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Before The
State Of Wisconsin
MEDICAL EXAMINING BOARD

In the Matter of the Disciplinary Proceedings
Against **CHRISTOPHER S. WILSON, M.D.,**
Respondent

FINAL DECISION AND ORDER
Order LS0910231MED

Division of Enforcement Case No. 08 MED 286

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, make 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 at Madison, Wisconsin on the 21 day of Sept, 2011.

S/Kailco

Member
Medical Examining Board

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Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **CHRISTOPHER S. WILSON, M.D.,**
Respondent

PROPOSED DECISION AND ORDER
DHA Case No DRL-09-0108

DOE Case No. 08 MED 286

The Parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53, and Wis. Admin. Code § RL 2.037, are:

Christopher S. Wilson, M.D., by

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Sager, Colwin, Samuelson & Associates, S.C.
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Division of Enforcement
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The Division of Enforcement (the Division) filed a Complaint against the Respondent, Dr. Christopher S. Wilson, on October 29, 2009, alleging that Dr. Wilson's post-operative care of an adult male patient identified in the Complaint as "Mr. A" fell below the minimal level of competence for a physician and exposed the patient to unreasonable risks of harm. Dr. Wilson denied these allegations in a timely Answer to the Complaint.

Pursuant to due notice, a contested case hearing was conducted by Administrative Law Judge William S. Coleman, Jr., in Madison on March 29 and 30, 2011. Thereafter, counsel for the Division and the Respondent entered into a Stipulation of Facts on June 10, 2011. Both counsel filed written closing arguments on June 14, 2011.

FINDINGS OF FACT

1. Christopher S. Wilson, M.D., Respondent, date of birth April 8, 1965, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the State of Wisconsin pursuant to license number 40285, which was first granted August 7, 1998. (Stipulation).

2. Dr. Wilson's last address reported to the Department of Regulation and Licensing is 13855 Lloyd Street, Elm Grove, WI 53122. (Stipulation).

3. Dr. Wilson is a general surgeon who in October 2005 was in a group practice with Dr. Frederick Steele, another surgeon. They each had privileges at West Allis Memorial Hospital where they performed surgery. (Stipulation).

4. On October 18, 2005, Thomas Czaplewski ("Mr. A") was admitted to West Allis Memorial Hospital and seen by Dr. Steele. Dr. Steele examined him, had diagnostic procedures performed and concluded that it was necessary to perform a cholecystectomy to remove his gallbladder. (Stipulation).

5. Dr. Steele attempted a laparoscopic cholecystectomy, which is performed by making small incisions or ports in the patient's abdomen through which a scope and surgical instruments are passed. However, it was necessary to convert the procedure to an open cholecystectomy which involves a larger incision and direct access to and viewing of the inside of the abdomen. The pathology report showed the gallbladder was gangrenous. (Stipulation).

6. Dr. Steele continued to provide care to Mr. A for the first three post-operative days, October 19, 20 and 21. On those days, the patient had a typical post-operative course for an obese man following an open cholecystectomy with infected tissue. Dr. Steele allowed the patient to resume a general diet on October 19th. His plan was to have the patient ambulate by walking. On October 19th, the day after surgery, there was a little ambulation and on October 20th, the patient was up in the hallway. (Stipulation).

7. Dr. Steele's last progress note was on Friday, October 21, and indicates his assessment that Mr. A had post-operative ileus and atelectasis. Mr. A had an emesis (vomited) that day, which is not unusual following this kind of surgery. (Stipulation).

8. "Ileus" is when the rhythmic contraction that moves material through the bowel stops. Ileus is very common following abdominal surgery. Usually, no treatment is necessary and it resolves itself. "Atelectasis" is a collapsing of the lungs from not inhaling deeply enough and is also common following abdominal surgery. It too normally resolves itself without treatment and is also treated with incentive spirometry or supplemental oxygen. (Stipulation).

9. Dr. Wilson was covering Dr. Steele's patients over the weekend. Dr. Steele sent Dr. Wilson an email on Friday, October 21, which said that the patient had a routine post-operative ileus following an open cholecystectomy and routine care. Dr. Wilson read the email sometime Friday evening or early Saturday, October 22. (Stipulation).

10. Mr. A's condition from the time of the open cholecystectomy surgery on October 18 through October 21 was a typical post-operative course for an obese man following an open cholecystectomy with infected tissue. (Stipulation; Toth testimony, T. 48-49).

