WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
DAVID S. ALMASY, M.D., RESPONDENT.	:	ORDER 0000900

Division of Enforcement Case No. 10MED137

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

David S. Almasy, M.D.
307 E. Madison Street
P.O. Box 311
Dodgeville, WI 53533

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The terms of the Stipulation include that Respondent neither admits nor denies the allegations in this matter. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. David S. Almasy, M.D. (DOB November 20, 1973) is licensed and currently registered to practice medicine and surgery in the state of Wisconsin pursuant to license number 51194, which was first granted on January 16, 2008.

2. Respondent completed a four year residency in obstetrics and gynecology in 2007. Respondent is eligible to become board certified in obstetrics and gynecology and has

passed the written board examination but must pass the oral examination before he can become board certified. Respondent's last address reported to the Department of Regulation and Licensing is 307 E. Madison Street, P.O. Box 311, Dodgeville, Wisconsin 53533.

3. Ms. A, who was 35 years of age, had an abnormal Pap smear on April 2, 2010 and her primary care physician referred her to Respondent. On April 14, 2010, Respondent performed a colposcopy and biopsy which showed moderate dysplasia/ high grade squamous intraepithelial lesion.

4. On April 21, 2010, Respondent saw Ms. A, and recommended a loop electrosurgical excision procedure (LEEP). This procedure uses a thin wire loop electrode to remove abnormal tissue from the cervix, and is generally a routine and low risk procedure. Respondent explained the typical risks of LEEP and Ms. A agreed to have the procedure.

5. On May 13, 2010, Respondent performed the LEEP on Ms. A at Upland Hills Health in Dodgeville, Wisconsin, with conscious sedation anesthesia. The other participants were a Certified Registered Nurse Anesthetist (CRNA), a RN and a surgical technician.

6. The usual use for epinephrine during LEEP is as a local anesthetic, in combination with lidocaine or marcaine. The concentration of epinephrine in those mixtures is either 1:200,000 or 1:100,000 depending on the percentage of the lidocaine or marcaine. Because Ms. A's procedure was done under conscious sedation, Respondent did not use any local anesthetic.

7. A separate surgeon's preference card is created and maintained by the surgery department staff at Upland Hills for each procedure each surgeon performs. The card lists the materials, instruments and equipment the surgeon wants present in the operating room when the procedure is being performed. Respondent's LEEP preference card had included "Local 1% Lidocaine with Epi 10 ml." That entry had been lined out at some point and Respondent does not know why or when it occurred.

8. During the LEEP, Respondent decided to inject epinephrine into Ms. A's cervix to decrease bleeding. Respondent asked the RN for epinephrine. The CRNA, the RN and the surgical technician all heard Respondent ask for "Epi" which all understood to mean epinephrine. Epinephrine was available in concentrations of 1:1,000 or 1:10,000. There is a dispute as to what, if anything, was said about the concentration of epinephrine Respondent wanted.

9. There was no epinephrine in the operating room and the RN went to the stock room between the operating rooms to obtain the epinephrine 1:1000. After the surgical technician drew it up, labeled it "Epi" and verbalized that it was epinephrine, it was provided to Respondent who then injected the epinephrine into Ms. A's cervix. The surgical technician told the CRNA that it was being injected. The CRNA noted the increase in heart rate and a subsequent drop. Within moments Ms. A's status deteriorated and she arrested. She was intubated and rescue attempts were made. She was ultimately transferred to the University of

Wisconsin Hospital where she could not be resuscitated. The coroner's report indicates the cause of death as acute bilateral pulmonary edema – accidental epinephrine toxicity.

10. On May 14, 2010, as a result of this event, Respondent's medical staff privileges at Upland Hills Health were suspended. Respondent was required to undergo a comprehensive individualized assessment at the Physician Assessment Center in the Office of Continuing Professional Development, University of Wisconsin School of Medicine and Public Health. The Assessment report was received on January 28, 2011 and it concluded Respondent had the knowledge and clinical skills to practice independently and unsupervised in his specialty of obstetrics and gynecology. It was recommended that Respondent work on developing his communication skills, especially his listening skills. Based on the assessment results, Respondent's privileges were fully restored at Upland Hills Health, effective February 21, 2011.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3), and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in the conduct as set out above, has engaged in conduct which tends to constitute a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code § MED 10.02(2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. David S. Almasy, M.D., is hereby REPRIMANDED for the above conduct.

2. The license of David S. Almasy, M.D. to practice medicine and surgery in the State of Wisconsin is LIMITED, as follows:

3. Within six months of the date of this Order, Respondent shall successfully complete continuing education programs, which have been approved by the Board or its designee, on the following topics: 1) Six hours in risk management and 2) Twenty-three hours in physician communication. Respondent shall provide proof sufficient to the Board, or its designee, of satisfactory completion. Respondent is prohibited from applying any of the hours of education completed to satisfy the terms of this Order toward satisfaction of the continuing education required for any biennial registration renewal. The following courses are approved:

a. Risk Management Consult: Avoiding Never Events, a 6.0 credit on-line program being offered by MedRisk® at medrisk.com.

b. Intensive Course in Physician Communication (including the reflective essay and post-reflective essay), a 23.0 credit program being offered by Case Western Reserve University School of Medicine November 16-18, 2011.

4. Pursuant to Wis. Stat. § 440.22(2), within six months of the date of this Order, Respondent shall pay to the Department of Regulation and Licensing the costs of this proceeding in the amount of $1,200.00.

5. All requests, notices, reports and payments shall be provided to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

6. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered or fails to comply with the ordered continuing education as set forth above, the Respondent's license (#51194) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

7. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: _____ 6/15/11
A Member of the Board Date

AlmasyOrder05-31-11