

The following information is for:

1999 SB-317

and

1999 SB-318



Tommy G. Thompson
Governor

Marlene A. Cummings
Secretary

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Testimony on Senate Bill 317
Before the Committee on Health, Utilities, Veterans and Military Affairs
Wednesday, February 16, 2000, 1:30 p.m.
411 South, State Capitol.

Good afternoon Chairperson Moen and members of the Committee. Thank you for allowing me to appear this afternoon to testify. My name is John Temby; I am the Administrator of the Division of Enforcement of the Wisconsin Department of Regulation and Licensing. Secretary Cummings is out of the office today and she directed me to testify on her behalf. On behalf of the Department of Regulation and Licensing I would like to testify **for information only and neither for nor against SB 317.**

The Joint Legislative Council's Special Committee on Discipline of Health Care Professionals held many lengthy and informative meetings concerning the legislative proposals that appear in SB 317. Consumers and members of the medical community testified concerning the issues addressed by this bill. The efforts of the committee that lead to the introduction of this bill by the Joint Legislative Council are greatly appreciated. There are many very positive aspects to Senate Bill 317. Indeed, the department has already implemented some of the proposals in the bill. For example, Sec. 440.037 (2) requires the department to establish a priority system for disciplinary cases involving health care professionals. We have accomplished that. Sec. 440.037 (7) of the bill requires the department to establish disciplinary procedure time guidelines, and this has also been done. There are other excellent parts to this bill.

There are two issues in this bill that concern the Department and that the Committee may wish to consider. The first issue [Sec. 440.037 (3)] is the introduction of a “marker” system to identify health care professionals who perhaps should be investigated. The second issue is the inclusion of all health care professionals, as defined by the bill, in most parts of the bill. Let me address those two issues.

Sec. 440.037 (3) provides “The department shall develop a system for identifying health care professionals, who, even if not the subject of a specific allegation of, or specific information relating to, unprofessional conduct, may nonetheless warrant further evaluation and possible investigation.”

This is a new concept and one that could require a substantial investment in staff time and resources. When the fiscal note was prepared for the bill, the Department concluded that a number of additional staff members would be needed to establish and implement this part of the bill. Those who prepared the fiscal estimate assumed that after this system of markers was developed it would be necessary to implement it. However, if the bill does not require implementation, the number of staff needed to establish such a “marker” system would be significantly reduced. It might also be advisable to begin with one group of health care professionals to determine how effective and useful such a system would be before it is pursued with other groups.

The second issue relates to the scope of much of the bill. All health care professionals as identified in the bill are included in most parts of the bill. This dramatically increases the number of credential holders involved from approximately 12,000 physicians to approximately

100,000 health care credential holders. This is a substantial increase in the number of persons involved and will have a negative impact on the efforts of the staff to complete their work in a timely manner. The Committee may wish to consider whether including physicians only within the scope of the bill would be advisable. If all health care professionals are to be included, perhaps it could be done over a period of time.

Those are the two issues that Secretary Cummings asked me to address.

Thank you again for this opportunity to testify. If you have any questions, I would be happy to try and answer them.



TO: State Senator Rodney Moen, Chair
Members, Senate Committee on Health,
Utilities, Veterans and Military Affairs

FROM: Paul Wertsch, MD
Board of Directors

RE: SB 317

DATE: February 16, 2000

Good afternoon. I am Paul Wertsch, and I am a family physician practicing on Madison's east side. I also serve on the Board of Directors of the State Medical Society of Wisconsin. I am pleased to have the opportunity today to address the committee about Senate Bill 317, one of the products of the Legislative Council's Special Committee on the Discipline of Health Care Professionals.

The issue of the discipline of health care professionals is of significant importance to my physician colleagues and more importantly, to our patients. Patients need to be able to trust that the physicians, the nurses, the chiropractors and other health care professionals are able to safely and competently meet their health care needs. The State Medical Society has supported several bills over the last few legislative sessions designed to improve the way the Medical Examining Board functions, including 1997 Act 311 which will enhance the Board's ability to protect the public. For years, physicians argued for staff dedicated to the Medical Examining Board to eliminate the backlog of cases, with the clear expectation that increased physician licensure fees would fund the needed positions. We are grateful to the Legislature and the governor for supporting that legislation.

The legislation before the committee today, SB 317, is generally supported by the State Medical Society. The Medical Society has long supported adding public members to the Medical Examining Board as a means of ensuring adequate representation of the public's perspective and timely completion of the Board's duties. The Medical Society also supports the requirement that the Department of Regulation and Licensing establish priorities in health care discipline cases. This will help to ensure that those professionals who may pose a significant threat to the health of the public are investigated and evaluated as quickly as possible. It also will be helpful to have guidelines in place for completing each stage of the disciplinary process to assure that cases are handled in a timely fashion.

The Medical Society also supports the notice to health care professionals, complainants and patients as to when various stages of the discipline process have been completed. Notice will be to the benefit of all involved.

There are two areas of SB 317 that are of concern to the State Medical Society. The first area is the requirement that the Department of Regulation and Licensing establish a system for identifying health care professionals who may warrant possible investigation. The Medical

Society does not oppose this idea, but we believe that as a means of ensuring that physicians and other health care professionals are not targets of a witch hunt, any system established should be evidenced-based. That is, there should be evidence that certain attributes have been shown to impact patient outcomes. It also is important to make this an evidence-based system to prevent overloading the Medical Examining Board with extraneous work that takes away from their efforts to discipline physicians who truly require discipline.

The Medical Society is opposed to the language in the bill that requires a coroner or medical examiner to indicate his/her belief that a death was therapeutic-related. This change would require adding a new box to the death certificate. Physicians believe it would be more appropriate, as well as more ethical, to simply require that if a coroner or medical examiner believes that a death was the result of unprofessional conduct or negligence in treatment, she or he make a report to the Medical Examining Board.

