WISCONSIN DEPARTMENT OF
SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Safety and Professional Services 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 Safety and Professional Services 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 Safety and Professional Services 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 Safety and Professional Services, 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 Safety and Professional Services 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 DSPS website: An individual who believes that information on the website is inaccurate may contact DSPS@wisconsin.gov

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	DLSC Case No. 22 MED 418
VICTORIA J. MONDLOCH, M.D., RESPONDENT.	:	ORDER0008550

ORDER OF SUMMARY SUSPENSION

The Petition for Summary Suspension of the license of Victoria J. Mondloch, M.D., to practice medicine and surgery, dated May 4, 2023, was noticed to be presented to the Wisconsin Medical Examining Board (Board) at 9:30 a.m., or as soon thereafter as the matter could be heard, on May 17, 2023. At that time, Attorney Carley J. Peich Kiesling appeared for the Petitioner, Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division). Respondent appeared in person as did Respondent's attorney Mary Ratzel.

The Board, having considered the sworn Petition for Summary Suspension and the Affidavit of Carley J. Peich Kiesling and attached exhibits, as evidence; the Affidavit of Service of Renee Hammond, certifying that a true and accurate copy of the Notice of Presentation of Petition for Summary Suspension, Petition for Summary Suspension and Affidavit of Carley J. Peich Kiesling and attached exhibits were sent via certified and regular U.S. Mail, as well as by electronic mail, to Respondent on May 4, 2021; and having heard the arguments of counsel, makes the following:

FINDINGS OF FACT

1. Respondent Victoria J. Mondloch, M.D., (Year of Birth: 1955) is licensed in the state of Wisconsin to practice medicine and surgery, having license number 26004-20, first issued on July 1, 1984, with registration current through October 31, 2023.

2. Respondent's most recent address on file with the Department is W220 S3731 Hidden Court, Waukesha, Wisconsin 53189.

Prior Board Action

3. On July 21, 2004, the Board issued Order LS0407212MED (Division case number 02 MED 379), reprimanding Respondent and ordering her to complete a re-education program under the supervision of Thomas C. Meyer, M.D., as recommended by a recent CPEP evaluation. The Order was based on Respondent's substandard care of several obstetrics patients and subsequent summary suspension of her obstetrical privileges at Waukesha Memorial Hospital. Respondent's license was reinstated to full unencumbered status on April 27, 2005.

4. On February 20, 2013, the Board issued Order 0002309 (Division case numbers 09 MED 258 and 10 MED 363), reprimanding Respondent and limiting her license as follows: Respondent will not engage in the practice of obstetrics, Respondent will refer all patients who present with possible pregnancy of any type to an obstetrician, Respondent will refer all patients who present with symptoms of abnormal bleeding or cramping where possible pregnancy of any type is part of the differential to an obstetrician or gynecologist, Respondent will not perform any surgical or gynecological procedure on any patient except pelvic exams and pap smears, and Respondent will cease performing ultrasounds. The basis of this Order was Respondent's conduct as follows:

a. Misdiagnosing a patient with PCOS and hormone imbalance, and recommending ovarian drilling for PCOS or hormone imbalance when such treatment was not indicated;

b. Performing a laparoscopic-assisted vaginal hysterectomy with bilateral salpingo-oohorectomy surgery on a patient to treat menometrorrhagia and menstrual migraines, prior to attempting more conservative medical management of the patient's symptoms; and failing to address the patient's intraoperative bleeding during the laparoscopic portion of the procedure;

c. Failing to properly and timely evaluate a patient for a possible ectopic pregnancy; and

d. Misdiagnosing a patient's condition as a molar pregnancy.

Board Order 0002309 further states "Violation of any 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."

5. On September 15, 2021, in Board Order 0007603 (Division case number 18 MED 523), the Board reprimanded Respondent and suspended her license for one (1) week for her failure to complete the required 30 hours of continuing education credits during the 2016-2017 biennium.

Current Case

6. The Division's investigation has obtained evidence of the facts listed below.

7. At all times relevant to this proceeding, Respondent practiced at her own clinic located in Waukesha, Wisconsin (Clinic). Respondent's website refers to her as an "OB/GYN and wellness physician" as well as a physician specializing in women's health, family medicine, preventive health and wellness. According to her Clinic's website, Respondent's practice focuses on hormone therapy, nutritional therapy, and other alternative methods of treatment.

8. On June 23, 2021, Patient A (female born in 1956) presented to Respondent for a second opinion on surgery and treatment regarding a recent biopsy and diagnosis of FIGO Grade 1 Endometrioid uterine cancer. Respondent informed Patient A that endometrial ablation is a sufficient treatment alternative in most patients and recommended Patient A return for a total body thermogram, a CT scan of her abdomen/pelvis to determine if it was superficial in the endometrial

lining only, and bloodwork to check her hormone levels. Respondent did not refer Patient A to a gynecological oncologist, nor did she consult with a gynecological oncologist at any time regarding Patient A's diagnosis and treatment.

