almasy needed to work on his listening skills.

"He will live with this for the rest of his life," Wasserman said. "That's a tremendous punishment."

Disciplining doctors, whose work often involves life or death, is different from punishing criminals, Musser said.
"We have people in general who did not mean to do bad," he said. "They are meaning to do good."

**An unwanted hysterectomy**

Laurel Dean — of Spooner, in northwest Wisconsin — lost her ability to bear children at age 28 after Dr. Neal Melby performed an emergency hysterectomy.

Melby scheduled the surgery in 2005 at Baldwin Area Medical Center. It was needed to stop bleeding from complications of a routine procedure he had done to remove tissue from Dean's uterus, according to medical board records.

Dr. Marvin Klingler asked Melby to do the routine procedure — dilation and curettage, or D&C — after a pelvic ultrasound was "suspicious" for tissue in Dean's uterus.

But pelvic ultrasounds have a high rate of false positives in women who have recently given birth, the medical board said, and Dean had delivered her first baby seven weeks earlier.

Klingler should have considered nonsurgical options, the board said.

Klingler told the State Journal his recommendation for a D&C was reasonable, and he discussed the potential risks with Dean.

Dean's lawsuit against Melby, who works in New Richmond, led to a confidential settlement in 2008. Her lawsuit against Klingler, who worked in Baldwin until starting a new job in Hudson this year, went to trial the same year. The jury cleared him of negligence but found Melby negligent. Melby declined to comment.

In 2011, the medical board reprimanded both doctors, ordered each of them to take a class, and fined Melby $2,400 and Klingler $850.

Dean said she has a hard time seeing pregnant women and learning that her friends are pregnant. The emotional toll led her and her husband to divorce, she said.

She planned to have at least one more child. Her daughter is 7.

The medical board should have suspended Melby and Klingler and required them to take more classes, Dean said.

"The way it's impacted my life, I feel that it should also have an impact on their lives," she said. "I almost died."

**Mad, sympathetic over reprimands**

Elsie Nelson, of Two Rivers, went for surgery on the right side of her spine in 2002.

But Dr. Paul Baek operated on the left side, according to medical board records and a lawsuit by Nelson that led to a confidential settlement in 2007.
In 2003, Baek, a neurosurgeon with Aurora Health Care in Green Bay, made the same mistake with another patient, according to the medical board.

The board reprimanded Baek, fined him $2,500 for both incidents and required him to attend a two-day patient safety workshop. Baek declined to comment.

"I would yank his license for six months," said Robert Nelson, Elsie's husband.

Elsie, 83, said another doctor later operated on her right side but she still has pain.

"It makes you mad that doctors screw up more than once and the population at large doesn't know that," she said.

Roger Schwartz is more sympathetic.

In 2003, he suffered a stroke that left him permanently disabled on his left side, according to medical board records and his lawsuit against Dr. Joel Stoeckeler. The suit led to a confidential settlement in 2008.

Stoeckeler, who works in Baldwin, failed to adequately monitor Schwartz's blood thinner levels, putting him at risk for the stroke, according to the medical board.

Stoeckeler told the State Journal he didn't have access to important home health data for Schwartz, and at least six other doctors were involved. "This was a health information failure, not an individual failure," he said.

The board reprimanded Stoeckeler in 2011, fined him $1,900 and required him to take courses in blood thinner management.

"He shouldn't have cut me off (the blood thinner drugs) like that. ... I've got to live with it," said Schwartz, 71, a resident of Wisconsin Veterans Home at King, near Waupaca.

But Schwartz said the reprimand was appropriate. "Other people think he's a good doctor," he said.

**Epinephrine overdose**

To Jaimie Barnes, Almasy's reprimand was insufficient for her mother's epinephrine overdose.

"It's nothing," she said. "He killed my mom."

Johnston, of Barneveld, was working at Madison Family Dental Associates in April 2010 when she had an abnormal Pap smear.

She had also tested positive for HPV, putting her at greater risk for cervical cancer. After another test found abnormal tissue, Almasy recommended a loop electrosurgical excision procedure to remove it. Johnston agreed.
During the low-risk procedure, doctors usually inject epinephrine mixed with lidocaine or Marcaine, drugs that reduce pain. The concentration of epinephrine in such mixtures is 1:100,000 or 1:200,000.

Almasy asked for 20 milliliters of epinephrine to inject into Johnston.