Thank you very much for your time and attention. I am happy to answer any questions you may have.



Tommy G. Thompson
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Marlene A. Cummings
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Testimony on Senate Bill 318
Before the Committee on Health, Utilities, Veterans and Military Affairs
Wednesday, February 16, 2000, 1:30 p.m.
411 South, State Capitol.

Good afternoon Chairperson Moen and members of the Committee. Thank you for allowing me to appear this afternoon to testify. My name is John Temby; I am the Administrator of the Division of Enforcement of the Wisconsin Department of Regulation and Licensing. Secretary Cummings is unavailable to testify today and she directed me to testify on her behalf. On behalf of the Department of Regulation and Licensing I would like to testify **in favor of Senate Bill 318.**

The Joint Legislative Council's Special Committee on Discipline of Health Care Professionals held many meetings concerning the proposal that appears in Senate Bill 318. The efforts of the committee that lead to the introduction of this bill by the Joint Legislative Council are greatly appreciated by all concerned.

This bill will be of benefit to the citizens of this state and is a positive step forward. The bill will give consumers much needed information and will enable them to be better educated when choosing a physician. However, the Committee must recognize that implementation of the bill will require staff and other resources. The department's fiscal estimate to the bill has outlined in detail what the Department's needs will be to carry out the new responsibilities given to us in SB 318. We want to be able to implement the new program successfully. Please keep that in mind when you consider the bill.

Thank you again for this opportunity to testify. If you have any questions, I would be happy to try and answer them.

RegislatSB 318.DOC

State Medical Society of Wisconsin

Working together, advancing the health of the people of Wisconsin



TO: State Senator Rodney Moen, Chair
Members, Senate Committee on Health, Utilities,
Veterans and Military Affairs

FROM: Ayaz Samadani, MD, President-elect

RE: Senate Bill 318

DATE: February 16, 2000

Hello, I am Doctor Ayaz Samadani, president-elect of the State Medical Society of Wisconsin. The State Medical Society appreciates this opportunity to provide information for your committee with regard to SB 318.

Clearly, it is in the best interest of our patients to provide them with meaningful information when they are trying to locate a new doctor or learn more about their own physician. The State Medical Society would like to extend our help in collaborating with the Legislature, Medical Examining Board and Bureau of Health Information in the process of developing this meaningful information.

In 1999, we adopted a new strategic plan. The plan refocused the Society's energy on a purpose we have held for more than 150 years—to advance the health of the people of Wisconsin. One of our goals is to provide public access to information that will help patients make health care decisions that are best for them.

Our first phase has been to develop an on-line physician directory. The programming is largely complete. Our biggest challenge has been to verify addresses of both our member physicians as well as those physicians who don't belong to the medical society. The SMS receives our physician information from individual physicians, clinics, the Medical Examining Board and the Patients Compensation Fund. We want to ensure the information is valid before we go live on-line. We have a screen print of what will be available in Phase One for you. We are very excited about the physicians' directory. We believe it will be a valuable tool for patients and doctors.

The second phase of our directory is designed to increase the amount of information available about the physicians and their practices. We envisioned some of the types of information outlined in this bill such as disciplinary actions and malpractice claims paid and also a place where physicians can give patients a better sense of what their practice is like. For example, I may include this description for my profile.

I practice family medicine in Beaver Dam, Wisconsin, with patients who range in age from newborn to elderly. One patient may have a cold requiring minimum care, while the next may be in his 50s and suffering potentially serious chest pain. Yet another patient could be a senior citizen with a gastric or respiratory problem. In addition, I welcome patients who are pregnant with a normal or complicated course of pregnancy. I also review occupational injuries, which range from minor to severe. Whatever the ailment or condition, each patient requires and receives individualized care. The specific type of care is determined after we gather the necessary information and speak with the patient

and/or family members. Although science offers us no guarantee, I endeavor to provide patients with high quality medical care that will lead to the best possible outcome.

We believe a comprehensive physician directory is a tool patients need, and we are working in that direction. We would very much like to partner with the MEB and Bureau of Health Information in a coordinated effort to create a single physician directory for Wisconsin that is comprehensive and easily accessible for patients, and useful for the State and the SMS alike. Thank you. I would be happy to answer any questions.

State Medical Society of Wisconsin

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advocacy professionalism community

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- Worker's Comp
- WMJ
- Upcoming Events
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- AMA "Doctor Finder"
- Members Only
- Public Home Page
- Talk Back

Welcome to WISMED Physician Directory, your resource for finding Wisconsin licensed Physicians.

Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Clinic:	<input type="text"/>
City:	Beaver Dam
County (WI only):	All Counties <input checked="" type="checkbox"/>
Specialty*	Internal Medicine <input checked="" type="checkbox"/>
Graduation Year:	<input type="text"/>
Medical School:	All Schools <input checked="" type="checkbox"/>
Limit Results:	25 records <input checked="" type="checkbox"/>

*Note: Only physician members of the State Medical Society of Wisconsin are listed by specialty.

If you have questions, problems or feedback about the SMS Physician Directory contact us at info@smswi.org.
Directory information incorrect? [Click here for changes.](#)

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- Search WISMED
- AMA "Doctor Finder"
- Members Only
- Public Home Page
- Talk Back

Member Physicians

Record Count = 3
Query Size = 25

- | | |
|----------------------------|---|
| <u>Dr. Sharon Haase</u> | UW Medical Foundation
Beaver Dam, WI
(920) 885-3369 |
| <u>Dr. Gerald Klomberg</u> | Beaver Dam, WI
(920) 887-3991 |
| <u>Dr. Ayaz Samadani</u> | Doctor Ayaz M. Samadani
Beaver Dam, WI
(920) 887-7731 |

