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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
STEPHEN R. KREUSER, M.D., RESPONDENT.	:	ORDER 0002255

Division of Legal Services and Compliance[1] Case No. 10 MED 389

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

Stephen R. Kreuser M.D.
320 Superior Ave
Washburn, WI 54891

Wisconsin Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

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

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 Wisconsin Medical Examining Board (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Respondent Stephen Robert Kreuser, M.D., (dob April 17, 1952) is licensed in the State of Wisconsin as a physician and surgeon, having license no. 20-26675, first issued on April 19, 1985 and current through October 31, 2013. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 320 Superior Ave., Washburn, WI 54891. Respondent is a solo practitioner in general practice, and is not certified by any board recognized by the American Board of Medical Specialties. He was formerly licensed in Ohio.

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

2. For several years preceding November 2010, Respondent provided care and treatment to patient A, a man born in 1934. The patient had a residence in southeastern Wisconsin, but spent his summers and autumns in northern Wisconsin, receiving treatment from physicians in both locations.

3. On June 10, 2010, the patient returned to care after not being seen since October 28, 2008. The patient needed an INR check, because he was on warfarin therapy, and also requested a prescription for sleep. Respondent noted that the patient was also on valsartan, levothyroxine, simvastatin, amlopidine, and amiodarone. Respondent failed to mention in the visit note that the patient also had stable chronic renal insufficiency diagnosis going back to at least 2001. The patient's blood pressure was 140/50, and he complained of fatigue without shortness of breath, night sweats, fevers, or other symptoms. Upon examination, HEENT was clear, lung sounds were noted to have rhonchi [illegible] on the left, heart sounds were RRR; the examination was otherwise unremarkable. The patient was diagnosed with history of atrial fibrillation, hypertension, hypothyroidism and hypercholesteremia; and with pneumonia. Respondent prescribed zolpidem for sleep, and azithromycin. An INR and other blood tests were ordered. A chest x-ray was performed in Respondent's office and read by Respondent as "RLL infiltrate." The blood test results included an INR of 3.6, and a creatinine level of 2.5.

4. On June 14, 2010, the patient returned to care. Respondent's chart note demonstrates that the patient's temperature was not taken, that his pulse was 53, blood pressure 130/60, oxygen saturation 97%, that the patient was "better." Upon examination, the patient's lung sounds demonstrated rales, although his heart sounds were RRR. Another chest x-ray was ordered, which Respondent again read as "infiltrate RLL." Respondent then charted in the progress note that the chest x-ray showed "worse." Respondent diagnosed pneumonia, hypertension, and hypothyroidism, and prescribed levofloxacin. There was no charted follow-up on the patient's INR, which was clearly high. A repeat creatinine was ordered, with result 2.3. Respondent then charted on the laboratory results sheet: "Why? Dehydrated?"

5. On June 17, 2010, the patient returned to care. Respondent's progress note reads: "not better. Overdid 6/16/10." The patient's temperature was 98.2, pulse 56, blood pressure 122/62, oxygen saturation 96%. Lungs sounds demonstrated rales, and his heart was again RRR. Respondent diagnosed pneumonia and renal insufficiency, and ordered a creatinine test, which the patient is charted as having refused. Another chest x-ray was taken, which Respondent read as "RLL infiltrate improved." There is no charted discussion of the patient's creatinine test result, or its implications, or that Respondent discussed this with the patient, or advised the patient to increase fluid intake.

6. On June 21, 2010, the patient returned to care. The patient's pulse was 56 and blood pressure 120/52; other vital signs were not recorded. Respondent's progress note reads: "better, more energy." The patient's lung sounds were noted as being rales, with heart sounds RRR. The patient was again diagnosed with pneumonia and renal insufficiency, and another prescription for levofloxacin was issued. Creatinine and electrolyte tests were ordered. The creatinine level was 2.7. There is no charted discussion concerning the implications of a diagnosis of renal insufficiency, or why this diagnosis is made in favor of a diagnosis of dehydration.

7. On June 28, 2010, the patient returned to care. The patient's pulse was 55, blood pressure 122/60, and oxygen saturation 98% no other vital signs were charted. Respondent's staff noted that the patient "states feels good and continues to feel better with each day." Respondent then charted: "big improvement, but not normal yet." The lung sounds were again noted to exhibit rales, and heart sounds RRR. A new chest x-ray was read by Respondent as "worse"; there is no other description in the record. The patient was again diagnosed with pneumonia and renal insufficiency, and prescribed Bactrim DS®; a creatinine test was ordered, with result 2.3.