Nurse Brenda MacKinnon asked if he wanted "just epinephrine," according to her deposition. She said she also asked if he wanted 1:1,000.

According to her, he said, "Yes. I use this in the clinic for all my cases in the clinic."

Almasy said he didn't recall MacKinnon specifying 1:1,000.

**Education vs. accountability**

After Almasy injected the epinephrine, Johnston had a toxic reaction. She was taken to UW Hospital in Madison but could not be revived.

The state Board of Nursing didn't discipline MacKinnon after an investigation found insufficient evidence of wrongdoing.

A lawsuit against Almasy led to an $885,000 settlement last year for Barnes and her three siblings, now ages 14, 9 and 3. The four children have three fathers, and with Johnston gone, "now we're all separated," Barnes said.

Musser, the former medical board chairman, said medical errors — especially system errors like Almasy's appeared to be — call for re-education, not harsh discipline.

Almasy had no other complaints in Wisconsin.

What happened to Johnston is "horrible," Musser said but the board looks at whether doctors endanger patients and have problematic track records, not at the severity of the outcome of a mistake, he said.

"We could all be revoked if you revoked for error," Musser said. "None of us work error free."

Madison attorney Keith Clifford, who filed the suit against Almasy, said it "shocks the conscience" that the medical board issued its least serious discipline for the most serious harm.

"It's just woefully inadequate," he said. "The health care system is almost rendered unaccountable."

— David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC’s Annenberg School for Communication and Journalism.

**Case study: Dr. Michael Dehner's career in state plagued by mistakes, lawsuit, deaths**

CASE STUDY: DR. MICHAEL DEHNER
Dr. Michael Dehner’s career in Wisconsin started on a sour note in 1999, with a restricted license because of drug prescription problems.

It ended with a finding in 2011 that his medical knowledge was "superficial."

In between, a death, a stillbirth and a misdiagnosis led the Wisconsin Medical Examining Board to discipline Dehner three times for substandard care.

The board expressed concern about another death but took no action. It hasn't investigated an additional death settled out of court last year.

Dehner’s time in Wisconsin shows how the board’s authority to investigate in reaction to complaints, but not launch its own inquiries, can lead the board to clear doctors after one mishap without knowing other problems have occurred.

The board reprimanded Dehner and limited his practice but never suspended him. He worked in Boscobel before moving in late 2010 to Storm Lake, Iowa, where he worked at a community health center until October 2012.

He declined to comment to the State Journal.

"When you get disciplined, you get slapped on the hand and get to continue to practice," said attorney John Cates of Madison.

Cates sued on behalf of the family of 9-year-old Andrew Chase, of Fennimore, who died from diabetic ketoacidosis in 2008. The suit led to a confidential settlement last year.

Andrew slipped into a diabetic coma at the hospital in Boscobel, but Dehner didn’t transfer him to UW Hospital until the next day, according to the lawsuit. The boy died two weeks later.

"It was pretty gross mismanagement," Cates said.

Malpractice settlements are supposed to generate complaints to the medical board, but a board spokeswoman said the board hasn’t received a complaint in the Chase case; she couldn’t explain why. Dehner’s license in Wisconsin expired in October 2011.

Kent Nebel, legal affairs director of the Iowa Board of Medicine, said he couldn’t say if that board has been notified of the case.

According to medical board documents:

- In 1999, the board issued Dehner’s license, immediately restricting it because he had over-prescribed controlled substances to patients in Iowa. The Wisconsin board ordered Dehner to
undergo drug screening four times a month. In 2001, it reduced the requirement to twice a month. In 2004, it removed all restrictions from his license.

- A week before the board reduced the drug screenings in 2001, Dehner failed to decompress the stomach of an 88-year-old woman with a bowel obstruction. He gave her a drug that could make her obstruction worse. She died the same day. The board reprimanded Dehner in 2006, fined him $4,000 and required him to take a gastroenterology review course. Three months later, the board acknowledged he had taken the course.

- In 2006, two weeks after he took the course and a month before the board's acknowledgment, Dehner diagnosed a 94-year-old man with a viral gastrointestinal illness even though an X-ray showed a bowel obstruction, according to a radiologist. The man died two weeks later. "Dehner is a problem," Dr. Suhatha Kailas, a board member investigating the incident, wrote in 2007. "I think Dehner missed a small bowel obstruction. What worries me about him is the fact that he had just been disciplined for similar issues just a few months prior." But the board took no action in the new case, saying there was insufficient evidence of a violation.