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Talk Back

State Medical Society Physician Information

Dr. Ayaz Samadani
Clinic of Doctor Ayaz M. Samadani
148 Warren Street
Beaver Dam, WI 53916
Phone: (920) 887-7731
Fax: (920) 887-3201
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Medical School: Liaquat Medical College, Hyderabad
Graduation Year: 1964
Residency: Royal College of Physicians and Surgeons of London
Residency Graduation Year: 1967
Fellowship:
WI License Year: 1976
Specialties: Internal Medicine, Pediatrics
Medicare Participant: Yes
Partner Care Participant: Yes
Health Plan Affiliation: Unity Health Plans Ins. Corp.
State Medical Society Activities: President-Elect (1999)

If you have questions, problems or feedback about the SMS
Physician Directory contact us at info@smswi.org.
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**STATE OF WISCONSIN
JOINT LEGISLATIVE COUNCIL**

REPORT NO. 14 TO THE 1999 LEGISLATURE

LEGISLATION ON DISCIPLINE OF HEALTH CARE PROFESSIONALS

1999 SENATE BILL 317, Relating to Priorities, Completion Guidelines and Notices Required for Health Care Professional Disciplinary Cases; Identification of Health Care Professionals in Possible Need of Investigation; Additional Public Members for the Medical Examining Board; Authority of the Medical Examining Board to Limit Credentials and Impose Civil Forfeitures; Reporting Requirements for Reports Submitted to the National Practitioner Data Bank; Inclusion of Health Care Professionals Who Practice Alternative Forms of Health Care on Panels of Health Care Experts Established by the Department of Regulation and Licensing; Indication of Therapeutic-Related Deaths on Certificates of Death; and Providing a Penalty

1999 SENATE BILL 318, Relating to Making Available to the Public Information on the Education, Practice and Disciplinary History of Physicians, Requiring Rules of the Department of Health and Family Services to Include Procedures Affording Health Care Providers Opportunity to Correct Health Care Information and Granting Rule-Making Authority

Legislative Council Staff
January 21, 2000

One East Main Street, Suite 401
Madison, Wisconsin

RL 99-14

JOINT LEGISLATIVE COUNCIL
REPORT NO. 14 TO THE 1999 LEGISLATURE*

LEGISLATION ON DISCIPLINE OF HEALTH CARE PROFESSIONALS

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* This Report was prepared by Don Dyke, Senior Staff Attorney, Legislative Council Staff.

PART I

**KEY PROVISIONS OF LEGISLATION; COMMITTEE
AND JOINT LEGISLATIVE COUNCIL VOTES**

The Special Committee on Discipline of Health Care Professionals recommends the following proposals to the Joint Legislative Council for introduction in the 1999-2000 Session of the Legislature:

A. SENATE BILL 317, RELATING TO PRIORITIES, COMPLETION GUIDELINES AND NOTICES REQUIRED FOR HEALTH CARE PROFESSIONAL DISCIPLINARY CASES; IDENTIFICATION OF HEALTH CARE PROFESSIONALS IN POSSIBLE NEED OF INVESTIGATION; ADDITIONAL PUBLIC MEMBERS FOR THE MEDICAL EXAMINING BOARD; AUTHORITY OF THE MEDICAL EXAMINING BOARD TO LIMIT CREDENTIALS AND IMPOSE CIVIL FORFEITURES; REPORTING REQUIREMENTS FOR REPORTS SUBMITTED TO THE NATIONAL PRACTITIONER DATA BANK; INCLUSION OF HEALTH CARE PROFESSIONALS WHO PRACTICE ALTERNATIVE FORMS OF HEALTH CARE ON PANELS OF HEALTH CARE EXPERTS ESTABLISHED BY THE DEPARTMENT OF REGULATION AND LICENSING; INDICATION OF THERAPEUTIC-RELATED DEATHS ON CERTIFICATES OF DEATH; AND PROVIDING A PENALTY

• **Key Provisions**

1. Requires the Department of Regulation and Licensing (DRL) to develop a system to establish the relative priority of cases involving possible unprofessional conduct on the part of a health care professional.
2. Requires the DRL to develop a system for identifying health care professionals who, even if not the subject of a specific allegation of unprofessional conduct, may nonetheless warrant further evaluation and possible investigation.
3. Requires the DRL to notify a health care professional's place of practice or employment when a formal complaint alleging unprofessional conduct by the health care professional is filed.
4. Requires the DRL to give notice to a complainant and a health care professional when: (a) a case of possible unprofessional conduct by the health care professional is closed following screening for a possible investigation; (b) a case of possible unprofessional conduct by the health care professional has been opened for investigation; and (c) a case of possible unprofessional conduct by the health care professional is closed after investigation. In addition, DRL is required to provide a copy of the notices under (b) and (c), above, to an affected patient (when the patient is not also the complainant) or the patient's family members.

5. Requires that a patient or client who has been adversely affected by a health care professional's conduct that is the subject of a state disciplinary proceeding be given opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effect of the unprofessional conduct on the patient or client.

6. Requires the DRL to establish guidelines for the timely completion of each stage of the health care professional disciplinary process.

7. Requires, if the DRL establishes panels of health care experts to review complaints against health care professionals, that DRL attempt to include on the panels health care professionals who practice alternative forms of health care to assist in evaluating cases involving alternative health care.

8. Requires, by May 1, 2001, the DRL to submit to the Legislature a report on the disciplinary process time lines which were implemented by the department as guidelines in February 1999.

9. Adds two public members to the Medical Examining Board (MEB), resulting in a 15-member MEB with five public members, nine medical doctor members and one member who is a doctor of osteopathy.

10. Authorizes the MEB to summarily limit any credential issued by the MEB pending a disciplinary hearing.

11. Authorizes the MEB to assess a forfeiture of not more than \$1,000 for each violation against a credential holder found guilty of unprofessional conduct (not including negligence in treatment).