8. On July 6, 2010, the patient returned to care. The patient's pulse was 50, blood pressure 120/64, oxygen saturation 99%; no other vital signs were charted. Respondent's chart note reads: "still tired." The patient's lung sounds were noted to exhibit rales on the left, his heart sounds were RRR. Another chest x-ray was taken, and Respondent's reading was: "still RLL infiltrate but better." Respondent's diagnoses were pneumonia and atrial fibrillation; he extended the Bactrim DS® prescription. There is no discussion of the patient's creatinine, or its possible implications for the patient.

9. The patient returned to care on July 15, 2010. Respondent notes that the patient is "still tired." The patient's pulse was 56, and his blood pressure 120/58; no other vital signs were charted. Upon exam, Respondent noted that the lung sounds exhibited "few rales" and that his heart sounds were RRR. Respondent again x-rayed the patient's chest, and his entire reading was: "better." Respondent noted that the patient refused a creatinine test, diagnosed him with pneumonia, and prescribed cephalaxen and Bactrim DS®.

10. On July 19, 2010, the patient returned to care. His pulse was 61, blood pressure 120/60, oxygen saturation 95%; the other vital signs were not charted. The patient was weighed for only the second time. The medical assistant noted: "patient with increased weakness, diminished balance, increased disorientation last night with not finding way from bathroom two-bedroom. Patient states falling down, running into walls. Patient states Friday feeling better but started feeling worse Saturday and Sunday. Friend states slurred speech, disorientating and, and unable to finish thoughts. Patient did not take any meds this morning." Respondent's own notes are: "[illegible] felt pneumonia gone 7/17. Last. Fell standing in water [illegible] 7/18. Last p.m. awoke in dark bumped into walls, sounded confused, slurred this a.m., wobblely, hard to stand, slowly improved but needed help." Upon examination, the lungs were noted to be clear. Neurological exam noted slightly slurred speech, decreased DTR on the right LE [illegible] Motor 5/5 all, C II-XII intact, sense intact, decreased coordination." Respondent noted that the patient took two zolpidem but does not say when. Respondent ruled out stroke, and charted his impression that this was medication overuse resulting in "decreased sensorium." Blood tests were ordered. Another chest x-ray was taken, which Respondent read as: "infiltrate better." The patient's blood test results included white blood count of 11.6, hemoglobin of 11.7, creatinine of 2.9, and several other out of range results, none of which were ever charted as having been discussed with the patient.

11. On July 22, 2010, the patient returned to care. His charted vital signs were: pulse 55, blood pressure 118/58, oxygen and 88%, weight 198 pounds. No other vital signs were charted. Respondent noted that the patient was using only one zolpidem, and that in general he was "brighter, more alert." Respondent again detected rales upon listening to the lungs, and noted an

irregularity in the heart beat. Respondent discontinued zolpidem, and ordered eszopiclone. Respondent x-rayed the patient's chest, and read the x-ray as: "RLL density." Respondent then ordered a CT of the chest, and a CBC. The blood test results included white blood count of 12.9, hemoglobin of 11.5, and hematocrit of 33.1. There is no evidence in the chart that any of these out of range results was discussed with the patient.

12. The radiologist read the CT and compared it with the July 22, 2010 x-ray from Respondent's office. The radiologist observed a node at the right lung apex, and stated that "neoplasm is not excluded." The radiologist also stated: "the area of increased density at the right lung based on recent chest x-ray is felt to be more likely related to overlying soft tissue. No evidence of an apparent abnormality is seen in this region on the CT."

13. The patient returned to care on July 28, 2010. A medical assistant has noted that eszopiclone was not covered by the patient's insurance company, which had requested a return to zolpidem. The patient's sole vital sign charted was his blood pressure, 120/60. Respondent charted: "energy not better. Long discussion with patient and friend. Doesn't want lung surgery." Rales were observed, together with an illegibly described irregularity in the patient's heart beat. Respondent diagnosed "pulmonary nodule, pneumonia." Respondent then prescribed itraconazole, and noted "refer pulmonary – refused."

