

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY :
PROCEEDINGS AGAINST :
 : FINAL DECISION AND ORDER
ROBERT J. DEFATTA, M.D., :
RESPONDENT. : 0005301

Division of Legal Services and Compliance Case Nos. 14 MED 104, 14 MED 518
and 15 MED 034

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

Robert J. DeFatta, M.D.
N1706 945th Street
Eau Claire, WI 54701

Wisconsin Medical Examining Board
P.O. Box 8366
Madison, WI 53708-8366

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

The parties in these matters agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Medical Examining Board (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in these matters adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Robert J. DeFatta, M.D., (DOB February 8, 1973) is licensed in the state of Wisconsin to practice medicine and surgery, having license number 55984-20, first issued on July 1, 2011, with registration current through October 31, 2017. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is N1706 945th Street, Eau Claire, Wisconsin 54701.

2. Respondent is certified by the American Board of Otolaryngology and at all times relevant hereto practiced otolaryngology at Sacred Heart Head and Neck Center (2011-2014) and DeFatta ENT and Facial Plastic Surgery (2014 to present).

PATIENT A

3. On December 6, 2012, Patient A, a female born in 1950, presented to Respondent having had recurrent sinusitis that was refractory to multiple trials of antibiotics, over the counter medicine, antihistamines and saline spray. Respondent ordered a paranasal sinus CT scan to evaluate Patient A for radiographic evidence of sinus disease.

4. On December 11, 2012, Patient A underwent CT scan and saw Respondent at his office. Respondent interpreted Patient A's CT scan as depicting mucosal thickening of the ethmoid sinuses and sphenoid sinuses, thickening of the bilateral maxillary sinuses, severe obstruction of the bilateral ostiomeatal complexes and bilateral agger nasi cells causing obstruction of the openings to the frontal sinuses.

5. Also on December 11, 2012, Patient A's CT scan was interpreted by a radiologist as a negative CT scan for sinus disease on December 11, 2012. The interpreting radiologist authored a report of his findings which was provided to Respondent prior to the December 20, 2012 surgery.

6. Based on his own review of Patient A's CT scan, Respondent recommended that he perform sinus surgery on Patient A.

7. At no time did Respondent discuss with the radiologist or Patient A that his interpretation of the CT scan was different than the radiologist's interpretation.

8. On December 20, 2012, Respondent performed sinus surgery on Patient A which included bilateral inferior turbinate submucosal resection, bilateral meatal maxillary antrostomy with removal of tissue, bilateral total ethmoidectomy, bilateral frontal sinusotomy with removal of tissue and bilateral sphenoidotomy.

9. Respondent's medical charting for Patient A indicated he discussed all the risks and benefits but failed to list the specific surgical risks he discussed with the patient.

10. Respondent's medical charting for Patient A failed to document a discussion of the availability of all alternative, viable medical modes of treatments and the benefits and risks of those treatments with the patient.

11. Respondent's medical charting for Patient A after the December 20, 2012 surgery failed to document his postoperative examination findings and Respondent repeated pre-operative examination findings.

12. On August 5, 2013, Patient A sought treatment for tinnitus from another physician who informed Patient A for the first time that her CT scan was read by the radiologist as negative for sinus disease. Other physicians including a neuroradiologist dispute that the CT scan was negative.

PATIENT C

13. On August 14, 2013, Patient C, a female born in 1925, was seen by her primary care physician who referred Patient C to Respondent for evaluation of a right sided neck mass.

14. Patient C's primary care physician ordered a neck CT scan which was performed on August 15, 2013.

15. On August 15, 2013, Respondent interpreted Patient C's CT scan as depicting a superficial and deep lobe parotid mass on the right.

16. Respondent recommended a further study, fine needle aspiration to confirm the diagnosis, but charted that Patient C preferred surgical intervention because fine needle aspiration was not offered at the satellite clinic where the patient was seen.

17. Respondent informed Patient C of the risks of the surgery Respondent was recommending to her, including risk of facial nerve injury, but did not document that the risks were increased due to the swelling and inflammation for which the patient was being evaluated.

18. At no time did Respondent inform Patient C that a radiologist's interpretation of Patient C's CT scan could be obtained to help Patient C consider the surgery Respondent was recommending.

19. Respondent made arrangements to perform surgery on Patient C on August 29, 2013; however, he did not perform surgery as Patient C sought care from another otolaryngologist closer to home.