11. On Saturday morning, October 22, at about 1:30 a.m. Mr. A had an emesis. At 8:30 a.m. he had another emesis and Dr. Wilson was called by hospital staff and he ordered Protonix, 40 mg, orally for the patient for heartburn, and incentive spirometry to improve lung function. Mr. A told the nurse he was not nauseated and it was just reflux. At 12:45 p.m., Mr. A had his third emesis that day and Dr. Wilson was paged. There were no further emesis episodes. (Stipulation).

12. Sometime between 1:30 and 2:00 p.m. on October 22, Dr. Wilson saw the patient at the hospital for the first time. He reviewed the patient's chart and talked to the nurses. The patient's temperature was 101 and his heart rate was 117. Dr. Wilson examined the patient's abdomen and it was soft and distended. Dr. Wilson changed the IV pain medication from Demerol to Morphine and added another analgesic, Toradol. He ordered a complete blood count (CBC) and basic metabolic panel (BMP) to be done the following morning, October 23. (Stipulation).

13. The Graphic Patient Daily Care Sheets (Exhibit 1, pp. 122-123) show the following for the patient (Stipulation):

DATE TIME	Blood Pressure	Heart Rate	Temp.	Resp.	Urine	Stool
10/20/05						
0825	128/66	88	99.9	18		
1600	120/68	108	99.1	20		
2330	132/80	99		22		
10/21/05						
0300	146/80	101	99.2	20		
0900	138/84	104	99.4	18		
1245	160/60	111	99.1	20		
1515	150/60	110	100	22		

DATE TIME	Blood Pressure	Heart Rate	Temp.	Resp.	Urine	Stool
2030	128/70	107	99.4	20		
10/22/05						
0020	148/80	104	99.6	20		
0330	130/80	116	99.8	20	23-07 BRPx3	X2
0700	135/75	117	100.7	24	07-15 BRPx2	X1
1245	129/70	118	99.1	24		
1600(?)	170/80	148	100.9	36	15-23 400+BR	
1940	130/98	121	99.4	24		
2340	110/60	120	96.4	24		
10/23/05						
0330	70/55	116	96.5			
0645	83/52					
0645	116/60	112	97.7			

14. Sometime between 2:05 p.m. and 4:45 p.m. (the time on the note is not clear) on October 22, Mr. A was having chills and shaking. His blood pressure was elevated and his heart rate was in the 140's. His temperature was noted as febrile. The note says that Dr. Wilson was aware and that orders were received. Dr. Wilson then discontinued the antibiotic Cefoxitin and started the stronger antibiotic Zosyn 3.375 gm IV every 6 hours, ordered Tylenol 650 mg every 4 hours as needed, repeated the order for a CBC in the morning, and ordered blood cultures and a urinalysis and urine culture. (Stipulation; T. 224).

15. Dr. Wilson gave another telephone order at 4:45 p.m. It was for additional antibiotic medications called Levaquin (500 mg IV daily) and Flagyl (500 mg IV every 6 hours), which were intended to provide broader coverage than Zosyn alone against infection. (Stipulation; T. 224).

16. The time of the third telephone order by Dr. Wilson on October 22, after he had seen the patient, is not certain. This third telephone order was for a nasogastric (NG) tube at low intermittent suction (LIS), 500 cc normal saline bolus, and that the patient was not to have anything orally (NPO). The entry at Physician's Orders says this telephone order was at 5:10 p.m. But the nurse's note at Patient Outcomes has a time of 4:45 p.m. and says she was

unsuccessful in several attempts to insert the NG tube. (Stipulation). The patient started to sweat a lot and his heart rate increased to the 160's at or near the time of the unsuccessful efforts to insert the NG tube, but he denied any pain. (Ex. 4). The nurse informed Dr. Wilson of these events around 5:00 p.m. (Ex. 4).

17. Dr. Wilson's telephone order is noted at Physician's Order at 5:45 p.m. This order was to leave the NG tube out and keep the patient on NPO. Dr. Wilson was not contacted again until shortly after midnight on Sunday morning, October 23. (Stipulation).

18. The patient's condition deteriorated on October 23 and he died on October 24. The Division does not contend that Dr. Wilson violated the standard of care during the time after 5:45 p.m. on October 22. (Stipulation).

19. There is no evidence that Dr. Wilson's conduct at any time caused the patient's death. (Stipulation). The precise cause of the patient's death was never determined to a reasonable degree of medical certainty. (Toth testimony; Mikkelsen testimony).