12. Creates a state requirement that reports on medical malpractice payments and on professional review actions by health care entities, which currently must be submitted to the National Practitioner Data Bank (NPDB), must also be submitted to the MEB in accordance with the time limits set forth in federal law. A person or entity who violates the state requirement is subject to a forfeiture of not more than \$10,000 for each violation.

13. Provides that when a coroner or medical examiner receives a report of a death under s. 979.01, Stats., and subsequently determines that the death was therapeutic-related, as defined, the coroner or medical examiner must indicate that determination on the death certificate and forward the information to the DRL.

• Votes

Senate Bill 317 consists of several proposals that were acted on separately by the Special Committee on Discipline of Health Care Professionals. The separate proposals that were combined into Senate Bill 317 and the votes on those proposals by the Special Committee on

Discipline of Health Care Professionals for recommendation to the Joint Legislative Council for introduction in the 1999-2000 Session of the Legislature are set forth below.

WLCS: 0014/1, relating to directing the DRL to establish priority discipline cases for health care professionals, factors to identify health care professionals in possible need of investigation and time lines for the health care professional disciplinary process and requiring notice to health care professionals and their places of employment and to complainants, patients and clients in connection with the disciplinary process (as amended): Ayes, 11 (Sens. Huelsman; Reps. Underheim, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 5 (Sen. Risser; Reps. Cullen and Seratti; and Public Members Rosenberg and Wolverton).

WLCS: 0060/2 relating to changing the composition of the MEB: Ayes, 9 (Sen. Huelsman; Reps. Cullen, Underheim and Urban; and Public Members Clifford, Freil, Noack, Schultz and Schulz); Noes, 3 (Rep. Wasserman; and Public Members Newcomer and Roberts); and Absent, 4 (Sen. Risser; Rep. Seratti; and Public Members Rosenberg and Wolverton).

WLCS: 0067/1, relating to authorizing the MEB to summarily limit a credential granted by the board: Ayes, 9 (Sens. Huelsman and Risser; Rep. Wasserman; and Public Members Newcomer, Noack, Rosenberg, Schultz, Schulz and Wolverton); Noes, 0; and Absent, 7 (Reps. Underheim, Cullen, Seratti and Urban; and Public Members Clifford, Freil and Roberts).

WLCS: 0068/1, relating to authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct: Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

WLCS: 0101/1, relating to requiring reports which must be submitted to the NPDB to be submitted to the MEB and providing a penalty (as amended): Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

WLCS: 0104/P1, relating to including health care professionals who practice alternative forms of health care in panels of health care experts established by the DRL: Ayes, 10 (Sen. Huelsman; Reps. Underheim, Cullen and Seratti; and Public Members Clifford, Freil, Noack, Roberts, Schultz and Schulz); Noes, 2 (Reps. Urban and Wasserman); and Absent, 4 (Sen. Risser; and Public Members Newcomer, Rosenberg and Wolverton).

WLCS: 0021/2, relating to requiring coroners and medical examiners to indicate on certificates of death when a death is therapeutic-related and to provide this information to the DRL: Ayes, 13 (Sen. Huelsman, Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

At its September 23, 1999 meeting, the Joint Legislative Council voted to introduce 1999 Senate Bill 317 (WLCS: 0147/1) by a vote of Ayes, 15 (Reps. Kelso, Bock, Foti, Freese, Huber, Jensen, Schneider, Seratti and Stone; and Sens. Risser, Burke, Cowles, Erpenbach, Grobschmidt and Robson); Noes, 0; and Absent, 7 (Reps. Gard and Krug; and Sens. Chvala, Ellis, George, Rosenzweig and Zien).

B. SENATE BILL 318, RELATING TO MAKING AVAILABLE TO THE PUBLIC INFORMATION ON THE EDUCATION, PRACTICE AND DISCIPLINARY HISTORY OF PHYSICIANS, REQUIRING RULES OF THE DEPARTMENT OF HEALTH AND FAMILY SERVICES TO INCLUDE PROCEDURES AFFORDING HEALTH CARE PROVIDERS OPPORTUNITY TO CORRECT HEALTH CARE INFORMATION AND GRANTING RULE-MAKING AUTHORITY

• **Key Provisions**

1. Directs the MEB to make available for dissemination to the public, in a format established by the board, specified information concerning a physician's education, practice, malpractice history, criminal history and disciplinary history. The costs incurred by the DRL in connection with making physician information available to the public is funded by a surcharge on the license renewal fee paid biennially by physicians licensed in this state.

2. Requires administrative rules of the Department of Health and Family Services (DHFS) to include procedures affording health care providers the opportunity to correct health care information collected under ch. 153, Stats.

• **Votes**

Senate Bill 318 combines two drafts separately considered by the Special Committee on Discipline of Health Care Professionals. One of the drafts, WLCS: 0015/1, was voted on by the Special Committee at its April 20, 1999 meeting; subsequent to that meeting, two remaining issues related to the draft were resolved by the adoption of two amendments by mail ballot. The other draft included in WLCS: 0015/2 is WLCS: 0034/P1. The votes by the Special Committee on Discipline of Health Care Professionals to recommend the two drafts that were combined to create WLCS: 0015/2 to the Joint Legislative Council for introduction in the 1999-2000 Legislature are set forth below.

WLCS: 0034/P1, relating to procedures to provide an opportunity to correct certain health care information and providing rule-making authority: Ayes, 10 (Sens. Huelsman and Risser; Reps. Urban and Wasserman; and Public Members Newcomer, Noack, Rosenberg, Schultz, Schulz and Wolverton); Noes, 0; and Absent, 6 (Reps. Underheim, Cullen and Seratti; and Public Members Clifford, Freil and Roberts).

