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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
Matthew Clayton, M.D., Respondent.	:	LS0310291MED

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 16th day of March, 2005.

Alfred Franger
Board Member
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	PROPOSED DECISION AND ORDER
MATTHEW CLAYTON, M.D. RESPONDENT	:	LS0310291MED

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

Matthew Clayton, M.D.
853 Mendakota Court
Mendota Heights, Minnesota 55120

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue

P.O. Box 8935
Madison, WI 53708-8935

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

PROCEDURAL HISTORY

A hearing in the above-captioned matter was held on November 22, 2004 before Administrative Law Judge Dennis C. Schuh. The Division of Enforcement appeared by Attorney Jeanette Lytle. Matthew Clayton, M.D. appeared in person and by his attorney John Markson.

FINDINGS OF FACT

1. Matthew Clayton, M.D., (DOB 09/07/1962) is duly licensed and currently registered to practice medicine and surgery in the state of Wisconsin, license #40393. This license was first granted on 08/28/1998.

2. Respondent's most recent address on file with the Wisconsin Department of Regulation and Licensing is 853 Mendakota Court, Mendota Heights, MN 55120.

3. At all times relevant to this action, Respondent was specialized in general surgery and is board certified.

4. MT, the patient herein, is a female and was born on November 20, 1961. She had a body mass index of 44. She had a history of Asthma, obesity, gastroesophageal reflux disease, glucose intolerance, hypertension, migraines and non-cardiac chest pain.

5. On January 22, 2002, the Respondent performed a gastrointestinal bypass, incidental splenectomy and cholecystectomy on MT at the River Falls Area Hospital.

6. During the course of the surgery, a splenectomy had to be performed due to a capsular tear of the spleen. Total blood loss for the surgery was estimated at 1400 cc.

7. The patient did well on the evening of January 22, 2002, but began to experience mild respiratory distress beginning in the afternoon on January 23, 2002.

8. A chest x-ray was obtained on January 23, 2002. The Respondent thought the distress to be due to atelectasis secondary to surgery and splinting from pain. Incentive spirometry was reinforced and MT remained on nasal cannula oxygen.

9. On January 24, 2002, MT's oxygen saturations dropped to the upper 80's although nasal cannula oxygen was given and a high flow mask was now being used.

10. A spiral CT scan of the chest occurred at 3:14 a.m. on January 24, 2002. No embolus was seen, but there was patchy alveolar based infiltrate bilaterally. The CT scan was ordered by a colleague of respondent, Dr. Poulin, to investigate the possibility of pulmonary embolism. Dr. Clayton reviewed the film with a radiologist at approximately 1:30 p.m. on January 24, 2004**.** Dr. Clayton noted fluid in the splenic bed but attributed it to the removal of the spleen. The radiologist, Dr. Kovar noted that the fluid could be due to postoperative hemorrhage or to an abscess.

11. A chest x-ray was taken later in the morning on January 24, 2002, and progression with bilateral fluffy infiltrates were noted.

12. MT's condition worsened throughout the day on January 24, 2002. In the afternoon, she was intubated and placed on spontaneous mode ventilation.

13. On the morning of January 25, 2002, MT was hypoventilated with a pH of 7.26, a pCO2 of 63, a PAO2 of 80 and a bicarb of 29. The ventilation was increased and the blood gases normalized. A central line was placed and the patient was started on TPN.

14. A subsequent chest x-ray on the 25th showed an increase in fluffy infiltrates bilaterally. The Respondent believed that MT was showing a pattern of adult respiratory distress syndrome which respondent believed to be secondary to surgery, possible fat embolism or hypotension related to blood loss during the splenectomy. The patient experienced fever beginning on the 23rd and continuing. The fevers were up to 102 degrees.

15. The River Falls Area Hospital could not provide continued ventilator support beyond a period of 48 hours. Respondent believed MT would require more that one day more of ventilator support. MT was transferred to the Regions Hospital, St. Paul, Minnesota.

16. MT was transferred to Regions Hospital on January 25, 2002 and co-responsibility for her care was accepted by a physician at the Regions Hospital. MT left River Falls Hospital at 6:00 p.m. on January 25, 2002.

17. On January 26, 2002, a CT scan was administered at Regions Hospital due to further deterioration of MT's condition. The scan showed a large amount of free fluid in the left upper abdomen.