20. Neither the Medical Examining Board nor the Department of Regulation and Licensing has ever received any other complaint about Dr. Wilson. (Stipulation).

21. Minimum standards of treatment did not require that Dr. Wilson (a) order a chest x-ray on October 22 to determine whether there was a pneumonia starting, (b) order an abdominal x-ray on October 22 to determine whether there was a bowel perforation or a bowel obstruction, or (c) order a complete blood count (CBC) and basic metabolic panel (BMP) to be done in the afternoon of October 22 in order to determine (i) whether an infection was occurring, (ii) whether the patient's electrolyte status was changing, or (iii) whether his kidney function was impaired. (Mikkelsen testimony).

22. The absence, on October 22, of the diagnostics described in the preceding paragraph did not create an unacceptable level of risk, either separately or in concert. (Mikkelsen testimony).

23. After a nurse was unsuccessful in the late afternoon of October 22 in inserting a nasogastric (NG) tube for the purpose of decompressing the patient's stomach and to prevent further vomiting, minimum standards of treatment did not require Dr. Wilson personally to attempt to insert an NG tube or to order another attempt to insert an NG tube. The absence of further efforts to insert an NG tube did not create an unacceptable level of risk. (Mikkelsen testimony, T. 232-234, 241-42).

Discussion

Wisconsin Statute § 448.02(3)(c) empowers the Board to impose discipline when a credential holder has committed "unprofessional conduct," or has been "negligent in treating a patient."

Count I of the Complaint alleges that Dr. Wilson engaged in "unprofessional conduct" as defined by Wis. Admin. Code § Med 10.02(2)(h), which provides that "unprofessional misconduct" includes the following: "Any practice or conduct which tends to constitute a danger

to the health welfare or safety of patient or public." Wisconsin courts have ruled that a physician violates this provision if the physician's conduct falls below the minimum standards of treatment accepted of a physician at that time and the conduct created an unacceptable level of risk for the patient. *Gimenez v. State Medical Examining Board*, 203 Wis.2d 349, 355, 552 N.W.2d 863 (Ct. App. 1996). The court in *Gimenez* set out the five elements that must be proven to establish a violation of section Med 10.02(2)(h). Those elements are as follows:

1. What course of treatment the physician provided;
2. What the minimum standards of treatment required;
3. How the physician's treatment deviated from the standards;
4. How the treatment created an unacceptable level of risk; and
5. What course of treatment a minimally competent physician would have taken.

Count II of the Complaint alleges that Dr. Wilson is subject to discipline pursuant to Wis. Stat. § 448.02(3)(c) by virtue of having "been negligent in treating a patient." The civil standard for medical negligence applies in determining whether, for disciplinary purposes, a physician was negligent in treating a patient under section 448.02(3)(c). *Dept. of Reg. & Lic. v. Med. Exam. Bd.*, 215 Wis.2d 188, 197-8, 572 N.W.2d 508 (Ct. App. 1997). This civil standard is whether the physician used the degree of skill and care that a reasonable physician would use in the same or similar circumstances. *Id.*, 215 Wis.2d at 200; see also Wisconsin JI–CIVIL 1023 "Medical Negligence." Unlike a civil action for medical negligence, however, section 448.02(3)(c) does not require that the credential holder's negligence to have caused harm to anyone, but rather only that there has been negligence in treatment.

Thus, the focus of both counts of the Complaint is on the conduct of Dr. Wilson, not on what may or may not have actually occurred as a result of his conduct. While the presence or absence of actual harm caused by a credential holder's conduct may have some bearing on the issues of whether a credential holder has violated an applicable standard or has created an unacceptable risk to a patient, the presence or absence of resulting harm is not itself determinative of these issues.

Through Friday, October 21, 2005, which was the day that Dr. Wilson assumed responsibility for the care of Mr. A as the weekend cover physician, Mr. A's post-operative course from an open cholecystectomy had been typical. (Stipulation). The Division's averments in support of its request for discipline relate only to Dr. Wilson's treatment of Mr. A up to 5:45 p.m. on Saturday, October 22, 2005.

Between 1:30 a.m. and 12:45 p.m. on October 22, Mr. A had three emesis events. Beginning about 7:00 a.m. and continuing through the afternoon of October 22, Mr. A's heart rate and respiration rate were somewhat more elevated from the rates of the preceding day, and his body temperature had also risen slightly. The Division contends that Dr. Wilson's treatment of Mr. A in response to these symptoms did not meet minimum standards of competence, and created an unacceptable level of risk for Mr. A.