20. On August 15, 2013, a radiologist interpreted Patient C's CT scan as showing diffuse swelling, no discrete mass or abscess, no definite obstructing stone and recommended non-surgical medical management with antibiotic therapy. The radiologist authored a report of his findings which was not provided to Respondent prior to Patient C leaving Respondent's care.

21. On August 23, 2013, Patient C sought a second opinion from an otolaryngologist closer to where Patient C resided. Patient C was treated medically with antibiotics.

PATIENT D

22. On May 7, 2012, Patient D, a female born in 1935, underwent a maxillofacial CT scan ordered by Respondent to evaluate for a chronic history of headache, sinusitis and facial congestion since fracturing her nose years before.

23. On May 7, 2012, Patient D's CT scan was interpreted by the radiologist as depicting no appreciable sinus disease, well aerated sinuses, widely patent bilateral ostiomeatal complexes and a stable osteoma. The radiologist authored a report of his findings which was provided to Respondent on or before August 21, 2012.

24. On August 21, 2012, Patient D presented to Respondent for evaluation of nasal airway obstruction, chronic sinusitis and sinus headaches.

25. Respondent reviewed Patient D's May 2012 CT scan and interpreted it as depicting mucosal thickening of all sinuses, narrowing of the bilateral ostiomeatal complexes due to bilateral agger nasi cells, Haller cells obstructing frontal recesses, and right frontal sinus osteoma causing near complete obliteration of the sinus.

26. Respondent's clinical exam revealed an extremely large deviation of the patient's septum to the right and a large septal spur on the left. She also had bilateral inferior turbinate hypertrophy which was most probably a compensatory result of her septal deviation due to airway obstruction.

27. Respondent recommended sinus surgery to open up the patient's sinuses with removal of the osteoma to Patient D, which Respondent performed on September 5, 2012.

28. At no time did Respondent inform Patient D that a radiologist had reviewed Patient D's CT scan and made different findings than Respondent.

29. Respondent's medical charting for Patient D indicates he explained all risks and benefits of surgery but did not delineate individual surgical risks of bleeding, infection, scar formation, potential for future sinus problems and additional surgery, change in vision, loss of vision, cerebral spinal fluid leak, meningitis, damage to sense of smell, and damage to tear ducts.

30. Patient D's headaches resolved after surgery but she continued to experience persistent facial pain and sought treatment from another physician. The physician reviewed Patient D's May 2012 CT scan and informed Patient D that it did not support the surgery performed by Respondent as related to the osteoma. Respondent and the subsequent physician disagree on the role the osteoma played in Patient D's symptomology.

PATIENT E

31. On September 21, 2011, Respondent performed surgery on Patient E, a male born in 1986. The pre-operative informed consent identified the surgery as septoplasty, functional endoscopic sinus surgery, possible medial maxillectomy sinonasal polypectomy, possible excision of left skull base mass.

32. Respondent's operative report described the surgery as septoplasty, left maxillectomy, removal of left nasal maxillary mass entering the infratemporal fossa, removal of left nasal maxillary mass entering the middle cranial fossa (pterygopalatine fossa), use of neuronavigation, and left inferior turbinate submucous resection.

33. Respondent did not in fact perform a left maxillectomy on Patient E, but instead performed an endoscopic medial maxillectomy as described in the operative report.

34. Respondent's medical charting for Patient E does not include documentation of any discussion with Patient E prior to surgery regarding alternative medical modes of treatment and/or the benefits and risks of surgery versus non-surgical medical management.

35. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in these matters 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 Robert J. DeFatta, M.D., engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002) by engaging in any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

3. By the conduct described in the Findings of Fact, Respondent Robert J. DeFatta, M.D., engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(u) (Nov. 2002) by obtaining consent for treatment without adequately charting his discussion with the patient informing the patient of the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.

4. By the conduct described in the Findings of Fact, Respondent Robert J. DeFatta, M.D., engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(za) (Nov. 2002) by failing to maintain patient health care records consistent with the requirements of ch. Med 21.

5. As a result of the above conduct, Robert J. DeFatta, M.D., is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.
2. Respondent Robert J. DeFatta, M.D., is REPRIMANDED.
3. The medicine and surgery license issued to Robert J. DeFatta, M.D. (license no. 55984-20) is LIMITED as follows:
 - a. Within thirty (30) days of the effective date of this Order, Respondent shall retain a professional mentor who shall be pre-approved by the Board or its designee. The following professional mentor is pre-approved:
 - i. James Nathan Palmer, M.D. Department of Otorhinolaryngology: Head and Neck Surgery, 3400 Spruce Street, 5 Silverstein, Philadelphia, PA 19104-4283
 - b. The professional mentor shall have no personal or professional relationship with Respondent that could reasonably be expected to compromise the ability of the professional mentor to render objective and

unbiased reports to the Department. For purposes of this Order, a professional mentor shall be a physician holding a current, unlimited Wisconsin or Pennsylvania credential, who specializes in otolaryngology, and who has read this Final Decision & Order and subsequently agrees to be Respondent's professional mentor.