18. A Minnesota physician performed an exploratory surgery on January 26, 2002 at approximately 8:00 pm and located a 1 cm. hole in the distal stomach at the proximal end of the greater curve and fluid coming out of the hole. A total of 2700 cc of green, foul-smelling fluid was aspirated primarily from the left upper quadrant.

19. The patient, MT, died on January 30, 2002. The cause of death was not directly attributable to the surgery performed by the Respondent.

20. The Respondent's management of MT's medical condition as set forth above fell below the minimum standards of competence established in the profession in the following respects:

a. The Respondent failed to recognize anastomotic leak as one of the possible causes of the patient's respiratory deterioration and adult respiratory distress, when the patient had a gastric bypass for which an accepted complication is an anastomotic leak and having had an emergency splenectomy, each increasing the possibility of an intraabdominal infection.

21. The Respondent's conduct created the following unacceptable risks to the health, welfare and safety of the patient: The Respondent's failure to evaluate for an intraabdominal cause of infection in a patient with deterioration as described above placed the patient at unacceptable risk of further deterioration and death.

22. The minimally competent physician, to avoid or minimize the unacceptable risks would have investigated or sought another cause of the Adult Respiratory Distress Syndrome, specifically an anastomotic leak as a cause, by doing a CT scan with contrast of the abdomen and pelvis at least by January 25, 2002 or an x-ray with contrast of the abdomen and pelvis.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. §448.02(3) and Wis. Admin. Code MED §10.02(2) (h).

2. Respondent's conduct as herein described was unprofessional conduct contrary to § 448.02(3), Wis. Stats., and Wis. Admin, Code MED §10.02(2) (h) in that he engaged in conduct that tended to constitute a danger to the health, welfare and safety of the patient. Respondent's care tended to constitute a danger to the health, welfare and safety of his patient and are acts which showed Respondent to be unfit for the practice of medicine and surgery as a reasonably competent surgeon would have earlier recognized that MT had Adult Respiratory Distress Syndrome as a result of an anastomotic leak rather than secondary to surgery.

3. The conduct described in paragraphs 20, 21, 22 & 23, above, constitutes a violation of Wisconsin Administrative Code MED §10.02(2) (h) and Wis. Stat. §448.02(3).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that MATTHEW CLAYTON, M.D. is **REPRIMANDED**.

IT IS FURTHER ORDERED that Matthew Clayton M.D. take and successfully complete within twelve (12) months of the date of this Order, a course of study totaling not fewer than twelve (12) hours of continuing education (CE) credits in the area of post-operative care of patients.

1. These continuing education credits shall be approved in advance by the Board.

2. This education shall be in addition to continuing medical education otherwise required under sec. 448.13, Wis. Stats.

3. Respondent shall arrange for the course sponsors of any education approved pursuant to this Order to certify to the Board the results of the course work upon completion and to release all records of Respondent's performance and attendance.

4. Respondent shall be responsible for all costs associated with taking the course work required under this Order and shall pay the cost of any examination(s) required for successful completion of the course work.

5. The Board may, at its option, require Applicant to appear before the Board following completion of the continuing education referred to above to answer any questions that it may have concerning this matter.

6. If Applicant fails to successfully and timely complete all requirements set forth in this Order the respondent's license shall be **SUSPENDED** without further notice or hearing until such time as the Board accepts documentation of respondent's completion of the education requirements set forth in this Order.

The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving and coordinating all requests for approval of education, payments, reports or other petitions. The Department Monitor may be reached as follows:

Department Monitor
Division of Enforcement
PO Box 8935
Madison, WI 53708-8935
FAX (608) 266-2264 TEL. (608) 261-7938

IT IS FURTHER ORDERED that Matthew Clayton M.D. pay the assessable costs of this proceeding to be paid with twelve (12) months of the date of this order.

This Order is effective on the date of its signing.

OPINION

Applicable Law

Wisconsin Statutes §448.02(3) provides in part;

448.02(3) (a)
(a) the board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license,

certificate or limited permit granted by the board. …

448.02(3)(b)
(b) After an investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct or negligence in treatment, the board shall hold a hearing on such conduct.

