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FILE COPY

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

Case No. LS-9310223-MED

R. A. NIELSEN, D.P.M.,

Respondent

FINAL DECISION AND ORDER

The parties in this matter for purposes of review under § 227.53, Stats., are:

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

R. A. Nielsen, D.P.M.
2300 North Mayfair Road, Suite 295
Milwaukee, WI 53226

State of Wisconsin
Medical Examining Board
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53703

A Class II hearing was conducted in the above-captioned matter on August 28 through 31, 1995, and September 5 and 6, 1995. The Administrative Law Judge, John N. Schweitzer, filed his Proposed Decision on April 10, 1996. Gilbert C. Lubcke, attorney for the complainant, filed his objections to the Proposed Decision on May 6, 1996, and James M. Fergal, attorney for the respondent, filed his response to complainant's objections on May 20, 1996. The parties appeared before the board on June 27, 1996, for arguments on the objections, and the board considered the matter on that date.

Based upon the entire record in this matter, the Medical Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

(Numbers in brackets refer to pages in the transcript)

1. The respondent, R. A. Nielsen, is a podiatrist licensed in the state of Wisconsin, under license number 263, which he has held continuously since it was originally granted on July 11, 1951. His office address is 2300 Mayfair Road, Wauwatosa, Wisconsin.

2. Dr. Nielsen obtained his initial education and training in podiatry at the Chicago College of Chiropody, now called the Scholl College of Podiatry, from 1947 to 1951. [49]

3. Minimal Incisional Surgery (MIS) is a surgical technique in which instruments are inserted through an incision of one centimeter or less to operate on a surgical site without exposing and visualizing the site. In podiatric M.I.S., drills and rasps may be inserted to remove bone from a deformity.

4. Dr. Nielsen obtained some of his education and training in minimal incision surgery (MIS) from seminars, meetings, and publications of the Academy of Ambulatory Foot Surgeons (AAFS), though he began using MIS prior to his first AAFS seminar in 1973. [55, 69]

5. From 1971 to the present, Dr. Nielsen has increasingly specialized in MIS and in ostectomies, especially modified Silver bunionectomies. Early in his use of MIS, Dr. Nielsen formed the opinion that it is a superior technique for certain types of surgery, in that it causes less postoperative pain and eliminates the need to remove stitches. [75-6] He now performs surgeries exclusively with MIS. [72]

PATIENT A. [Exhibits 16-20, 37-39, 41, 88-92]

6. Patient A had seen Dr. Nielsen for medical treatment some time prior to 1987, but for the purpose of this proceeding, she visited him for the first time on 2-26-87. Her presenting problem was pain on the second toe of her left foot.

7. In the oral history taken by Dr. Nielsen's assistant, Patient A indicated that she did not have circulatory problems, although she did indicate that she had high blood pressure for which she was taking "pills", and that she had very bad varicose veins. She did not mention an arterial flow study which had been performed on 8-5-86.

8. Dr. Nielsen conducted a routine physical examination, and took and reviewed x-rays of Patient A's left foot.

9. Though Dr. Nielsen has no recollection of Patient A or of the examination he conducted, Dr. Nielsen's routine vascular and neurological foot examination in 1987 consisted of checking pulses, doing a capillary refill test, seeing if the foot was red or swollen, checking the temperature and the hair, and doing a Babinski test for reflexes. [357] Dr. Nielsen noted no abnormal vascular or neurological findings in his examination of Patient A's foot.

10. Dr. Nielsen's diagnosis of Patient A was a hammertoe of the second toe of the left foot, a bunion on the right foot, and an ingrown toenail on the first toe of her left foot. [279] As he testified in the hearing, he was able to observe numerous other abnormalities on her x-rays, including osteoporosis, gouty arthritis, a severe hallux valgus deformity, and hammertoes of all of her lesser toes. [345, 380] Her main complaint involved an overgrowth of bone at the head of the proximal phalanx of the second toe on her left foot, where it rubbed against the first toe, with consequent tissue damage. She had applied a corn pad to this area, which had produced a chemical burn.

11. Dr. Nielsen recommended to Patient A surgery consisting of the removal of the osseous proliferation and part of the head of the proximal phalanx of the second toe on her left foot. He performed this surgery using MIS techniques in his office on 2-26-87.