- In 2008, the board restricted Dehner's license for a stillbirth and fined him $12,548. The stillbirth happened in 2004, six weeks after the board removed all restrictions from his initial license. He failed to recognize placental abruption, when the placenta peels away from the wall of the uterus. He also gave the laboring mother two drugs too closely together and administered fentanyl, which can worsen fetal distress. The board required Dehner to take obstetrics courses, be mentored by an obstetrician, have his obstetrics charts reviewed and refrain from deliveries unless another doctor was present.

- In 2010, the board investigated an incident from 2008 — which happened in the weeks just before the discipline for the stillbirth — in which Dehner repeatedly misdiagnosed a young woman's gallstones as constipation. She eventually went to a doctor in La Crosse who promptly removed her gallbladder and gallstones.

Five doctors lost licenses over crimes, drugs

JANUARY 26, 2013 2:00 PM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL | DWLAHLBERG@MADISON.COM | 608-252-6125

Murder, child pornography and improper prescribing of pain medications are among the reasons the Wisconsin Medical Examining Board revoked the licenses of five doctors from 2010 to 2012.
None of the doctors could be reached for comment. Summaries of their cases, according to board documents:

- **Gerhard Witte, 2010**: Witte, of Milwaukee, was convicted of first-degree intentional homicide in 2010 for killing his former wife, a musician with the Milwaukee Symphony Chorus. He stabbed her and slit her throat in 2008 as she walked to her car after a performance. Witte, who practiced internal medicine, was sentenced to life in prison without parole.

- **Eric Schwietering, 2011**: Schwietering, of Milwaukee, pleaded guilty to two counts of possession of child pornography in 2007. Three years later, the child psychiatrist was convicted of fourth degree sexual assault and exposing his genitals to a child. He now lives in Ohio, according to Wisconsin's sex offender registry.

- **William Braunstein, 2011**: Braunstein, of St. Louis Park, Minn., told the state of Minnesota that he had depression and possible attention deficit disorder and obsessive compulsive disorder. After the internal medicine doctor failed to attend therapy sessions and cooperate with the Minnesota Board of Medical Practice, that board threatened to suspend his license. That prompted the Wisconsin medical board to investigate. After he failed to cooperate, the board revoked his Wisconsin license. Then the Minnesota board suspended his license there.

- **Steven Greenman, 2011**: Greenman, of Milwaukee, prescribed controlled substances "indiscriminately" to six patients over five years, despite signs of drug abuse, addiction and diversion. He also directed the patients to multiple pharmacies. When one patient called him prior to reporting to jail, she asked for more pain medications as a "last hurrah" and he complied.

- **Mark Fantauzzi, 2012**: Fantauzzi, of Circleville, Ohio, had his license revoked by the State Medical Board of Ohio after surrendering his controlled substances privileges with the federal Drug Enforcement Administration. The DEA said the anesthesiologist prescribed controlled substances outside of the usual course of professional practice, causing a patient's fatal overdose. The Wisconsin board followed up on the Ohio board's action.

**Other cases where patients were seriously harmed but doctors were only reprimanded**

*JANUARY 26, 2013 2:00 PM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL | DWAHLMBERG@MADISON.COM | 608-252-6125*

*Here are summaries of five other cases in which patients died or were seriously harmed and their doctors received reprimands from 2010 to 2012, based on court and Wisconsin Medical Examining Board records:*

- Sherry Bartz, of Edgerton, died in 2008 at age 58 from blood clots in her lung after battling an infection in her abdomen from hernia surgery a month earlier. **Dr. Mark McDade** did the surgery at Mercy Hospital in Janesville.

- Bartz had a sinus infection before the elective surgery, so McDade should have postponed the procedure, the medical board said. In addition, McDade didn't properly treat Bartz's post-surgery infection, the board said.

- A lawsuit by Jeff Bartz, Sherry's husband, led to a confidential settlement in 2011. McDade declined to comment.

- Last year, the board reprimanded McDade, who works at Dean Clinic in Janesville, and fined him $2,050. He had already attended a conference on abdominal wall surgeries.
Laron Birmingham was born at St. Joseph Regional Medical Center in Milwaukee in 2005 with cerebral palsy and other neurological problems. Dr. Donald Baccus used two kinds of forceps and a vacuum in the delivery. In 2010, a jury found negligence and awarded the family $23.3 million.