Wis. Admin. Code Med 10.02
Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:
…
(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct.
State v. Aldrich, 71 Wis. 2d 206, 209 (1976).
Punishment of the licensee is not an appropriate consideration.
State v. McIntyre. 41 Wis. 2d 481, 485 (1969).
The state's purpose in licensing professionals is to protect its citizens.
Strigenz v. Department of Regulation and Licensing 103 Wis.2d at 286, 307 N.W.2d at 667.
License revocation is the ultimate means of protecting the public short of fining or imprisonment.
Strigenz v. Department of Regulation and Licensing, 103 Wis.2d 281, 287, 307 N.W.2d 664 (1981).

Respondent performed gastric bypass surgery on MT. Respondent's pre-operative approach was adequate and professionally appropriate. While resulting in the unexpected splenectomy, the surgery, a Roux-en-Y procedure was performed in a professionally competent manner.
At issue is the post-operative care provided by the Respondent.

The patient, MT, died shortly after the surgery. Her death - while tragic, untimely and lamentable - is not a factor in this hearing. She died of blood loss following a second surgery performed by another surgeon in another state. That surgery was performed to locate and close an anastomotic leak in the distal stomach. The presence of that leak does not suggest professional misconduct or any failure on the part of the respondent. Anastomotic leak is a recognized risk or complication of the procedure known as Roux-en-Y bypass. Because MT developed a leak, a second surgery was necessary. The complainant does not suggest that discipline be imposed due to the existence of the leak or for the death of MT. In this type of surgery, leaks can and do happen despite due care by the surgeon.

Complainant's argument is summarized as follows. At some point after the surgery, MT's lack of healing progress, her list of symptoms and complaints indicated that something more serious than normal postoperative issues was occurring. Respondent appropriately took steps to determine the cause of the lack of progress and other symptoms. The symptoms noted by Respondent included fever, tachycardia, abdominal soreness, anxiety, respiratory distress, leukocystosis, hypotension, and low urine output. These symptoms, when treated without success, would lead a minimally competent surgeon to conclude that a patient, post RYGB, is likely to have an anastomotic leak. A minimally competent surgeon would investigate and remediate that cause of these symptoms. Respondent did not investigate the possibility of an anastomotic leak and therefore he failed to act as a minimally competent surgeon creating and continuing a danger to the health, welfare and safety of MT.

Complainant presented two witnesses, the Respondent adversely and Chad Kort, M.D. Also presented were copies of the medical records of MT regarding this surgery and her postoperative care both in River Falls and at Regions Hospital in Minnesota.

Dr. Kort is a general surgeon practicing in Elkhorn, Wisconsin. He is a graduate of the University of Illinois and licensed to practice medicine and surgery in the State of Wisconsin.
Dr. Kort acknowledged that he has performed gastric bypass surgery on only one occasion and has limited experience in bariatric surgery. Dr. Kort noted that he had observed 5 bypass procedures and performed one himself. Dr. Kort attended a

course on bariatric surgery in January 2004 sponsored by the American Society of Bariatric Surgery.

Dr. Kort noted that the published literature regarding gastric bypass surgery suggests that occurrence of anastomotic leaks may be as low as 1% to 5% or as high as 5% to 10% of patients. Dr. Kort noted that leaks vary in severity and may have a variety of symptoms depending on the severity of the leak. He noted that his training and the literature agree that early and aggressive approaches to finding and fixing an anastomotic leak is the better approach and will frequently provide better results. Dr. Kort opined that the Respondent's post operative care on January 22 and 23 was professionally competent.

Dr. Kort noted that the symptoms and complaints of MT on Jan 22, and Jan. 23, 2002 were consistent with normal post operative issues common to most post operative patients. Those symptoms included abdominal soreness, fever, tachycardia, anxiety and respiratory distress. Dr. Kort noted that the Respondent early on treated MT for atelectasis. This course of treatment included pain control, early ambulation and supplemental oxygen. This treatment is consistent with appropriate practice.

On Jan 23, 2004, MT's respiratory distress progressively became worse and her other symptoms remained relatively constant. Dr. Kort noted that the appropriate response to the continuing deterioration MT suggested Adult Respiratory Distress Syndrome. The appropriate treatment of this syndrome is to provide ventilator support while attempting to identify the source of the ARDS and then treat the source. Dr. Kort noted that a CT scan with contrast was performed on MT on Jan 24. A chest x-ray was obtained as well. The CT scan disclosed the existence of fluid in the left upper abdomen. Such fluid could have been a result of the splenectomy, a sign of an abscess or a sign of an anastomotic leak.