12. Medical attention of some sort to the lesion on Patient A's toe was urgent, but not an emergency. Dr. Nielsen considered the surgery to be something more than simply elective, because a lesion existed at the site. [349] Surgical attention to correct bone deformities was elective, and surgery of any sort could have been postponed for a number of days. [281]

13. Patient A returned to Dr. Nielsen's office on 3-5-87, one week after surgery. Dr. Nielsen's office notes reflect no abnormal findings on that date.

14. Patient A returned to Dr. Nielsen's office on 3-23-87, 25 days after surgery, and reported that up until a week earlier the second toe on her left foot had looked and felt all right, but that at that time "it started to look different" and had begun to hurt. Dr. Nielsen noted that "there is a ulcer on the tibial aspect of 2nd digit left foot but does not look infected". Dr. Nielsen took an x-ray of her foot, which he reviewed and found negative. He referred Patient A to another doctor and had no further contact with her.

15. Inadequate vascular circulation in an extremity decreases the likelihood that surgery on that extremity will heal. [439]

16. An arterial flow velocity and pressure study done for Patient A on 8-15-86 at the Mt. Sinai Medical Center shows a "Pressure Index - PT/DP" of 0.71 (right) and 0.59 (left), with the notation that "> 0.95 is within normal limits". For "Flow Velocity Patterns" it reports "Abnormal left common femoral velocity waveform with absence of flow reversal. Monophasic signals in pedal arteries bilaterally." Under "Impression" it states "Abnormal resting ankle pressures bilaterally. Left limb pressures diminished compared to right. Resting ankle pressures in mild arterial ischemic range. Segmental pressures demonstrate left iliac and bilateral femoral popliteal occlusive disease." [Exhibit 92]

17. On 3-23-87, upon Patient A's admission to Northwest General Hospital, Dr. Kourakis noted her history of treated hypertension and recorded "peripheral pulses bilaterally present and decreased. Dorsalis pedis pulses were faint." He recorded no other abnormal findings for tests commonly performed for circulation in the foot. [Exhibit 37]

18. On 3-24-87, Dr. Papendick recorded that Patient A's pedal pulses were diminished but palpable (1 over 4), with "minimal edema", but he recorded no other abnormal findings for tests commonly performed for circulation in the foot. [628, Exhibit 37]

19. On 3-25-87, Dr. Bass was unable to palpate pulses on Patient A's right foot. [489] However, bleeding occurred during surgery by Dr. Bass on 4-1-87 [506], sufficient for him to decide to close the surgical site. [535]

20. On 4-7-87, Dr. Majer noted Patient A's varicosities and recorded an "impression" of "arterial insufficiency", but he recorded no difficulty in palpating pulses or other abnormal findings for tests commonly performed for circulation in the foot. [Exhibit 37]

21. The circulation in Patient A's left foot was reduced in August of 1986 and in March of 1987. [498-502, 630]. A preponderance of the evidence establishes that circulation in Patient A's left foot was also reduced at the time of Dr. Nielsen's surgery on February 26, 1987, to an extent that a minimally competent clinical evaluation would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated.

PATIENT B. [Exhibits 10-15, 45-48, 67-70, 73-76, 79-82]

22. Patient B first came to Dr. Nielsen on 7-11-86. Her presenting problem was pain in both of her feet. Dr. Nielsen conducted a history and a physical examination, and took and reviewed x-rays of her feet. Dr. Nielsen diagnosed bunions on both feet, osseous proliferations on the first metatarsal heads on both feet, and hammertoes of the second toe on both feet. [227] As he testified in the hearing, he was able to observe numerous other abnormalities in the x-rays, including hallux valgus, buckling of the first metatarsal-phalangeal joint, severe flexion deformities of all four lesser toes, and an excessively long second shaft. [383]

23. Dr. Nielsen performed surgery on Patient B's left foot on 7-11-86. The first part of this surgery consisted of the removal of the osseous proliferation and part of the head of the first metatarsal. He performed this surgery, a "modified Silver bunionectomy", using MIS techniques in his office. The second part of the surgery consisted of the removal of part of the head of the proximal phalanx of the second toe, using similar MIS techniques. [249] On 7-18-86, he repeated both of these procedures on Patient B's right foot.

24. Dr. Nielsen did not attempt to correct Patient B's hallux valgus deformities, nor did he attempt to correct the underlying structural hammertoe deformity.