Baccus should have done a cesarean section, the medical board said. The board reprimanded him in 2012 and fined him $3,850. He had already stopped doing obstetrics and retired in June.

Baccus told the State Journal he delivered about 5,000 babies over 25 years and was sued only two other times; both of those cases were dismissed early on.

He noted that defense witnesses said the problems with Laron Birmingham's brain were not the result of Baccus' actions.

Cara and Vince Dreyer's first baby was stillborn in 2008 at Westfields Hospital in New Richmond. Dr. Susan Frazier misread the fetal monitoring strip, leading to a delayed cesarean section delivery, the medical board said.

The Dreyers' lawsuit against Frazier led to a confidential settlement in 2011. The board reprimanded Frazier in 2012 and fined her $275. She now works in Rib Lake, northwest of Wausau.

She told the board she stopped doing obstetrics. She declined to comment, other than to confirm that she isn't delivering babies.

Elizabeth Ferris, of Marshfield, was 37 weeks pregnant with her third child when she went to the emergency room at St. Joseph's Hospital in Marshfield at 4:40 a.m. one day in 2005. She was worried her fetus wasn't moving enough.

Fetal heart monitoring suggested distress, but Dr. Katherine Kaplan discharged Ferris at 6:30 a.m. She told her to return for her scheduled appointment with her regular doctor at 10 a.m.

At that appointment, an ultrasound showed the fetus had died. Ferris' lawsuit against Kaplan, who still is with Marshfield Clinic, led to a confidential settlement in 2009. Kaplan declined to comment.

The medical board reprimanded Kaplan in 2011 and fined her $1,000. She had already taken fetal monitoring courses ordered by North Carolina's medical board.

Patricia Jungwirth, of Oshkosh, died from a bowel obstruction in 2008, five days after pelvic reconstruction surgery. The day before she died, she saw Dr. Megan Landauer for a bloated stomach at Aurora Medical Center in Oshkosh.

"I see no reason to think she has a bowel obstruction," Landauer wrote.

Landauer told Jungwirth to take milk of magnesia and come back the next day. She should have considered Jungwirth's symptoms to be a potential emergency, the medical board said. A lawsuit led to a confidential settlement in 2010.

The board reprimanded Landauer in 2011 and fined her $958. She had already taken 50 hours of continuing education.

Landauer, who declined to comment, now works at Marshfield Clinic in Minocqua and Park Falls.

2. Some doctors not disciplined, even following large malpractice settlements
Every three hours, even at night, Ken Plants dials up his morphine pump and rocks on his therapy ball.

Back and leg pain on his right side came from a work injury, he said. But similar pain on his left side came from surgery by Dr. Cully White, according to a lawsuit settled in 2009 for $2.9 million.

White was supposed to operate on the right side of Plants’ spine in 2004. But he did the procedure on the left side, according to the lawsuit and a complaint before the Wisconsin Medical Examining Board.

Yet, nine years after the surgery and four years after the medical board was notified about the settlement, the board has taken no action against White, who works in Milwaukee.

White is one of at least 21 doctors in Wisconsin who settled malpractice lawsuits for large sums or were found negligent by juries, from 2007 to 2011, who have not been disciplined by the medical board, a State Journal analysis found.

White’s case remains open, but most of the other cases are closed.

Plants, 56, a former carpenter from Bristol, near Kenosha, said his pain has kept him from working, hunting, fishing and playing with his children and grandchildren.

He and his attorney were so motivated to have the medical board discipline White that they took an unusual step in 2010: filing a court petition seeking action. A judge dismissed it.

“To see him still practicing just kills me,” Plants said. “I accept human error, but you’ve got to admit it.”

White declined to comment, other than to say through a spokeswoman that he’s cooperating with the medical board’s investigation.

In 2009, a jury found Dr. Lorraine Novich-Welter negligent for causing brain damage to Dan Nelson in 2000. She had trouble clearing a clog in his tracheotomy tube at Froedtert Hospital in Milwaukee, depriving him of oxygen, according to medical board records.

The jury awarded $2.1 million to Nelson, who lives east of Lake Geneva, but the case was later settled without a judgment against Novich-Welter.

In 2011, the medical board decided not to discipline her because she was a resident, or doctor-in-training, at the time of the incident and had no other complaints. She works in Utah and declined to comment.

“I think she should definitely be censured in some form,” said Nelson’s mother, Jean Nelson. “The judgment of a doctor is essential in a crisis situation.”