Dr. Kort opined that the Respondent's conduct fell below the minimally competent standards on January 24, 2002. MT's condition continued to deteriorate. Her respiratory system was failing. As a result of the CT scan, Respondent was aware that there was fluid in MT's abdomen. MT continued to display additional symptoms of fever, tachycardia, anxiety and abdominal pain. The Respondent's conduct suggests that he was content with his diagnosis of ARDS secondary to surgery. Subsequent to the CT scan, (which was ordered by a colleague) the respondent failed to pursue any other means to determine the source or cause of ARDS, such as an abscess in the splenic bed or an anastomotic leak.

MT remained under the care of the Respondent on the 25th of January and her condition continued to deteriorate. The Respondent made arrangements to transfer MT to a tertiary hospital which was accomplished in the evening of the 25th.

Dr. J. David Lewis testified on behalf of the Respondent. Dr. Lewis is a retired general surgeon. Prior to retirement in July 2004, Dr. Lewis was in practice in West Bend, Wisconsin. His practice consisted of general surgery including 75 to 100 bariatric surgeries but only modest experience with RYGB. Dr. Lewis was a full and part time instructor at the Medical College of Wisconsin.

Dr. Lewis stated that MT was an appropriate candidate for bypass surgery. His review of the records indicates that the Respondent's performance of the procedure was as taught and expected. He noted that the splenectomy as a result of the tear in the spleen was a reasonably recognized complication and was addressed competently by the Respondent.

Dr. Lewis opined that anastomotic leaks can and do happen despite due care by the surgeon. He estimated that leaks occur in approximately 5% of the patients and noted that some commentators suggest the figure is as high as 10%. Dr. Lewis noted that some leaks resolve by themselves and others require surgery to close.

Dr. Lewis opined that the diagnosis of ARDS secondary to surgery was a decision a reasonable surgeon could have made. He further opined that a reasonable surgeon could have delayed further investigation into the continuing deterioration of MT's condition until January 26. Because MT was transferred to Regions Hospital due to issues unrelated to Respondent's actions, he was denied the opportunity to continue treatment. Dr. Lewis stated that the Respondent's actions were within reasonable standards. He noted that the entire set of symptoms was explained by what was going on in the patient's lungs, i.e. ARDS. Dr. Lewis further stated that most anastomotic leaks are not diagnosed until 3 to 10 days postoperatively. Dr. Lewis determined that while the quality of the CT scan was not ideal, the amount of fluid was consistent with the residual effects of the splenectomy. Dr. Lewis holds the opinion that given the risks associated with returning the patient to surgery for exploration, the delay in further investigation was reasonable.

Under cross examination Dr. Lewis acknowledged that all of the symptoms noted by Dr. Clayton are also symptoms of an anastomotic leak and of pneumonia. He agreed that the fluid noted on the CT scan of Jan 24 were suggestive of an abscess or of an anastomotic leak. Dr. Lewis noted however that atelectasis is more common than an anastomotic leak. Overall, Dr. Lewis agreed with the Respondent that MT presented an ARDS type picture until January 25 or 26, 2002.

The Respondent has submitted without objection, a learned treatise entitled "Roux-en-Y Gastric Bypass Leak Complications" written in May 2003 and published in Arch Surg Volume 138, pages 520-524. The authors[1] conclude;

"Enteric leakage is a significant complication of the RYGB. Patients who are suspected of having an enteric leak because of signs of sepsis or hemodynamic instability require emergent exploration. Leaks that are more insidious may be treated successfully with percutaneous drainage. *Aggressive exploration of patients who appear to be septic,* and percutaneous drainage of insidiously developing leaks *may decrease patients' morbidity and mortality.*" (Emphasis added)

Anastomotic leak is a recognized complication of Roux-en-Y gastric bypass surgery. According to the treatise submitted by respondent, its reported incidence is between 1% and 5.1%. The authors noted that signs and symptoms of leaks include, fever, chills, tachycardia (>110 beats/min), nausea, malaise, left-sided abdominal pain, and a change in the nature of the drain effluent and shortness of breath with pleural effusion.