WLCS: 0015/1, relating to making available to the public certain information on the education, practice and disciplinary history of physicians and granting rule-making authority (as amended): Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman;

and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

At its September 23, 1999 meeting, the Joint Legislative Council voted to introduce 1999 Senate Bill 318 (WLCS: 0015/2) by a vote of Ayes, 17 (Reps. Kelso, Bock, Foti, Freese, Gard, Huber, Jensen, Seratti and Stone; and Sens. Risser, Burke, Chvala, Cowles, Grobschmidt, Robson, Rosenzweig and Zien); Noes, 2 (Rep. Schneider and Sen. Erpenbach); and Absent, 3 (Rep. Krug; and Sens. Ellis and George).

PART II

COMMITTEE ACTIVITY

A. ASSIGNMENT

The Joint Legislative Council established the Special Committee and appointed the chairperson by a June 24, 1998 mail ballot. The Special Committee was directed to study procedures for imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards identified by the Special Committee, for the purpose of ensuring that such procedures are effective, fair and consistent.

The membership of the Special Committee, appointed by a September 4, 1998 mail ballot, consisted of two Senators, five Representatives and nine Public Members.

A membership list of the Joint Legislative Council is included as **Appendix 1**. A list of the Committee membership is included as **Appendix 2**.

B. SUMMARY OF MEETINGS

The Special Committee held seven meetings at the State Capitol in Madison on the following dates:

October 8, 1998	February 9, 1999
November 18, 1998	March 11, 1999
December 18, 1998	April 20, 1999
January 20, 1999	

At the October 8, 1998 meeting, the Special Committee received testimony from Marlene Cummings, Secretary, DRL; Dr. Walter R. Schwartz, Chairperson, MEB; Mark Adams, Corporate Counsel, and John La Bissioniere, Peer Review Consultant, State Medical Society of Wisconsin (SMS). Secretary Cummings described the DRL complaint handling process for cases of unprofessional conduct. She described recent DRL efforts to strengthen and expedite the complaint handling process and provided data concerning complaints of unprofessional conduct and the disposition of those complaints. Dr. Schwartz outlined the current membership of the MEB and discussed MEB involvement in cases of unprofessional conduct by credential holders. Dr. Schwartz discussed common types of cases of unprofessional conduct involving physicians and typical discipline. Mr. Adams described past initiatives by the SMS regarding physician discipline. He also described the SMS Commission on Mediation and Peer Review, which reviews complaints against physicians and recommends solutions. Mr. La Bissioniere described the Statewide Physician Health Program of the SMS, which assists physicians in dealing with alcohol and chemical dependency problems.

The Special Committee also briefly reviewed a staff brief on discipline of health care professionals and a staff memorandum concerning recommendations of the DRL Ad Hoc Enforcement Advisory Committee concerning time lines for disciplinary cases.

At the November 18, 1998 meeting, the Committee received testimony from Richard Roberts, M.D., Department of Family Medicine, University of Wisconsin (UW)-Madison Medical School; Steve Baker, M.D., Medical Director, Wendy Potochnik, Director of Quality Management and Candice Freil, Vice President, Health Services, PrimeCare Health Plan, Milwaukee; Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison; Barbara Rudolph, Ph.D., Director, Bureau of Health Care Information, DHFS; Tom Meyer, M.D., and George Mejicano, M.D., UW Office of Continuing Medical Education Assessment and Remedial Continuing Education, Madison; and Don Prachthausser, Attorney, Murphy, Gillick, Wicht and Prachthausser, Milwaukee, and President, Wisconsin Academy of Trial Lawyers. In his presentation, Dr. Roberts discussed what is happening today in the health care system, provided an example of the various levels of quality review of an individual physician and discussed the issue of competence in connection with health care. Dr. Baker and Ms. Potochnik addressed physician monitoring in the health plan setting. Dr. Hendricks addressed the role of hospitals in physician reviews. Ms. Rudolph addressed the Bureau of Health Care Information's plans concerning an annual guide to assist consumers in selecting health care providers and health care plans. Dr. Meyer discussed the evolution of the program offered by the UW Office of Continuing Medical Education to assess the needs of individual physicians and to educate physicians who are in need of training in a specific area of practice. Dr. Mejicano provided information on the number of assessment programs, profiles of physicians who are referred to the programs and assessment tools used by the programs. He also discussed the assessment and remediation processes and the costs of those processes. Mr. Prachthausser addressed the issue of physician discipline for unprofessional conduct from the perspective of an attorney who has represented patients with malpractice claims against physicians and other health care providers.

At the December 18, 1998 meeting, the Special Committee received testimony from Don Rittel, Administrative Law Judge, DRL; Attorney Michael P. Malone, Hinshaw and Culbertson, Milwaukee; and Dr. Jeffrey Jentzen, Milwaukee County Medical Examiner. Mr. Rittel discussed his functions in DRL: (1) providing legal counsel services to various professional boards housed in the department; and (2) functioning as an administrative law judge in formal disciplinary proceedings. He focused his remarks on his role as an administrative law judge, including disciplinary proceedings involving physicians. Mr. Malone addressed the physician disciplinary process from the perspective of an attorney who has represented a number of physicians before the MEB since the early 1980s. Dr. Jentzen described the current role of coroners and medical examiners in reporting sudden or unexplained deaths in a health care setting and determining the cause and manner of death. He commented on the desirability of including an option for indicating therapeutic-related deaths on Wisconsin's death certificate. Committee members engaged in an initial discussion of possible recommendations from the Committee to improve the health care professional disciplinary process.

At the January 20, 1999 meeting, the Special Committee discussed issues and possible recommendations relating to the purpose of the MEB, the definition of "unprofessional conduct" on the part of physicians; required reporting in records provided to the MEB; a Massachusetts's

law on individual physician profiles provided over the Internet; issues relating to the MEB disciplinary procedure; whether a provision should be included on the Wisconsin death certificate for indicating therapeutic-related deaths; and DRL biennial budget requests of interest.