Negligence but no discipline

Dr. Gene Musser, a medical board member and former board chairman, said the board handles complaints against doctors differently than courts do.
In court, lawyers must show that negligence caused damage with financial implications, he said.

“In our rule, you have to prove that the action created a danger to the patient, and that’s it,” Musser said. “The outcome is irrelevant.”

Autumn Worden was born in 2002 with cerebral palsy and other permanent brain injuries. During her delivery by Dr. Debra Stockwell at Saint Mary’s Hospital in Rhinelander, she suffered from a lack of oxygen, according to medical board records.

Fetal heart monitoring showed signs of distress, but Stockwell left the room to do another delivery, the records show. By the time she returned about 40 minutes later, the situation had become worse. She called for an emergency cesarean section but it wasn’t done for another hour.

During a trial in 2008, Worden’s mother, Nancy, said her daughter, then 6, couldn’t crawl, walk, speak or feed herself and would always wear diapers.

The jury found Stockwell negligent and awarded $4.6 million. An appeal led to a $4.5 million settlement last year.

In 2011, the medical board decided not to discipline Stockwell, in part because her license expired in 2005. The board sometimes acts in such situations, however. Stockwell, whose last known address was in California, couldn’t be reached for comment.

Daniel Tomas, of the Iowa County village of Plain, died four days after Dr. Theodore Parins removed his appendix at Sauk Prairie Memorial Hospital in 2003. Tomas was 45.

An autopsy found torn abdominal tissue and bleeding, apparently from the surgery, according to a complaint filed with the state’s Medical Mediation Panel.

In 2009, a jury found Parins negligent and awarded $1.7 million to Tomas’ wife, Doris. An appeal led to a confidential settlement.

In a statement to the State Journal, Parins said the autopsy was incomplete. Tomas likely died from a complication of his appendicitis, not from the surgery, he said.

At discharge, Parins said, he told Tomas to return to the hospital if he had increased pain. But Tomas didn’t, despite having bad chest pain the day before he died.

The medical board took no action against Parins. Jury awards and settlements are supposed to automatically generate complaints to the board, but a spokeswoman said the board never received a complaint against Parins.

Sarah Jewell, of Mineral Point, had neck surgery at St. Mary’s Hospital in Madison in 2005 on bone spurs that were causing neck, shoulder and arm pain.
She woke up paralyzed on her left side from a spinal cord injury, according to a Medical Mediation Panel complaint. Her lawsuit against Dr. Todd Trier, who performed the surgery, led to a confidential settlement in 2009.

In 2007, Trier operated at St. Mary’s on Dennes McCartney, 52, of Linden, northwest of Mineral Point.

Trier was supposed to remove an infected shunt in McCartney’s brain. The device had been placed years earlier when McCartney had a tumor removed.

During the surgery to remove the shunt, the device broke and Trier left part of it in, according to a Medical Mediation Panel complaint. A piece removed tested positive for staph bacteria.

Pus started draining from McCartney’s inflamed neck. Eventually another doctor operated and found a two-inch fragment of the shunt. After the doctor removed it, McCartney’s neck wound healed.

McCartney’s lawsuit against Trier in 2011 led to a confidential settlement last year. Trier’s shunt removal “conformed with the standard of care,” according to a statement by his attorney.

The medical board hasn’t disciplined Trier for the Jewell or McCartney cases. The board spokeswoman said the board didn’t receive complaints in either case.

In June, Dean Clinic announced that Trier had stopped working there at a neurosurgeon. He couldn’t be reached for comment.

No pulse for 11 minutes

Nelson, who won the jury verdict against Novich-Welter, was in a motorcycle accident in 2000. He broke several bones and suffered a traumatic brain injury. He wasn’t wearing a helmet.

He was taken to Froedtert, where he had several surgeries before going to the hospital’s rehab unit.

On his first morning in rehab, a nurse saw that his tracheotomy tube was clogged, according to medical board records. She called for Novich-Welter, who was unable to clear it. Though a replacement tube was on the wall, Novich-Welter didn’t try to change it, records show.

By the time an emergency team removed the clog and revived Nelson, he had gone without a pulse for 11 minutes, according to a Medical Mediation Panel complaint filed by his attorney.

The lack of oxygen caused an additional, permanent brain injury, the complaint says. Also, a condition in which bone develops in soft tissue allegedly was made worse because medications were stopped while he recovered.