The Division presented the expert testimony of Dr. Susan Toth to prove unprofessional conduct and negligence in treatment, and Dr. Wilson presented the countervailing expert testimony of Dr. Robert Mikkelsen. As between the conflicting opinions of Drs. Toth and Mikkelsen, Dr. Mikkelsen's was the more persuasive and convincing, as is discussed more fully below.

The Division's expert witness, Dr. Susan Toth, is a general surgeon who was board certified in surgery in 1995 and was recertified in 2003. She is employed in the University of Wisconsin system. She is a clinical professor of surgery who treats patients and teaches surgical residents who are becoming surgeons. Dr. Toth has performed thousands of cholecystectomies. (T. 35).

Dr. Toth testified that by 2:10 p.m. on October 22, a reasonable surgeon caring for Mr. A should have "started trying to figure out why things were changing." She testified that there were several possible causes for the changes in Mr. A's status, and that a surgeon could not determine what the cause or causes were without performing additional diagnostics (T. 59), specifically the following:

- Ordering a chest x-ray, which might have determined whether there was a pneumonia starting. (T. 60).
- Ordering an abdominal x-ray, which might have indicated whether there was a bowel perforation or a bowel obstruction. (T. 60, 64).
- Ordering a complete blood count (CBC) and basic metabolic panel (BMP) to be done that day (rather than the following morning, as Dr. Wilson had ordered early in afternoon of October 22). The results of a CBC would indicate whether an infection was occurring. The results of a BMP would indicate whether electrolyte status was changing and whether kidney function was impaired. (T. 60, 65).

Dr. Toth testified that if Dr. Wilson had ordered these diagnostics to be done on October 22, the results would have provided him the information necessary to "rule in" or to "rule out" the presence of pneumonia, intra-abdominal infection, bowel perforation, bowel obstruction, renal failure, and electrolyte abnormalities. (T. 61). Dr. Toth testified that in the absence of such diagnostic information, it was not possible to determine the cause of Mr. A's changing condition. (T. 65). According to Dr. Toth, if the cause or causes of the changing condition had been determined through such diagnostics, such cause or causes could have been treated for the better. Dr Toth opined further that the failure to treat any such undiscovered causes exposed Mr. A to unreasonable risks from any cause or causes that remained unidentified and thus potentially untreated. (T. 61-65).

Dr. Toth testified further that after a nurse was unsuccessful in inserting an NG tube in the late afternoon of October 22, that Dr. Wilson should have then personally attempted to insert an NG tube in order to decompress the patient's stomach (which was distended as a result of the ileus) and to alleviate the risk of further emesis. She testified that a reduced risk of further emesis would have protected against Mr. A becoming even sicker. (T. 66-67).

Dr. Wilson's expert witness, Dr. Robert Mikkelsen, is a general surgeon who has served as Attending Surgeon at St. Agnes Hospital in Fond du Lac since 1976, in addition to service at other hospitals in the region. (Ex. 203). He has been certified and recertified by the American Board of Surgery several times. Like Dr. Toth, he too has personally performed "thousands" of cholecystectomy surgeries. (T. 209).

With respect to the changes in Mr. A's changing vital signs and three emesis events on October 22, Dr. Mikkelsen opined that Dr. Wilson responded appropriately. Mr. A's postoperative ileus and atelectasis are "universal" conditions following cholecystectomy surgery. (T. 208-09). Ileus "always, always" takes five days to resolve, and there is nothing that can be done to speed its resolution. (T. 210). About 30% of postoperative open cholecystectomy patients suffer episodes of emesis (vomiting) as a consequence of ileus, and of those patients who do vomit, the emesis events typically occur on the fourth day after surgery. (T. 252). Mr. A's three emesis events on the fourth day after surgery (October 22) were not unusual postoperative events (T.252), and, in Dr. Mikkelsen's opinion, Dr. Wilson responded to them appropriately by prescribing anti-nausea medication.

According to Dr. Mikkelsen, Mr. A's vital signs on October 22 through 4 p.m. or so revealed nothing really unusual. (T. 213). While Mr. A's respiration rate was somewhat elevated, Dr. Mikkelsen opined that the respiratory rate of post-operative patients is not particularly useful data, but rather the existence of any respiratory distress is of greater significance. Notwithstanding Mr. A's elevated respiration rates on October 22, there was no evidence that he was under any respiratory distress. (T. 213-214).