Dr. Matthew Clayton is licensed in the State of Wisconsin to practice medicine and surgery. He has been practicing full time in River Falls, Wisconsin since 2000. His residency was in general surgery and included three rotations in bariatric surgery. Between 1998 and 2000 he was at Regions Hospital in Minnesota were he performed 5 to 10 gastric bypasses. His practice in Wisconsin included bariatric surgery.

Respondent admits that he was aware of the possibility of an anastomotic leak. Respondent admits the anastomotic leak is a recognized and accepted complication of the procedure he performed. Dr. Clayton noted such leaks occur in 5% to 10% of the patients. Two of his previous patients were subsequently found to have anastomotic leaks. None of his prior bypass patients developed ARDS secondary to surgery. He has experienced the development of ARDS in prior burn or accident patients. Respondent argues that all of MT's symptoms and signs were "well explained" by other established conditions.

Dr. Clayton testified that MT started having respiratory distress on January 23, the first postoperative day. MT's other symptoms included tachycardia, low urine output, high white blood cell count, anxiety and abdominal pain. Dr. Clayton reported that he considered "the surgery" as the cause of these symptoms and began treating them. His list of possible diagnosis's included atelectasis, pneumonia, transfusion rejection and anastomotic leak.

Dr. Clayton noted that after treatment, MT's urine output improved. He asserted that overall he considered MT's complaints to be a standard post-operative regimen for a gastric bypass patient. He further asserted that the symptoms noted were the sign of a sick patient. Dr. Clayton acknowledged that respiratory distress is a symptom of anastomotic leak.

Dr. Clayton noted that despite MT's deteriorating respiratory distress, her white blood cell count on January 24 was within the normal range (11,000).

Dr. Clayton acknowledged that he looked at the results of the January 24, CT scan and observed a fluid collection in the left upper quadrant. He stated that he believed this fluid to be consistent with the splenectomy.

Dr. Clayton stated that on January 25, MT's condition that he had diagnosed as ARDS secondary to surgery was getting worse, her need for ventilator requirements was getting worse and that he believed that a more aggressive search for the source of the ARDS was necessary. Dr. Clayton justifies his actions however as being limited due to the impending transfer of MT due to ventilator restrictions within the hospital.

River Falls Hospital was served by only two respiratory therapists. Hospital protocol required that patients could receive a maximum of 48 hours of ventilator support. Patients were required to be removed from ventilator support or transferred to another facility. Because of this protocol and the expectation that MT would need ventilator support beyond the 48 hour window, Dr. Clayton arranged her transfer to Regions Hospital on Jan 25. The testimony is not clear as to when on the 25th that these arrangements were made.

Dr. Clayton explains that he was prohibited from commencing a more aggressive search for the cause of the ARDS by the combination of factors including the impending transfer, and the physical limitations imposed by the ventilator itself. The impending transfer was a deterrent to an aggressive exploration as he did not want to further weaken MT's condition prior to the physical transfer. He reasoned that transferring a 4 day post operative patient on a ventilator presented significant problems for staff and significant health risks to the patient, exploratory surgery immediately prior would increase both those potential problems. The physical restrictions of the ventilator made the obtaining of a second CT scan impractical as the move from ICU to the CT scanner presented significant logistic problems for staff. He did not explain why those same logistic problems did not deter him from obtaining a chest x-ray on that date. It is not clear from the evidence whether obtaining that x-ray was any more or less difficult than a CT scan would have presented.

Dr. Clayton on cross examination acknowledged that the ARDS was caused by anastomotic leak not secondary to surgery as he had originally diagnosed. He posits that he would have aggressively searched for that cause but for the transfer to Regions, a transfer caused by hospital protocol.

Dr. Clayton does not challenge the jurisdiction of the Board to hear this matter. Prior to hearing he withdrew an affirmative defense in which he raised a possible statute of limitations issue. Respondent argues that his conclusion of Adult respiratory distress syndrome (ARDS) was a reasonable diagnosis that explains the signs and symptoms observed. ARDS symptoms include Dyspnea and Tachypnea followed by a progressive hypoxemia despite oxygen therapy. Diffuse fluffy infiltrates can be seen on chest radiographs. The diagnosis of ARDS is based on history of a recent event associated with the onset of ARDS, the presence of non-cardiogenic pulmonary edema on the chest radiograph and persistent hypoxemia on arterial blood gases.