- c. Every thirty (30) days for a minimum of one (1) year after the mentor has been approved, he or she shall review a list of all patients, identified by number, on whom Respondent has performed surgery in the past thirty (30) days.
- d. The mentor shall select from the patient list four (4) patients and shall further review for the selected patients all patient health care records authored by Respondent, all patient health care records available to Respondent at the time he rendered care and treatment, and all radiographic studies and radiology reports authored by any interpreting radiologist(s) which in any way related to the care Respondent provided to the patient.
- e. The mentor shall review the records to determine and identify whether:
 - i. Respondent reasonably interpreted radiographic studies;
 - ii. Respondent's radiographic findings were reasonably documented in the patient health care record;
 - iii. Respondent made available to the patient radiographic findings by other physicians, including the reviewing radiologist;
 - iv. Respondent discussed any differing interpretations of radiographic studies with other reviewing physicians;
 - v. Respondent's surgical recommendations and surgeries performed were reasonable;
 - vi. Respondent informed the patient of alternate, viable medical modes of treatment and the benefits and risks of the treatments; and
 - vii. Respondent documented in the patient health care record that he informed the patient of alternate, viable medical modes of treatment and the benefits and risks of the treatments.
- f. Respondent shall arrange for the mentor to submit formal written reports to the Department Monitor every ninety (90) days, addressing all points described in para. e. above.

- g. Respondent's professional mentor shall immediately report to the Department Monitor any action or inaction by Respondent which may constitute unprofessional conduct, including any deficiency in medical record keeping, any violation of this Order, or any other act or conduct which may constitute a danger to a patient or the public.
- h. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order, including any failures of the professional mentor to conform to the terms and conditions of this Order.
- i. Respondent is responsible for all costs associated with compliance with this mentoring requirement.
- j. This limitation may be removed or modified upon Respondent satisfying the Board that he successfully completed the required mentoring, and upon Respondent's appearing before the Board and satisfying the Board that he is not a danger to the health, welfare, or safety of patient or public.

4. Within six (6) months from the effective date of this Order, Robert J. DeFatta, M.D., shall pay COSTS of these matters in the amount of \$45,301.

5. Requests for approval of a professional mentor and payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be submitted to the Department Monitor at the address below:

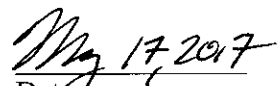
Department Monitor
 Division of Legal Services and Compliance
 Department of Safety and Professional Services
 P.O. Box 7190, Madison, WI 53707-7190
 Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

6. In the event Respondent violates any term of this Order, Respondent's license (no. 55984-20), may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

7. This Order is effective seven (7) days from the date of its signing.

WISCONSIN MEDICAL EXAMINING BOARD

by: 
 A Member of the Board


 Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

ROBERT J. DEFATTA, M.D.,
RESPONDENT.

:
:
:
:
:

STIPULATION

0005301

Division of Legal Services and Compliance Case Nos. 14 MED 104, 14 MED 518
and 15 MED 034

Respondent Robert J. DeFatta, M.D., and the **Division of Legal Services and Compliance, Department of Safety and Professional Services** stipulate as follows:


1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.
2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:
 - the ~~right to a hearing~~ on the allegations against Respondent, at which time the State has the ~~burden of proving~~ those allegations by a preponderance of the evidence;
 - the right to confront and cross-examine the witnesses against Respondent;
 - the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
 - the right to testify on Respondent's own behalf;
 - the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
 - the right to petition for rehearing; and
 - all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.
3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation. Respondent is represented by Attorney Paul R. Erickson.
4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Medical Examining Board (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.


6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent or Respondent's attorney, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.


8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.


Robert J. DeFatta, M.D., Respondent
N1706 945th Street
Eau Claire, WI 54701
License no. 55984-20

5/14/17
Date


Paul R. Erickson, Attorney for Respondent
Gutglass Erickson Bonville SC
735 North Water Street Suite 1400
Milwaukee WI 53202

5-15-17
Date


Colleen L. Meloy, Prosecuting Attorney
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

05-15-17
Date