25. Patient B called Dr. Nielsen on 7-21-86, three days after the second surgery, reporting that she had taken a lot of the Tylenol with codeine which he had prescribed for her and that she was feeling better, but that her right foot had started bleeding a little.

26. The following day, on 7-22-86, Patient B's husband called and reported that she was having a lot of pain, and brought her to Dr. Nielsen's office. Dr. Nielsen recorded no examination findings, but decided that she might be developing an infection and prescribed the antibiotic Keflex for her. [255]

27. On 7-22-86, Patient B's surgical incision was not open or draining.

28. Six days later, on 7-28-86, Patient B returned to the office. Dr. Nielsen recorded nothing on his patient notes for that date.

29. Three weeks later, on 8-18-86, Patient B returned again, Dr. Nielsen concluded that she probably had a developing infection, took a culture of the surgical site and sent it to a lab for sensitivity analysis, and renewed the prescription for Keflex.

30. Based on the sensitivity study he received from the lab three days later, on 8-21-86, Dr. Nielsen prescribed the antibiotic Erythromycin for Patient B. After talking to her on the phone on 8-26-86, he renewed the prescription for Erythromycin. Dr. Nielsen had no further contact with Patient B. [262]

PATIENT C. [Exhibits 1-2, 4-9, 28-32, 43-44, 49, 54-61, 83-86]

31. Patient C first came to Dr. Nielsen on 7-21-89 in response to an ad. [439] Her presenting problem (aside from an ingrown toenail, which is unimportant here) was pain on the medial sides of the metatarsal heads on both feet. Dr. Nielsen conducted a history and a physical examination, and took and reviewed x-rays of Patient C's feet. Dr. Nielsen diagnosed bunions on both feet and osseous proliferations on the first metatarsal heads on both feet. [101] As he testified in the hearing, he was able to observe numerous other abnormalities in the x-rays, including osteoporosis, hallux valgus, metatarsus primus varus, a short first metatarsal shaft, lateral movement of the sigmoid bones, and a second ray which was longer than the first. [298, 384]

32. Dr. Nielsen recommended to Patient C surgery consisting of the removal of the osseous proliferation and part of the head of the first metatarsal on her right foot. He performed this surgery, a "modified Silver bunionectomy", using MIS techniques in his office on 7-21-89. He also recommended that similar surgery be performed on her left foot at a later date. [442]

33. Dr. Nielsen did not attempt to correct Patient C's hallux valgus and metatarsus primus varus deformities.

34. Following the surgery on 7-21-89, Dr. Nielsen gave Patient C a supply of the antibiotic Erythromycin and a prescription for Tylenol #3 with general instructions regarding the surgery site, made arrangements for a return visit a week later, and discharged her. [187]

35. On 7-25-89, four days after surgery, Patient C returned to Dr. Nielsen's office complaining of pain and swelling. Dr. Nielsen examined the surgical site and found some blood on the bandage but no inflammation, and formed the opinion that the site was not infected. [198] The surgical site was not open or draining. He had Patient C soak her foot in a whirlpool bath at the office for about five minutes. [312, 388, 447] He gave her an antibiotic ointment and instructed her to soak her foot in warm water. [198, 447]

36. Patient C canceled her scheduled follow-up appointment on 7-28-89 and did not return until 8-4-89, two weeks after surgery, at which time Dr. Nielsen trimmed the incision area and noted no symptoms or complaints of pain, swelling, inflammation or suppuration. [200]

37. Twelve days later, on 8-16-89, Patient C called Dr. Nielsen's office complaining that the surgical site was painful, swollen, red, and warm to the touch. Because she wanted to attend a reunion, Patient C was not willing to come in on that day, but she agreed to an appointment on 8-18-89. Dr. Nielsen formed the opinion that the site was infected, and prescribed the antibiotic Cipro over the phone.

38. When Patient C came to Dr. Nielsen's office on 8-18-89, he examined the area of the infection, found no evidence of red streaks, shininess or suppuration, found the pain localized, and decided that the infection was not severe. He continued her on the medication, and she returned again on 8-21-89, at which time the pain, redness and swelling had all decreased.

39. Eighteen days later, on 9-8-89, Patient C returned to Dr. Nielsen's office complaining of pain and swelling. Dr. Nielsen examined her and formed the opinion that the site was not infected. No draining or heat were complained of or noted. Dr. Nielsen injected 1/2 cc of Celestone Soluspan into the area of the surgery.