9. On July 16, 2021, Patient A returned for her lab results. Respondent told Patient A that her hormone levels were low and/or imbalanced and recommended Patient A begin a trial of progesterone and vitamin supplements, reduce her intake of man-made carbohydrates, begin an aerobic exercise plan, repeat fasting bloodwork in 8-10 weeks, CT with contrast after six (6) months of high dose P4 (progesterone) treatment, and perform a cheek swab test to determine her metabolic body type.

10. On October 26, 2021, Respondent spoke to Patient A regarding her labs and bleeding, and recommended a temporary break in progesterone to "trigger a bleed," repeat an endometrial biopsy in 6-8 weeks, repeat labs in 8-10 weeks, continue vitamins and exercise, and possible pelvic ultrasound or CT.

11. On November 3, 2021, Respondent spoke to Patient A regarding bleeding that occurred when she stopped progesterone "to allow any uterine lining to shed." Patient A reported feeling bloated and awful. Respondent recommended she restart progesterone, repeat bloodwork, and endometrial biopsy.

12. On November 22 and 30, 2021, Respondent saw Patient A for UTI symptoms and prescribed Macrodantin. Respondent noted that Patient A was still bleeding.

13. On February 23, 2022, Respondent saw Patient A for URI symptoms and post-COVID exposure.

14. On March 24, 2022, Patient A saw Respondent with complaints of progressively significant abdominal bloat and lower abdominal pain with bladder leakage and vaginal bleeding. Respondent performed an endometrial biopsy on Patient A in violation of prior Board Order 0002309. Respondent recommended Patient A return for follow-up on the lab work, continue progesterone and vitamin supplements, and to consider a CT scan of her abdomen and pelvis with contrast.

15. On March 28, 2022, Patient A saw Respondent in follow up, noting continued bleeding and abdominal bloat, and that endometrial biopsy results were pending. Respondent recommended a pelvic and abdominal ultrasound in a week, continued progesterone, and repeat bloodwork.

16. On March 30, 2022, Respondent discussed and provided Patient A with non-confirmed and experimental reports about the use of kinase proteins and regenerative medicine to treat cancer, including exosome treatment. Respondent administered exosome intravenous treatment to Patient A.

17. On April 1, 2022, Respondent charted that the results of Patient A's recent endometrial biopsy now showed "high grade serous carcinoma." Respondent discussed treatment options with Patient A and provided her with three contacts for treatment including Hope4Cancer,

Cancer Treatment Centers of America in Zion, IL (integrative cancer center), and Froedtert Cancer Center. Respondent also discussed MedBed technology with Patient A.

18. On April 6, 2022, Respondent saw Patient A to discuss pelvic ultrasound results and next steps. Respondent noted that ultrasound showed increased ovarian volume which "may actually represent...possible ovarian cancer? vs endometrial CA as the primary etiology of pt's abom and pelvic sx's." Patient A reported having called both cancer centers and leaning toward surgical excision with Froedtert.

19. On May 4, 2022, Patient A underwent a total hysterectomy, bilateral salpingo-oophorectomy and omentectomy at Froedtert Cancer Center. Pathology results confirmed Stage IVB high grade serous endometrial carcinoma, with extensive involvement of the entire thickness of the myometrium, cervix and upper vagina, lymphovascular space, bilateral ovaries and fallopian tubes. It was recommended that Patient A undergo systemic therapy with chemotherapy.

20. On June 2, 2022, Respondent met with Patient A and again discussed "healing bed technology."

21. On August 27, 2022, Patient A died from Stage IVB endometrial cancer.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02 and has authority to summarily suspend the license of Respondent to practice medicine and surgery in the state of Wisconsin, pursuant to Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6.

2. Proper and sufficient notice of the Petition for Summary Suspension was provided to Respondent as required by Wis. Admin. Code § SPS 6.05.

3. Based on these facts, there is probable cause to believe that Respondent engaged in unprofessional conduct by violating a provision, condition, or term of a valid order of the board, pursuant to Wis. Admin. Code § Med 10.03(1)(a).

4. Based on these facts, there is probable cause to believe that Respondent engaged in unprofessional conduct by departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person, pursuant to Wis. Admin. Code § Med 10.03(2)(b).

5. There is probable cause to believe that Respondent has violated the rules of professional conduct as noted above and it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare.

ORDER

1. The license of Respondent to practice medicine and surgery in the state of Wisconsin is summarily suspended until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board.

2. A formal complaint alleging that Respondent has committed unprofessional conduct as set forth above shall be filed with the Division of Hearings and Appeals within 10 days of the date of this Order.

3. Respondent is notified of her right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause why this summary suspension order should not be continued and is further notified that any request for a hearing to show cause should be filed with the Wisconsin Medical Examining Board, 4822 Madison Yards Way, Post Office Box 8366, Madison, Wisconsin 53708-8366.

4. In the event that Respondent requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Board of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN MEDICAL EXAMINING BOARD

By: [signature]
A Member of the Board

5/17/23
Date