On January 25, 2002, MT's condition continued to deteriorate. The Respondent had the benefit of a CT scan performed in the early morning hours of January 24, 2002. He failed to obtain a second CT scan on the 25th. Such a scan would have provided valuable information concerning the accumulation of fluid in the left upper abdomen area. This comparison should have resulted in the discovery of the anastomotic leak. The Respondent asserts that by the 25th he was more seriously considering anastomotic leak as the cause of the ARDS. However his discharge note fails to mention the possibility of anastomotic leak. He attempts to justify his lack of investigation into that cause however. The Respondent protests that the physical restrictions of the ventilator made the obtaining of such a CT scan problematic from a logistical viewpoint. He did not explain his decision to order and obtain a chest x-ray. That decision suggests that the Respondent continued to believe that the source of the ARDS was secondary to surgery rather than anastomotic leak.

Additionally, Respondent failed to produce any witness or documentation that during his contacts with Regions Hospital, while arranging MT's transfer, that he informed Regions of the possibility of anastomotic leak as the source of ARDS. Presumably, such information accurately reported would have result in swift investigation of that possibility by Regions upon MT's arrival. The records however suggest that Regions was not made aware of the need to aggressively investigate this possibility. Regions records show that MT arrived on the 25th but a CT scan was not performed until the 26th and then only performed due to MT's continued deterioration.

The Respondent persisted in treating the symptoms of ARDS which he believed to be caused by surgery for four (4) post operative days despite the continuing deterioration of MT's condition. He failed to investigate alternative sources. The early detection of the correct source would have resulted in earlier treatment of the source. Presumably, earlier treatment of the correct source, i.e. closing of the anastomotic leak, would have resulted in more rapid elimination of ARDS and relieved the physical deterioration brought on by the respiratory distress. Thus the continuing of ventilator services and the transfer to Regions may have been unnecessary.

Through the Respondent's failure to investigate other sources of ARDS in the face of symptoms that were progressively more severe despite treatment of those symptoms, the Respondent created an unacceptable risk to the health, welfare and safety of MT. He stubbornly clung to his diagnosis of ARDS secondary to surgery rather than searching for and locating the real source. This is especially problematic because a CT scan performed on the 25th may have disclosed sufficient information to arrive at the correct diagnosis.

While Respondent's conduct fell below the minimum standard of competency, the violation was not egregious. He was adequately treating the symptoms he observed. The patient's true diagnosis was arrived at within 24 to 48 hours. The failures

of the Respondent did not directly contribute to the death of the patient.

A license suspension or revocation is a penalty that should be reserved for those circumstances in which the issue of public protection requires the ultimate response. The circumstances here do not rise to that level. The safety of the public may be adequately protected by calling the respondent's attention to his deficit and requiring that he improve his education and training in the area of post-operative care.

Educational and treatment requirements can be imposed to aid in the rehabilitation of the professional. Suspension, reprimand or forfeitures may be necessary to protect the public and to deter other licensees from similar conduct.

A reprimand will also deter other licenses from similar conduct. Such action by the Board will highlight the need to continually evaluate the medical condition of patients postoperatively and to adjust the diagnosis and course of treatment accordingly.

Costs

The assessment of costs against a disciplined professional is authorized by sec. 440.22(2), Wis. Stats. and sec. RL 2.18, Wis. Admin. Code, but neither the statute nor the rule clearly indicates the circumstances in which costs are to be imposed. The Medical Examining Board has the discretion to impose all, some, or none of the costs of the proceeding.

Section 440.22 (2), Stats., provides in relevant part as follows:

"In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department."

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the respondent is a discretionary decision on the part of the Veterinary Examining Board, and that the board's discretion extends to the decision whether to assess the full costs or only a portion of the costs.

This recommendation that the full costs of the proceeding be assessed is based on two factors. First, the Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following an evidentiary or default hearing, that licensee should bear the costs of the proceeding.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information".

Dated this 2nd day of December, 2004.

Dennis C. Schuh
Administrative Law Judge

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[1] J Stephen Marshall, MD; Anil Srivastava, MD; Samir K. Gupta,MD; Thomas Rossi, MD; James R. DeBord, MD are associated with The Department of Surgery, University of Illinois College of Medicine – Peoria, and The Peoria Surgical Group, Ltd.