40. Celestone Soluspan is a glucocorticoid (hydrocortisone) containing one compound for prompt activity and one for sustained activity. The Physicians Desk Reference describes the product as having "potent anti-inflammatory effects", warns that it "may mask some signs of infection", and recommends dosages of between 1/4 cc and 1 cc "at intervals of three days to a week". [Exhibit 87]

41. Three days later, on 9-11-89, Patient C returned to Dr. Nielsen's office and reported that the pain and swelling were greatly improved. Dr. Nielsen gave her a second injection of 1/2 cc of Celestone Soluspan.

42. Eight days later, on 9-19-89, Dr. Nielsen received a call from Patient C's boyfriend to ask if she could have another x-ray to tell if something else was wrong. On 9-25-89 Patient C called, complained of a sensation of pins sticking her foot, and came in to Dr. Nielsen's office for an x-ray. The x-ray showed no indication that an infection had invaded the bone. Dr. Nielsen saw Patient C for the last time on 9-29-89, at which time she said her foot was feeling better. [217, 325]

43. In July of 1991, Dr. Boudreau performed corrective surgery on Patient C's right foot. Dr. Boudreau did not attempt to correct the hallux valgus and metatarsus primus varus deformities on Patient C's left foot. [473]

CONCLUSIONS OF LAW

1. The Medical Examining Board is the legal authority responsible for issuing and controlling credentials for podiatrists, under ch. 448, Stats. The Medical Examining Board has jurisdiction over Dr. Nielsen's license, it has personal jurisdiction over Dr. Nielsen under sec. 801.04 (2), Stats., based on his receiving notice of the proceeding, and it has subject-matter jurisdiction over a complaint alleging unprofessional conduct by a podiatrist, under sec. 15.08(5)(c), Stats., sec. 448.02 (3), Stats., and ch. Med 10, Wis. Admin. Code.

2. Dr. Nielsen failure to conduct a minimally competent clinical evaluation, which would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated, constitutes a violation of sec. Med 10.02(2)(h), Code, and sec. 448.02(3), Stats.

3. Dr. Nielsen identified structural deformities of Patient B's feet but wrote down only those he intended to address. Dr. Nielsen did not fail to adequately diagnose Patient B's presenting problems.

4. Dr. Nielsen performed a surgical procedure which did not address the structural deformities in Patient B's foot, but this choice of procedure did not fall below minimum standards of treatment for Patient B's condition, and he did not create unacceptable risks for Patient B by his choice of treatment.

5. Dr. Nielsen did not fail to adequately assess Patient B's right foot for infection on 7-22-86.

6. Dr. Nielsen's documentation regarding Patient B on 7-22-86 and thereafter was below minimum standards of competent practice, exposing the patient to unacceptable risks to which a minimally competent physician would not expose a patient, constituting a danger to the health, welfare and safety of the patient, and thus unprofessional conduct under sec. Med 10.02(2)(h),. Code, and sec. 448.02(3), Stats.

7. Dr. Nielsen's decision not to take serial cultures or serial x-rays after an infection developed in Patient B's right foot did not fall below minimum standards of treatment.

8. Dr. Nielsen identified structural deformities of Patient C's feet but wrote down only those he intended to address. Dr. Nielsen did not fail to adequately diagnose Patient C's presenting problems.

9. Dr. Nielsen performed a surgical procedure which did not address the structural deformities in Patient C's foot, but this choice of procedure did not fall below minimum standards of treatment for Patient C's condition, and he did not create unacceptable risks for Patient C by his choice of treatment.

10. Dr. Nielsen's use of a whirlpool for Patient C on 7-25-89, and his advice to her to soak her foot in water, did not fall below minimum standards of competence.

11. Dr. Nielsen did not fail to adequately assess Patient C's right foot for infection on 7-25-89 and thereafter.

12. Because Patient C was unwilling to come to Dr. Nielsen's office earlier than 8-18-89, his failure to examine her on 8-16-89 did not fall below minimal standards of treatment.

13. Dr. Nielsen's administration of Celestone Soluspan on 9-8-89 and 9-11-89 fell within acceptable limits of professional treatment.

ORDER

NOW, THEREFORE, IT IS ORDERED that Count III of the complaint is dismissed.

IT IS FURTHER ORDERED that R. A. Nielsen, D.P.M., is reprimanded for his failure to adequately document positive and negative findings in his medical records and for his failure to conduct a minimally competent clinical evaluation, which would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated.