14. On August 5, 2010, the patient returned to care. The only vital signs charted were the patient's pulse, 53, and oxygen saturation, 98%. The medical assistant noted: "feeling better, started riding bike again." Respondent charted: "symptoms gone. Increased motivation. Fatigue gone. Respondent charted that the lung sounds exhibited rhonchi, and that the heartbeat was irregular, with [illegible]. Respondent diagnosed "pulmonary masses, pulmonary mycosis, CHF, atrial fibrillation, hypertension." Respondent then prescribed additional itraconazole.

15. On August 19, 2010, the patient returned to care. The medical assistant noted that the patient was taking the itraconazole twice a day "but spaced it out today." The patient's blood pressure was measured at 120/60, and his weight was taken, but no other vital signs were charted. Respondent's progress note reads: "much better. Breathing better. Fatigue gone. Better than before all this started last time felt this good was December 2009." The patient's lung sounds displayed rhonchi, and his heartbeat was irregular, without further description. The patient's chest was x-rayed and Respondent's reading was, in its entirety: "significantly better." Respondent then extended the itraconazole prescription.

16. On September 9, 2010, the patient returned to care. His pulse was 52, blood pressure 130/62 oxygen saturation 98%, and his weight was taken. Respondent charted "decreased energy but much better than six weeks ago. Rides a bike for 10 min. every day." Lung sounds displayed rhonchi, his heart sounds were RRR, and no edema was noted. Respondent x-rayed the patient's chest and read the x-ray as: "worse. Whole right lung increased haziness." Respondent diagnosed a pulmonary fungal infection, D discontinued the itraconazole, and prescribed fluconazole. Respondent noted that he would have the patient's INR checked at his next visit, and ordered other tests. The patient's creatinine was 1.95, which Respondent noted as "better"; the patient's white cell count had returned to normal; but his red blood cell count, hemoglobin, and hematocrit were all below normal; while his RDW was high.

17. On September 16, 2010, the patient returned to care. The only vital signs which were charted were the patient's pulse, 50, and oxygen saturation, 96%. Respondent noted: "feels better. Mentally off of Ambien. Increased energy." Rhonchi were again heard, and the patient's heart was described as irregular, without further description. Respondent x-rayed the patient's chest, and read the x-ray as: "RLL Slight better, get CT." Respondent charted "patient refused chest CT despite concerns of cancer." Respondent also charted that the patient left before an INR check could be done. Respondent extended the prescription for fluconazole.

18. The patient returned to care on September 30, 2010. His blood pressure was measured at 110/58; no other vital signs were charted. The medical assistant noted: "in ER with muscle cramps; other than, much improved." Respondent then charted: "terrible pain September 23, to ER, lasted 24 hours only, fine since then. Much better than two weeks ago." Respondent charted rhonchi and a normal heartbeat. Respondent again diagnosed pulmonary fungus, and extended the fluconazole prescription. Respondent x-rayed the patient's chest and read the x-ray as: "RLL improved."

19. The patient was last seen by Respondent on October 14, 2010. The patient's blood pressure was 130/62; no other vital signs were charted. Respondent noted: "feels better, best he's felt." Respondent noted decreased rhonchi, and heart sounds RRR. Respondent x-rayed the patient's chest and read the x-ray as: "little better RLL." Respondent again diagnosed pulmonary fungal infection, renal insufficiency, and extended the fluconazole prescription.

20. The Board caused Respondent's office records, x-rays and labs on this patient to be reviewed by its expert, a board certified internist. The Board's expert concluded that Respondent's care and treatment of the patient fell below the standards of the profession in the following respects:

a. Respondent's notes are frequently illegible, and are not helpful in understanding his thought process. They would not be helpful to a subsequent practitioner. They frequently fail to contain vital signs, or a statement that the patient refused them. This substandard clinic documentation in and of itself would lead to the conclusion that medical care provided by Respondent was inadequate.

b. There is an inadequate charted basis for a continuing diagnosis of pneumonia.

c. The number of x-rays was clearly excessive. The written x-ray findings are wholly inadequate.

d. When the CT was done, the report unequivocally states that the right lower lobe was normal; Respondent continued to make right lower lobe findings based on his own x-rays.

e. Antibiotics were changed without charted explanation. The failure of the patient to improve, or to show any change in his x-ray, compelled a broader differential.

f. Although there is a chart note that the patient declined a referral to a pulmonologist for evaluation of the nodule, Respondent should have insisted that the patient be evaluated separately for his apparently persistent pulmonary condition which was not responsive to the medications Respondent was prescribing. There is no charted discussion that the benefits of the proposed consultation were explained to the patient.

g. Once new medications were prescribed, and especially antifungals, the patient's INR should have been closely monitored, and was not. Respondent did see at least one INR reading which was elevated, but he failed to follow-up. During the investigation of this matter, Respondent informed the Board that the patient had actually refused an INR: this fact is not documented in the patient's chart, nor is there any charted discussion of the risks of such refusal or of the risk of interaction with the antifungal medications.