“It definitely caused me to be in this wheelchair,” said Nelson, 52, who lives in New Munster, between Lake Geneva and Kenosha.

Nelson said he had started walking, with assistance, when he got to rehab.
Though Nelson is not paralyzed, the bone condition — called heterotopic ossification — makes him unable to walk, he and his mother said. His speech is slurred, and his mental capacity is reduced. Home health aides assist him.

Before the accident and the tracheotomy clog, Nelson owned a restaurant in northern Illinois. He and his now ex-wife, who have two children, were runners.

Jean Nelson said the medical board should have at least reprimanded Novich-Welter “so this is on her permanent record.”

Dan Nelson said the doctor learned a lesson, even without medical board discipline. “Unfortunately, I paid for it,” he said.

Wrong-side surgery

Plants said his pain gets worse throughout each day, though his morphine pump provides some relief.

He can’t sleep more than a couple of hours at a time, he said. It’s hard for him to sit on a chair or a couch for long. He curls over his therapy ball and rarely leaves the house.

“We don’t socialize with people anymore,” he said.

He started receiving disability payments in 2006 but also applied unsuccessfully for dozens for jobs, he said.

After White’s operation, Plants had three spine surgeries by two other doctors. Those procedures didn’t ease his pain much, he said. It’s not clear why.

His right leg and lower back initially started hurting after he lifted a heavy bucket at work in July 2003, he said.

White operated in February 2004.

“When I woke up, both legs were bad,” Plants said.

An MRI showed that White did the procedure on the left side, according to the complaint against White before the medical board. A doctor who later operated on Plants also said White hadn’t operated on the right side.

After the surgery, when Plants told White about his left-side pain, White said it was from how he had been positioned on the operating table, the complaint says. White sent Plants for physical therapy.

In a statement by his attorney, White said the surgery didn’t cause Plants any harm.

Plants said he could have received more money from White if he had agreed to keep his settlement confidential. But he wants others to know what happened.
“For him to sit there and lie to me, that’s not acceptable at all,” he said.

— David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC’s Annenberg School for Communication and Journalism.

Case study: Reprimand didn’t end Dr. Victoria Mondloch’s problems

JANUARY 28, 2013 7:00 AM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL | DWAGLBERG@MADISON.COM | 608-252-6125

Dr. Victoria Mondloch tried to deliver twins vaginally in 2002 despite signs of distress, records show.

The first twin had significant brain injuries. The second was stillborn.

Hospital officials said Mondloch, an obstetrician/gynecologist from Waukesha, should have done a cesarean section, according to the Wisconsin Medical Examining Board.

She also cut another baby’s head during delivery, according to medical board records. In another case, she stripped a woman's membranes to induce labor and sent her home, where her uterus ruptured and the baby died.

The medical board reprimanded Mondloch for the incidents in 2004. It also fined her $2,000 and ordered her to finish a year-long education program she had started.

Nine months later, the board cleared her license. But the problems didn't end, raising questions about the board's ability to protect the public while trying to rehabilitate doctors.

In 2008, Waukesha Memorial Hospital investigated 23 of Mondloch's patient records from 2005 to 2008 for concerns including inadequate medical skills and poor quality of care. She surrendered her privileges at the hospital in 2009.

Problems with Mondloch's treatment of five patients from 2004 to 2010 led the medical board last year to order her to stop all obstetrics work while the board continues to investigate.

According to a complaint before the medical board, Mondloch:

- Missed an ectopic pregnancy after the patient saw her several times in a month. The patient eventually went to the emergency room, where doctors discovered a ruptured ectopic pregnancy and had to remove her right fallopian tube.
- Misdiagnosed a molar pregnancy — when tissue that normally becomes a fetus becomes an abnormal growth — and gave the patient the wrong drug for depletion of her red blood cells.
- Misdiagnosed polycystic ovarian disease in two patients and performed ovarian drilling, surgery that doesn't help the condition. The procedure can help with related infertility but should only be used after medications have been tried.
• Prescribed drugs that contributed to a patient’s rebound headaches and dependency. In addition, Mondloch did a hysterectomy on the patient without first attempting non-surgical treatments. She also failed to properly manage bleeding during the hysterectomy.

The complaint doesn't say how the five patients fared. But Mondloch told the State Journal that, other than the patient whose fallopian tube was removed, the patients were pleased with the care she provided. Three of them remain her patients, she said.

The hysterectomy patient's bleeding was from a platelet disorder not identified until after the surgery, Mondloch said.