IT IS FURTHER ORDERED that Dr. Nielsen participate in, and successfully complete, an educational program to address his failure to adequately document positive and negative findings in his medical records and his failure to conduct a minimally competent clinical evaluation, which would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated, as follows:

1. Within 10 days of the date on which this order is adopted by the board, Dr. Nielsen shall contact the University of Wisconsin School of Medicine, Continuing Medical Education Program (hereinafter, "the University") and meet with personnel of that program at their earliest convenience. Dr. Nielsen shall inform the University of this order and request that the University perform an assessment of his current clinical competence to practice podiatry as well as of his current record-keeping practices, in light of the findings and conclusions in this case.
2. Dr. Nielsen shall further request, if the University finds any inadequacy in his current clinical competence or in his record-keeping practices, that an educational program be established to address his needs. Dr. Nielsen shall cooperate with, participate in, and successfully complete any program so established. Dr. Nielsen shall complete the program within six months of the date it is established, unless the written terms of the

program itself set a different schedule. This deadline may be extended by the board. This educational program shall be in addition to Dr. Nielsen's other continuing medical education requirements.

3. Dr. Nielsen shall authorize the University and its personnel conducting the assessment and educational program to submit information to the board regarding Dr. Nielsen's participation in the program and to report upon the results of any evaluations. Dr. Nielsen shall request that the University submit a final report to the board upon completion of the program.
4. Dr. Nielsen shall make himself available to appear before the board upon invitation, to address any questions the board may have concerning the University's final report or his participation in the program.
5. Dr. Nielsen shall bear the University's costs of the assessment and educational program.

IT IS FURTHER ORDERED that, pursuant to sec. 440.22, Stats., two-thirds of the costs of this proceeding are assessed against the respondent.

EXPLANATION OF VARIANCE

The board has accepted the ALJ's Findings of Fact, with two exceptions. Finding #9 has been modified to make clear that while Dr. Nielsen's usual vascular and neurological foot examination in 1987 may have consisted of the elements noted, he has no independent recollection of either the patient or the examination. The second modification is to Finding of Fact #21. The ALJ's finding at paragraph #21 states as follows:

> 21. The circulation in Patient A's left foot was reduced in August of 1986 and in March of 1987. [498-502, 630] Logically, it was also reduced at the time of Dr. Nielsen's surgery on 2-26-87. Nevertheless, the reduction was not to the point where any of five treating physicians recorded any unusual observations regarding the capillary refill test, skin color, skin temperature, or hair growth; only one noted "minimal edema", and only one was unable to palpate a pulse.

Instead, the board finds as follows:

> 21. The circulation in Patient A's left foot was reduced in August of 1986 and in March of 1987. [498-502, 630]. A preponderance of the evidence establishes that circulation in Patient A's left foot was also reduced at the time of Dr. Nielsen's surgery on February 26, 1987, to an extent that surgery was contraindicated and also establishes that a minimally competent clinical evaluation would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated.

In addressing the adequacy of Dr. Nielsen's examination of Patient A, both of respondent's experts testified that Dr. Nielsen's examination appeared to be adequate, and that surgery was not contraindicated. Dr. Warren Kobak testified that there is no indication in Dr. Nielsen's records that he had found any abnormalities as to pulse, capillary refill, skin temperature, nails, hair, color of the skin, or edema, and that Dr. Kobak could therefore not "find any such indication that

there was any -- any -- that there was no vascular examination. That's a double negative, but." [1383-1384] Dr. Kobak further testified that based on his examination of Dr. Nielsen's records as well as the records of Patient A's subsequent hospitalization, and to a reasonable medical certainty, Dr. Nielsen's treatment did not create an unacceptable risk to the patient. [1391]

Dr. Weissman's testimony was similar in that he assumed that Dr. Nielsen conducted an evaluation sufficient to permit him to adequately assess Patient A's circulatory status because of the absence of abnormal findings in Dr. Nielsen's medical records. [1480] Also similar was his testimony that the hospital records of procedures performed prior and subsequent to Dr. Nielsen's intervention supported the conclusion that Dr. Nielsen's treatment did not create an unacceptable risk to Patient A. [1491-1495]

In stark contrast to the foregoing expert testimony, Dr. Hecker testified that absent any intervening surgical correction, Patient A's compromised peripheral vascular circulation at the time of Dr. Nielsen's treatment on February 26, 1987, would not have improved since the arterial flow velocity and pressure examination conducted on August 15, 1976, at Mount Sinai Medical Center, which established arterial flow pressure index of 0.59 on the left extremity. The board accepts that expert testimony, as well as Dr. Hecker's testimony that given that pressure index, a minimally competent evaluation would have revealed the diminished circulation.