Dr. Mikkelsen opined that Mr. A's tachycardia (a heart rate exceeding 100), which began late in the day on October 20 and continued through October 22, and which elevated further beginning in the early morning of October 22, was not such that required a surgeon exercising reasonable care to order diagnostics any differently than Dr. Wilson actually did. This is because tachycardia is commonly seen with atelectasis. While Mr. A's temperatures were mildly elevated on October 22, this symptom was also consistent with atelectasis. Dr. Mikkelsen opined that it was reasonable for Dr. Wilson to conclude that Mr. A's tachycardia and mildly elevated temperatures were related to his atelectasis. In Dr. Mikkelsen's opinion, Dr. Wilson responded appropriately to the tachycardia and elevated temperatures by ordering continued incentive spirometry and ambulation. (T. 216-218).

With respect to whether a CBC was needed immediately on October 22 in order to determine whether there was infection, Dr. Mikkelsen testified convincingly that if Dr. Wilson's physical examination of Mr. A's abdomen in the early afternoon of October 22 had shown increased pain or tenderness, such symptoms might have indicated a need for an immediate CBC. (T. 201). However, Dr. Wilson's examination showed that Mr. A's abdomen was soft, and Mr. A reported that he was not experiencing any increased pain or tenderness in the abdomen. Accordingly, the examination and Mr. A's report indicated that there was no serious infection within the abdomen. (T. 201; 218-219). Accordingly, the ordering of a CBC for the following day (rather than stat) was reasonable. (T. 201). While Mr. A's elevated vital signs around 4:00 p.m. on October 22, might have suggested the presence of an infection, in Dr.

Mikkelsen's opinion, Dr. Wilson's response to these conditions by ordering a broader spectrum of antibiotics for Mr. A was reasonable. (T. 224, 258-60).

Dr. Mikkelsen also opined that it was reasonable for Dr. Wilson to order a BMP for October 23 rather than "stat" on October 22. Both a CBC and BMP are typically ordered every two or three days following this type of surgery. Dr. Mikkelsen discerned no circumstances compelling the ordering of a BMP stat on October 22, rather than the following day as Dr. Wilson had ordered. (T. 223).

In Dr. Mikkelsen's opinion, the ordering of chest and abdominal x-rays on October 22, regardless of their result, would not likely have changed the management of Mr. A's care on October 22. He noted further that an abdominal x-ray taken the following day on October 23, when Mr. A was much sicker, was normal (except for the ileus, which was already known). (T. 234-35).

Dr. Mikkelsen opined further that it was reasonable for Dr. Wilson to discontinue efforts to insert an NG tube after the nurse had been unsuccessful in inserting one. The purpose of an NG tube is to make a patient more comfortable by keeping the patient from vomiting. As recently as 10 years ago, NG tubes were routinely inserted throughout the first five or six days following abdominal surgery, but the more recent trend in surgery is not to use them at all because they make many patients miserable and they frequently cause complications such as nose and throat infections. While some patients feel better with an NG tube, most patients report feeling terrible with them. (T. 232-33). Dr. Mikkelsen opined that after a nurse had been unsuccessful in inserting an NG tube, most physicians would not have tried a second time to insert an NG tube, and that Dr. Wilson did not breach any standard of care in not attempting to insert the NG tube himself or ordering a second attempt. (T. 234). With no NG tube inserted, it was appropriate for Dr. Wilson to continue the order that Mr. A ingest nothing orally, so as to reduce the potential for further vomiting. (T. 241-42). As events later developed, Mr. A had no further emesis events after the failed effort to insert the NG tube. This provides some validation of Dr. Mikkelsen's opinion that Dr. Wilson did not violate applicable standards of care or create an unacceptable level of risk by deciding not to make a second attempt to insert an NG tube.

There is no evidence that Dr. Wilson's conduct at any time caused Mr. A's death. (Stipulation, ¶ 17). No one has been able to explain the very unusual circumstances surrounding Mr. A's death, and it appears that the exact cause will never be known. There was some supposition that the death was the result of "abdominal compartment syndrome." However, Dr. Mikkelsen searched and was unable to find any documented case of this syndrome having occurred following abdominal surgery. (T. 238-239). Test results and observations after 5:45 p.m. on October 22, revealed none of the conditions that Dr. Toth thought might have been revealed by the diagnostics that she believed should have been completed on October 22. Dr. Toth's opinion that the cause of Mr. A's death might have been revealed and his death averted if the diagnostics that she opined should have been completed on October 22 had been done, while perhaps within the realm of possibility, was more supposition than it was expert opinion offered to a reasonable degree of professional certainty. (*See, e.g.* T. 62). Moreover, even if Dr. Toth's opinion in this regard had been proven to a reasonable degree of medical certainty, the greater

weight of the evidence nevertheless failed to establish that Dr. Wilson breached applicable standards of care by not following the diagnostic course that Dr. Toth testified he should have.