She said her care complies with American College of Obstetricians and Gynecologists guidelines.

The ban on Mondloch's obstetrics work, issued in January 2012, will continue until the board takes final action. She can still do routine exams, check-ups and tests such as Pap smears. She runs an independent clinic in Waukesha.

Dr. Sheldon Wasserman, chairman of the medical board, said the board ordered Mondloch to complete a mini-residency in 2004 and her mentors said she showed progress.

The obstetrics ban last year should further protect the public, said Wasserman, also an OB/GYN.

"OB/GYN is where she's dangerous," he said. "We're taking that away from her."

— David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.

3. Medical Board says lack of money, authority ties hands and may attract subpar physicians to state

DOCTOR DISCIPLINE: THIRD OF A THREE-PART SPECIAL INVESTIGATION

JANUARY 29, 2013 5:00 AM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL | DWAHLBEG@MADISON.COM | 608-252-6125

After the Wisconsin Medical Examining Board suspended Dr. Frank Salvi in 2009 for fondling four female patients, the Madison-area doctor won a circuit court ruling throwing out the sanction.

Then, the medical board won an appeals court decision restoring it. Salvi failed to get the state Supreme Court to take the case.

But he succeeded in making the medical board spend about $200,000 to fight him, said Dr. Sheldon Wasserman, board chairman.
The board, which has a $1.9 million annual budget and gets about 500 complaints against doctors each year, can't afford to do that very often, Wasserman said.

"We're using up our resources fighting their resources," he said.

The budget for Wisconsin's medical board appears to be smaller than for boards in other states. It's one of several factors that limit the board, its leaders say.

The board has supported bills to remove other limitations, such as a lack of authority to launch investigations on its own or to perform criminal background checks on doctors applying for licenses.

But the state Legislature didn't pass the measures. "I think that would expand their authority too far," said state Sen. Leah Vukmir, R-Wauwatosa, chairwoman of the Senate Committee on Health and Human Services, who opposed both moves.

Other changes have been approved, such as requiring doctors to report wrongdoing by others. That started in 2009.

The board doesn't have independent authority. As part of the state Department of Safety and Professional Services, it works within departmental rules as well as state statutes and Supreme Court rulings, said Gene Musser, a board member and previous chairman.

The department, for example, hires and fires board staff.

Despite the limitations, the medical board and the department protect the public by ensuring that doctors provide safe and competent care, said Greg Gasper, the department's executive assistant. Reforms have led to a 36 percent reduction in pending cases over the past two years, Gasper said.

"Better management has resulted in more disciplinary action and reduced pending caseloads," he said.

Musser acknowledged that a major reason Wisconsin ranks low in serious discipline against doctors is the board's preference for reprimands instead of more serious penalties in many cases.

Even if the board had more money or more power, its frequent use of reprimands likely would continue because the board generally values rehabilitation over harsh discipline, he said.

"Our wings are clipped"

In 2009, amid criticism that the medical board took too long to discipline doctors, Wisconsin raised the biennial license fee for doctors from $106 to $141 — an amount still lower than in most states.

That paid for more investigators and increased the board's budget to $1.8 million that year. This year, it's $1.9 million.

But while the board had a team of 10.5 attorneys, paralegals and investigators in 2010, a reorganization reduced the team to 7.7 positions, officials said.
"Our wings are clipped again," Wasserman said.

The board's total staff is about 14 positions, department officials said, but some of those people also work for other boards.

Wasserman said the board's limited resources mean the board must be cautious in taking a hard line against doctors such as Salvi, who worked at UW Hospital until resigning in 2007.

The result is more plea bargaining for lesser forms of discipline, Wasserman said.

Salvi, of Cottage Grove, denied the charges against him. His license remains suspended and he is looking for work, said his attorney, Lester Pines. Salvi declined to comment.

More resources in other states

No state-by-state comparison of medical board budgets is available, but medical boards in some states are better funded than in Wisconsin.

The State Medical Board of Ohio has a $9.1 million budget and the equivalent of 79 full-time staff. Though Ohio has twice as many doctors as Wisconsin, its medical board budget is nearly five times greater.

Ohio was among the top three states for serious discipline against doctors in Public Citizen reports the past two years.

The medical board in Ohio is a separate agency, not part of a state department, said Joan Wehrle, the board's outreach manager.

"It makes a huge difference," Wehrle said. "You set the priorities."