At the February 9, 1999 meeting of the Special Committee, the Special Committee reviewed drafts relating to: disclosure of certain health care services review records and information to examining or licensing boards or agencies; the purpose of the MEB, directing the MEB to establish priorities, factors to identify physicians in possible need of investigation, time lines for the disciplinary process and to give notice to physicians and their places of employment in connection with the disciplinary process; indicating therapeutic misadventures on certificates of death and providing information to the MEB; making available to the public certain information on the education, practice and disciplinary history of physicians; procedures providing opportunity to correct certain health care information; information to be provided by credential holders to the DRL; and the practice of alternative medicine by a physician.

At the March 11, 1999 meeting of the Special Committee, the Committee considered several previously considered drafts, including revised versions of some of those drafts. In addition, the Special Committee considered drafts relating to: changing the composition of the MEB; authorizing the MEB to summarily limit a credential granted by the board; and authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct. The Committee approved WLCS: 0034/P1, relating to procedures providing opportunity to correct certain health care information, and WLCS: 0067/1, relating to authorizing the MEB to summarily limit a credential granted by the board. The Committee voted to send to the Joint Committee on Finance, on behalf of the Special Committee, a letter expressing the Committee's support for two items contained in the Governor's Biennial Budget Bill (1999 Assembly Bill 133) providing appropriations to DRL for two items of particular interest to the Special Committee. That letter, included in **Appendix 3**, was sent to the Joint Committee on Finance, which subsequently approved the budget items.

At the Special Committee's April 20, 1999 meeting, the Committee heard from four members of the MEB: Public Members Virginia Scott Heinemann and Wanda A. Roever and Drs. Darold A. Treffert and Glenn Hoberg, Chair. The MEB members discussed the respective roles of public and professional members on the MEB. The Special Committee then voted on a variety of draft legislation and approved the following drafts: WLCS: 0014/1 (as amended), relating to directing DRL to establish priority discipline cases for health care professionals, factors to identify health care professionals in possible need of investigation, and time lines for the health care professional disciplinary process and requiring notice to health care professionals and their places of employment and to complainants, patients and clients in connection with the disciplinary process; WLCS: 0015/1 (as amended), relating to making available to the public certain information on the education, practice and disciplinary history of physicians. [The Committee set aside two issues relating to WLCS: 0015/1 for mail ballot. By mail ballot dated May 14, 1999, the Special Committee approved two amendments to WLCS: 0015/1.]; WLCS: 0021/2, relating to requiring coroners and medical examiners to indicate on certificates of death when a death is therapeutic-related and to provide this information to the DRL; WLCS: 0068/1, relating to authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct; WLCS: 0101/1, relating to requiring reports which must be submitted to the NPDB to

be submitted to the MEB; and WLCS: 0104/P1, relating to including health care professionals who practice alternative forms of health care on panels of health care experts established by DRL. At the request of Chairperson Huelsman, the Special Committee agreed to permit Chairperson Huelsman to package the Special Committee's recommendations into one or more drafts for consideration by the Joint Legislative Council.

C. STAFF MATERIALS AND OTHER MATERIALS

Appendix 4 lists all of the materials received by the Special Committee on Discipline of Health Care Professionals. In addition to these listed materials, Legislative Council Staff prepared several bill drafts for the Special Committee and a summary of each of the Special Committee's meetings.

PART III

BACKGROUND; DESCRIPTION OF BILLS

This Part of the Report provides background information on, and a description of, the bills introduced by the Joint Legislative Council on the recommendation of the Special Committee on Discipline of Health Care Professionals.

During the last three decades, the issue of discipline of physicians by the MEB and DRL has received considerable legislative attention, often in connection with consideration of medical malpractice issues. For example, in the 1975 Legislative Session, ch. 448, Stats., relating to licensure and discipline of physicians, was repealed and recreated in order to strengthen and modernize the chapter. [Ch. 383, Laws of 1975.] In that same session, significant legislation relating to health care liability and patients compensation was enacted. [Ch. 37, Laws of 1975.] In the 1985 Legislative Session, significant legislation addressing patients compensation and medical malpractice also included provisions on physician discipline. [1985 Wisconsin Act 340.] In the 1997-98 Legislative Session, the Legislature enacted 1997 Wisconsin Act 311, relating to the physician discipline process, and also considered medical malpractice issues in connection with limits on wrongful death actions. [1997 Wisconsin Act 89.]

While 1997 Wisconsin Act 311 addressed many issues in the physician discipline process, there was legislative interest in determining whether any remaining issues should be addressed. In addition, interest was expressed in reviewing issues that might arise in the discipline process for other health care professionals. The Special Committee on Discipline of Health Care Professionals focused its attention and deliberations on the physician discipline process; however, several of its recommendations also apply to the health care professional discipline process generally, in those areas where the Special Committee concluded that public policy, including consistency of treatment, warranted application to other health care professionals.

A. 1999 SENATE BILL 317

1. Definition of "Health Care Professional"

Several provisions of Senate Bill 317 apply to the discipline processes for "health care professionals." Included in the definition of "health care professional" under the draft are: acupuncturists; audiologists; chiropractors; dental hygienists; dentists; dieticians; hearing instrument specialists; licensed practical nurses; registered nurses; nurse midwives; occupational therapists; occupational therapy assistants; optometrists; pharmacists; physical therapists; physicians; physician assistants; podiatrists; private practice school psychologists; psychologists; respiratory care practitioners; and speech-language pathologists.

2. Establishment of Priority Discipline Cases

a. Background

Currently, the DRL effectively establishes priorities in health care professional discipline cases through the enforcement process, including utilization of complaint handling teams and periodic screening of possible discipline cases. The Legislature, in 1997 Wisconsin Act 311, effectively established that physician discipline cases involving the death of a patient be given priority by establishing time deadlines for initiating an investigation in such cases.