That Patient A's vascular insufficiency of the left lower extremity was of such severity as to permit a minimally competent circulation evaluation to reveal such insufficiency is also demonstrated by tests performed following her admission to Northwest General Hospital on March 23, 1987, less than one month after Dr. Nielsen's treatment. The admission physical performed noted that dorsalis pedis pulses and posterior tibial pulses were "decreased at +1/4 bilaterally." Dr. Hecker credibly testified that such a finding means that the pulses were diminished and barely palpable. Two days later, on March 25, 1987, Dr. James Bass, Jr., a thoracic and vascular surgeon, examined Patient A. He testified that on that date, he was unable to palpate any peripheral pulses in the left lower extremity. Accordingly, only a few weeks following the procedure performed by Dr. Nielsen, Dr. Bass diagnosed severe vascular disease and nonhealing ulcers secondary to the peripheral vascular disease. [491] Dr. Bass further testified that in his expert opinion, the situation in terms of Patient A's peripheral circulatory status present on March 25, 1987 was, in all likelihood, the same situation present a month earlier. That credible testimony is accepted by the board. The board concludes that Patient A's severe circulatory disease existed at the time of Dr. Nielsen's treatment on February 26, 1996, and that a minimally competent examination would have revealed the existence of her compromised vascular status.

Assuming, arguendo, that Dr. Nielsen's examination of Patient A. revealed the existence of vascular disease and that he merely neglected to enter this abnormal finding into the medical record, his treatment nonetheless constituted a danger to her health, safety or welfare; for the more persuasive expert testimony is that, given the extent of her vascular disease, she was not a candidate for surgery. After opining that Patient A's vascular circulatory status was the same on March 25, 1987 as it was on February 26, 1987, Dr. Bass testified that in his opinion, Patient A

"was not a candidate for any type of surgery on her feet." [495] Dr. Hecker also credibly testified that Patient A was not a candidate for podiatric surgery.

> Q (by Mr. Lubcke) Based upon the results of the examinations and the tests that we've been reviewing in this Northwest Hospital record, do you have an opinion to a reasonable degree of professional certainty whether or not [Patient A] was a candidate for the surgery performed by Dr. Nielsen on February 26 of 1987
>
> A. She was not a candidate for any type of invasive procedure, as far as surgery on that foot or toe. [637]

The board agrees with that expert opinion.

Having found that, in addition to the record-keeping violations, Dr. Nielsen failed to conduct a minimally competent clinical evaluation, which would have permitted him to adequately assess Patient A's peripheral vascular circulatory status and to determine that surgery was contraindicated, something more than an evaluation of current his record-keeping practices becomes necessary. Accordingly, the board has modified the ALJ's recommended order to include the requirement that Dr. Nielsen submit to an evaluation of his current clinical competence in the practice of podiatric medicine in addition to the requirement that his current record-keeping practices be evaluated. It is only through the conduct of both evaluations that the board and the public can be assured of Dr. Nielsen's current ability to competently and safely practice podiatric medicine.

Finally, the ALJ failed to assess costs in the matter based on his conclusion that the respondent was not "obstructionist or dilatory" and on the basis that all but one of the charges in the Complaint were recommended to be dismissed. Sec. 440.22, Stats., is intended to permit the department to recover the costs expended in conducting a disciplinary proceeding rather than as a penalty for a respondent's failure to cooperate in such a proceeding. The board has accepted the ALJ's recommendation that Count III of the Complaint be dismissed, but has found violations as to the other two Counts. The board therefore considers it appropriate to assess two-thirds of the costs of the proceeding against the respondent.

Dated this 15th day of July, 1996.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by W.R. Schwartz MD

W.R. Schwartz, M.D.
Secretary

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NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review. The Times Allowed For Each. And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN MEDICAL EXAMINING BOARD

1400 East Washington Avenue
P.O. Box 8935
Madison. WI 53708.

The Date of Mailing this Decision is:

July 18, 1996

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)