21. Respondent disagrees with a number of the findings set forth above and has submitted evidence disputing them but in the interests of resolving this matter in a timely and economical manner, and avoiding the costs of a hearing, agrees to the Conclusions and Order below. Respondent acknowledges that his inadequate medical record documentation substantially contributed to the findings set forth above.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. By the conduct described in the Findings of Fact, Respondent Stephen R. Kreuser, M.D., engaged in conduct defined in Wis. Admin. Code § Med 10.02(2)(h) and (u).

3. As a result of the above, Respondent Stephen R. Kreuser, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.

2. Respondent Stephen R. Kreuser, M.D., is REPRIMANDED.

3. The license to practice medicine and surgery in Wisconsin issued to Respondent Stephen R. Kreuser, M.D., (license number 20-26675) is LIMITED as follows: no later than eight months from the date of this Order, Respondent shall successfully pass, with a score of 75 or more, the SPEx (Respondent may not attempt the exam more than twice without Board permission), OR pass a board specialty examination for certification for a board recognized by the American Board of Medical Specialties, OR:

a. Respondent shall undergo an assessment to evaluate Respondent's current abilities to practice medicine at his current practice, given his current patient population and the facts of this case. The assessment shall be performed under the direction of a program listed as a Post Licensure Assessment System on the website of the Federation of State Medical Boards, and which is approved in advance by the Board or its designee, and may include a cognitive screening assessment, peer interview, and/or physical examination. Respondent shall initiate the assessment process within fifteen (15) days of the date of his receiving notice that he is not able to timely pass any of the examinations specified above, and shall timely complete all portions of the process for which he is responsible (including payment of all required fees), as requested by the program.

b. If the results of this assessment process show a deficiency in Respondent's abilities, Respondent shall participate in and successfully complete an educational program established through the program and based upon on the results of the assessment. The educational program shall include a post-intervention assessment which may be 6-18 months following the completion of the didactic portion of the program. Respondent shall complete this program within the time parameters established by the program, but no later than two years from the date of the report to the Board of the results of the assessment process. The Board may consider extension on request of the program.

c. In the event that the program states that it is unable to develop an educational program which adequately addresses the issues identified in the assessment, the program shall notify the Board of this fact, and the matter shall be returned to the Division of Legal Services and Compliance for further action. The results of the assessment shall be admissible as evidence in any subsequent proceedings in this action.

d. Respondent shall be responsible for all costs incurred for the assessment and training under the terms of this Order, and shall timely pay all fees when due.

e. The program shall certify to the Board the results of the assessment and educational program upon their completion, and may certify separately the didactic portion of the program and the post-intervention assessment. Upon receipt of certification of completion of the terms and conditions set forth above, the Medical Examining Board shall inform Respondent that his obligations under this portion of this order have been satisfied, and that his license is no longer limited in this respect.

f. If Respondent does not successfully complete the program or does not successfully achieve the objectives of the program, this matter shall be referred to the Board to determine any other appropriate discipline for the conduct set out in the Findings of Fact. Respondent and the Division will have the opportunity to present argument to the Board on that issue. The Board and Respondent will receive the results of the assessment and Respondent's performance in the program, including the post-intervention assessment, as evidence in determining appropriate discipline.

4. The license to practice medicine and surgery of Respondent is permanently LIMITED as follows: Respondent shall cause all x-rays ordered by him to be read by a qualified radiologist, with the results reviewed by Respondent and placed in the patient's chart.

5. Within six months from the date of this Order, Respondent Stephen R. Kreuser, M.D., shall pay partial COSTS of this matter in the amount of $1400.

6. Proof of successful course completion and payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be mailed, faxed or delivered by Respondent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935, Madison, WI 53708-8935
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

7. 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, Respondent's license (no. 20-26675) 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.

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

WISCONSIN MEDICAL EXAMINING BOARD

by: _____ January 16, 2013
A Member of the Board Date

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