The Special Committee determined that continuation of the practice of establishing priority of cases involving possible unprofessional conduct on the part of health care professionals is warranted and determined that special emphasis should be given to cases involving the death of a patient or client, serious injury to a patient or client, substantial damages incurred by a patient or client or sexual abuse of a patient or client.

b. Description of Bill

Senate Bill 317 requires the DRL to develop a system to establish the relative priority of cases involving possible unprofessional conduct on the part of a health care professional. The prioritization system is to give highest priority to cases of unprofessional conduct that have the greatest potential to adversely affect public health, safety and welfare. In establishing the priorities, the DRL is to give particular consideration to cases of unprofessional conduct that may involve the death of a patient or client, serious injury to a patient or client, substantial damages incurred by a patient or client or sexual abuse of a patient or client. The priority system is to be used to determine which cases receive priority of consideration and resources in order for the DRL and health care credentialing authorities to most effectively protect the public health, safety and welfare.

3. Establishment of System for Identifying Health Care Professionals Who May Warrant Possible Investigation

a. Background

Among the resources reviewed by the Special Committee was *Evaluation of Quality of Care and Maintenance of Competence*, Federation of State Medical Boards of the United States, Inc., 1998. The report contains a series of recommendations by the Federation's Special Committee on the Evaluation of Quality of Care and Maintenance of Competence, which were adopted as policy by the house of delegates of the federation in May 1998.

One of the recommendations included in the report suggests that state medical boards develop a system of markers to identify licensees warranting evaluation. Narrative comments to the recommendation note that historically, the disciplinary function of state medical boards may be characterized as reactive. It is suggested that measures to prevent, in contrast to only reacting to, breaches of professional conduct and to improve physician practice will greatly enhance public protection. The development of a system of markers is one means to identify physicians,

before a case of unprofessional conduct arises, who may be failing to maintain acceptable standards in one or more areas of professional physician practice as well as to identify opportunities to improve physician practice.

The Special Committee concluded that the rationale for developing a system of markers for identifying physicians who may need additional scrutiny applies as well to other health care professionals.

b. Description of Bill

Senate Bill 317 requires the DRL to develop a system for identifying health care professionals who, even if not the subject of a specific allegation of, or specific information relating to, unprofessional conduct, may warrant further evaluation and possible investigation.

4. Notice to Health Care Professionals, Complainants and Patients Concerning Disciplinary Cases

a. Background

In reviewing the physician disciplinary process, members of the Special Committee urged that both physicians and patients be informed of the early stages of the disciplinary process without adversely affecting DRL's investigative efforts. The Special Committee learned that current practice of DRL is to give physicians notice that a case of possible unprofessional conduct has been opened for investigation, but that the DRL may delay giving notice if the investigation will be adversely affected. It is not current practice to notify complainants or patients of the early stages of the disciplinary process. The Special Committee concluded that providing notice to credential holders, complainants and patients and clients of the early stages of a disciplinary case against a health care professional is desirable and will contribute to the fairness of, and confidence in, the disciplinary process. The Committee concluded, however, that no purpose would be served in notifying patients and clients who are not also complainants that a case has been closed following screening for possible investigation.

b. Description of Bill

Senate Bill 317 requires the DRL, within 30 days after the occurrence of the event requiring notice, to notify a health care professional in writing: (1) when a case of possible unprofessional conduct by the health care professional is closed following screening for a possible investigation; (2) when a case of possible unprofessional conduct by the health care professional has been opened for investigation; and (3) when a case of possible unprofessional conduct by the health care professional is closed after an investigation. These notice requirements address only the early stages of the disciplinary process because it is assumed that if a disciplinary case continues after an investigation is completed, the health care professional will be well aware of the course of proceedings from that point on. These notice requirements generally reflect current DRL practice.

The bill also requires the DRL to make a reasonable attempt to provide the complainant in a disciplinary case with a copy of each notice made under the requirement described above that relates to a disciplinary proceeding requested by the complainant. If the case involves conduct adversely affecting a patient or client of the health care professional and the patient or client is not a complainant, the DRL is required to make a reasonable attempt to: (1) provide the patient or client with a copy of a notice when a case of possible unprofessional conduct has been opened for investigation and when a case is closed after an investigation; or (2) provide the spouse, child, sibling, parent or legal guardian of the patient or client with a copy of such notice. The notice requirements for complainants and patients and clients are new.

5. Notice of Pending Complaint to a Health Care Professional's Place of Practice

a. Background

Many health care professionals practice in multiple settings. Thus, many or most of a health care professional's places of practice may be unaware of a pending disciplinary action against the health care professional even after a formal complaint is filed. The Special Committee concluded that upon the filing of a formal complaint alleging unprofessional conduct on the part of a health care professional, it is desirable for the DRL to notify all places of a health care professional's practice or employment to alert them of the pending disciplinary action, providing them opportunity to determine if any action on their part might be desirable.

b. Description of Bill

Senate Bill 317 requires the DRL, within 30 days after a formal complaint alleging unprofessional conduct by a health care professional is filed, to send written notice that a complaint has been filed to: (1) each hospital where the health care professional has hospital staff privileges; (2) each managed care plan for which the health care professional is a participating provider; and (3) each employer, not included under (1) or (2), above, who employs the health care professional to practice the health care profession for which the health care professional is credentialed.

The bill expressly requires a health care professional, if requested by the DRL, to provide information necessary for the department to comply with the notice requirements.

6. Opportunity for Patients and Clients to Confer Concerning Discipline

a. Background

Some members of the Special Committee contended that a means of enhancing public confidence in the health care professional disciplinary system is to increase public involvement in that process. More public involvement may increase understanding of the process and improve public perception of the process. Further, involvement may increase public scrutiny and result in more timely completion of the process. The Special Committee concluded that it is desirable to require that a patient or client of a health care professional who has been adversely

affected by conduct of the health care professional that is the subject of a disciplinary proceeding be given the opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effects of the unprofessional conduct on the patient or client.

b. Description of Bill

Senate Bill 317 provides that, following an investigation of possible unprofessional conduct on the part of a health care professional and before a disciplinary action may be negotiated or imposed against the health care professional, a patient, as defined under the bill, must be provided an opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effect of the unprofessional conduct on the patient. The bill provides that the prosecuting attorney may confer with a patient in person or by telephone or, if the patient agrees, by any other method. It is expressly provided that the duty to confer does not limit the authority or obligation of the prosecuting attorney to exercise his or her discretion concerning the handling of a case of unprofessional conduct against the health care provider.