As between the competing opinions of Drs. Toth and Mikkelsen, Dr. Mikkelsen's were more grounded in the circumstances that confronted Dr. Wilson at the time, and were more persuasively articulated and reasoned. Thus, the whole of the evidence demonstrated that Dr. Wilson's care of Mr. A on October 22, 2005: (a) did not amount to negligence in treatment, but rather met minimum standards of treatment; and (b) did not create an unacceptable level of risk. The Division has thus failed to prove essential elements of its allegations that Dr. Wilson violated either Wis. Admin. Code § Med 10.02(2)(h) [unprofessional conduct] or Wis. Stat. § 448.02(3)(c) [negligence in treatment].

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board (Board) has jurisdiction over this matter pursuant to Wis. Stat. § 448.02.

2. This proceeding is a Class 2 proceeding as defined in Wis. Stat. § 227.01(3)(b).

3. The Division of Enforcement has the burden of proof in this matter. The burden of proof in disciplinary proceedings before any examining board in the Department of Regulation and Licensing is a preponderance of the evidence. Wis. Stat. § 440.20(3).

4. "Unprofessional conduct" means those acts or attempted acts of commission or omission defined as unprofessional conduct by the Board under the authority delegated to the board by Wis. Stat. § 15.08(5)(b), and any act by a physician or physician assistant in violation of Wis. Stat. chapters 450 or 961. Wis. Stat. § 448.015(4).

5. In Wis. Admin. Code § Med 10.02(2)(h), the Board has defined "unprofessional conduct" to include the following: "Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public." To establish that Dr. Wilson engaged in unprofessional conduct under this provision, the Division of Enforcement was required to prove that Dr. Wilson's conduct fell below the minimal level of competence accepted of a surgeon at the time and that his conduct created unacceptable risks for Mr. A. *Gimenez v. State Medical Examining Board*, 203 Wis.2d 349, 355, 552 N.W.2d 863 (Ct. App. 1996). The Division of Enforcement has not carried its burden to prove by a preponderance of the evidence that Dr. Wilson's care constituted unprofessional conduct as defined by Wis. Admin. Code § Med 10.02(2)(h). Rather, a preponderance of the evidence established that Dr. Wilson's conduct met or exceeded the minimum standard of care. Dr. Wilson has not engaged in unprofessional conduct as defined in Wis. Admin. Code § Med 10.02(2)(h).

7. Pursuant to Wis. Stat. § 448.02(3)(c), a credential holder may be disciplined for having been negligent in treating a patient. To establish that Dr. Wilson was negligent in treating Mr. A, the Division of Enforcement was required to prove that Dr. Wilson did not use the skill and care in treating Mr. A that a reasonable surgeon would have used in the same or similar circumstances. *Dept. of Reg. & Lic. v. Med. Exam. Bd.*, 215 Wis.2d 188, 200, 572 N.W.2d 508 (Ct. App. 1997). The Division of Enforcement has not carried its burden to prove by a

preponderance of the evidence that Dr. Wilson's care of Mr. A did not meet this minimum standard. Rather, a preponderance of the evidence established that Dr. Wilson's conduct met or exceeded this minimum standard of care. Dr. Wilson was not "negligent in treating" Mr. A under Wis. Stat. § 448.02(3).

8. The Division has not shown Dr. Wilson to have engaged in any conduct that would subject him to discipline pursuant to Wis. Stat. § 448.02(3).

PROPOSED ORDER

WHEREFORE, IT IS HEREBY ORDERED that the Board shall take no disciplinary action against Christopher S. Wilson, M.D. and that the Complaint is DISMISSED.

Dated at Milwaukee, Wisconsin on June 28, 2011.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
819 N. 6th Street, Room 92
Milwaukee, Wisconsin 53203
Telephone: (414) 227-4781

By: William S. Coleman, Jr./lem
William S. Coleman, Jr.
Administrative Law Judge

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