Ohio's board developed guidelines that suggest minimum and maximum penalties for various violations. Wisconsin's board has no such guidelines.

From 2009 to 2011, the Ohio board revoked the licenses of 118 doctors and issued 20 reprimands. Wisconsin's board issued five revocations and 115 reprimands during that time.

"If there's patient harm, the board will usually issue a stronger sanction than a reprimand," Wehrle said.

The State Journal contacted medical boards in four states with populations and doctor numbers similar to Wisconsin's.

Their budgets: Colorado, $2.9 million; Minnesota, $5.3 million; Missouri, $2.6 million; and Tennessee, $2 million.

Legislature says no
Wisconsin statutes say the medical board should investigate complaints of unprofessional conduct against doctors, but they don't say the board can look into suspected wrongdoing on its own.

A 2003 bill to change some medical board operations, including allowing proactive investigations, wasn't approved by the state Legislature. The Federation of State Medical Boards doesn't track how many states do such investigations.

Musser said proactive probes could lead to more discipline.

"I believe there are physicians around the state doing stuff they shouldn't be doing that we don't hear about because it doesn't get reported to us," he said.

Likewise, requiring background checks when doctors apply for licenses could identify more doctors with criminal pasts, Musser said.

Medical boards in 36 states require background checks, according to the Federation of State Medical Boards. The Wisconsin board's attempt to do so last year was overruled by the Legislature.

Rep. Erik Severson, R-Star Prairie, co-sponsored the bill that prevented the board from doing routine criminal background checks.

Severson, a doctor, said requiring fingerprints for the background checks would be costly.

"They'd be adding an extra burden on physicians who want to come here to Wisconsin at a time when we have a physician shortage," he said. "It seems like an overreach on government's part to solve a problem that doesn't exist."

But by not doing the checks, Wisconsin could eventually attract doctors with criminal records, Musser said.

"As more states do that, we may become sort of a magnet," he said.

The Legislature approved a "duty to report" requirement in 2009. Doctors must report other doctors who engage in unprofessional conduct or endanger patients.

Wasserman said the requirement has led to more complaints and discipline, though a board spokeswoman said no data are available on the impact of the requirement.

More changes

Last year, the board revised the state's administrative rule defining unprofessional conduct for doctors. The changes are subject to approval this year by the Legislature and the governor.

The board specified wrong-site surgery as unprofessional conduct, for example. It also listed specific crimes, such as sexual assault and child enticement. That should bring quicker action in such cases, Wasserman said.
But some proposed changes weren't adopted by the board, largely because they were opposed by the Wisconsin Medical Society and the Wisconsin Hospital Association.

One would have required doctors to tell patients about alternative diagnoses and treatments. Another would have made doctors tell the board about actions taken against their hospital privileges.

"That was a battle I could not win," said Wasserman, a former Democratic state Assembly member from Milwaukee.

Wasserman and Musser said they hope the board will make other changes. One is to require more continuing education when doctors renew their licenses every two years. Currently, 30 hours are required.

They also want doctors to complete three years of training after medical school before qualifying for a license in Wisconsin.

Most states require one year for graduates of U.S. medical schools but two or three years for graduates of foreign schools. Wisconsin requires one year for both.

"We are basically the dumping ground for a lot of bad physicians who want to get their foot in the American medical system," Wasserman said.

— David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.

How the Wisconsin Medical Examining Board handles complaints about doctors

The state Department of Safety and Professional Services receives about 500 complaints against Wisconsin doctors each year.

Half are from patients or family members. Some are from health care workers. Others are malpractice findings or hospital actions reported through a national data bank.

State investigators request medical records and ask doctors for a response.

A screening panel of the Wisconsin Medical Examining Board reviews cases each month. The panel closes about two-thirds of the cases, generally because the complaints are minor or can't be proven, said Dr. Gene Musser, a board member and former chairman.

For the other cases, formal investigations are launched. An investigator, attorney and lead board member gather more information and decide if the doctor should be disciplined and how. The full board has the final say.
Options are an administrative warning (which doesn’t count as official discipline), required education, a reprimand, a license limitation, a suspension or a revocation. Many times a combination is used, such as a reprimand plus required education.

The board attorney generally negotiates with the doctor's attorney until they reach an agreement.

But sometimes doctors request a hearing before an administrative law judge. The judge recommends a type of discipline, which the board can adopt or not.

Doctors can appeal through the state court system.