7. Establishment of Guidelines for Timely Completion of Disciplinary Process; Report to Legislature

a. Background

The Special Committee was apprised of and was supportive of recommendations of the DRL Ad Hoc Enforcement Advisory Committee that established specific time lines for processing disciplinary cases, once a complaint is received by the DRL Division of Enforcement. The DRL adopted the recommended time lines as department policy in February 1999. The Special Committee concluded that the establishment of time guidelines for the health care professional disciplinary process is critical for the efficient and timely completion of discipline cases and concluded that statutorily requiring the establishment of time guidelines is desirable.

b. Description of Bill

Senate Bill 317 requires the DRL to establish guidelines for the timely completion of each stage of the health care professional disciplinary process. Under the bill, the guidelines may account for the type and complexity of the case and must promote the fair and efficient processing of cases of unprofessional conduct. It is expressly provided that the guidelines are for administrative purposes, to permit the department to monitor the progress of cases and the performance of personnel handling the cases.

In addition, the bill requires that, no later than May 1, 2001, the DRL submit to the Legislature a report on the disciplinary process time lines which were implemented by the department as guidelines in February 1999. The report is required to address compliance with and enforcement of the guidelines and the effect of the guidelines on the fairness and efficiency of the disciplinary process.

8. Inclusion of Alternative Health Care Practitioners on Panels of Experts

a. Background

During its deliberations, the Special Committee discussed the issue of alternative health care as it relates to the health care professional disciplinary process. While several options were discussed by the Committee, the only proposal in this regard voted on by the Committee was to place alternative health care practitioners on any panels of experts that the DRL establishes for use on a consulting basis by health care credentialing authorities. It was suggested that including alternative health care professionals on expert panels will enhance the fairness and expertise of the panels in dealing with alternative health care issues.

b. Description of Bill

Senate Bill 317 provides that if the DRL establishes panels of health care experts to be used on a consulting basis by health care credentialing authorities, the DRL must attempt to include health care professionals who practice alternative forms of health care on the panels. The alternative health care practitioners would assist in evaluating cases involving a health care professional alleged to have practiced health care in an unprofessional or negligent manner through: (1) the use of alternative forms of health care; (2) the referral to an alternative health care provider; or (3) the prescribing of alternative medical treatment. A health care professional who practices alternative health care and who participates on a panel must be of the same profession as the health care professionals regulated by the health care credentialing authority utilizing the panel.

9. Composition of MEB

a. Background

In reviewing the current membership of the MEB (nine licensed doctors of medicine, one licensed doctor of osteopathy and three public members), some members of the Special Committee expressed concern whether the three public members might be unduly influenced by the 10 professional members. The Special Committee considered proposals to revise the membership of the MEB, including replacing two of the current professional members with two public members. At its last meeting, the Special Committee heard from representatives of the MEB, including two current public members. It was the consensus of the MEB representatives that professional expertise on the MEB is vital, that public members are not unduly influenced by professional members and that removing any of the current professional members is undesirable; however, there was no objection to increasing the number of public members on the MEB.

b. Description of Bill

Senate Bill 317 adds two public members to the MEB, resulting in a 15-member MEB with five public members, nine medical doctor members and one member who is a doctor of osteopathy. The new members will serve four-year terms.

10. Summary Limitation of Credential Issued by MEB

a. Background

Current law authorizes the MEB to summarily suspend any credential granted by it, pending a disciplinary hearing, for a period not to exceed 30 days, when the board has in its possession evidence establishing probable cause to believe: (1) that the credential holder has violated the provisions of ch. 448, Stats.; and (2) that it is necessary to suspend the credential to protect the public health, safety or welfare. [s. 448.02 (4), Stats.] The credential holder must be granted an opportunity to be heard during the process for determination if probable cause for suspension exists. The MEB is authorized to designate any of its officers to exercise the suspension authority but suspension by an officer may not exceed 72 hours. If a credential has been suspended pending hearing, the MEB may, while the hearing is in progress, extend the initial 30-day period of suspension for an additional 30 days. If the credential holder has caused a delay in the hearing process, the MEB may subsequently suspend the credential from the time the hearing is commenced until a final decision is issued, or may delegate that authority to the administrative law judge.

It was pointed out to the Special Committee that the current authority of the MEB to summarily suspend any credential granted by the MEB, while limited as to duration, is a suspension of the entire credential, i.e., no limited summary suspension of a credential is authorized. It was suggested that it would be a useful enforcement tool for the MEB to be able to summarily limit any credential issued by the MEB; thus, for example, a physician could be restricted from practicing in a certain area of practice, pending a disciplinary hearing, but be permitted to practice in nonrestricted areas. The ability to summarily limit a credential may result in increased fairness to credential holders and increased use of the summary suspension procedure by the MEB.

b. Description of Bill

Senate Bill 317 adds to the current summary suspension authority and procedure the authority to summarily limit any credential issued by the MEB.

11. Authority of MEB to Impose a Forfeiture for Certain Unprofessional Conduct

a. Background

It was suggested to the Special Committee that an additional enforcement tool that might be useful for the MEB is a civil forfeiture against a credential holder found guilty of unprofessional conduct. It was noted that certain other health care professional credentialing authorities currently have forfeiture authority, such as the Dentistry Examining Board and the Pharmacy Examining Board. [ss. 447.07 (7) and 450.10 (2), Stats.] In discussing the issue, the Special Committee concluded that exposure to malpractice awards and the cost of defending malpractice actions make unnecessary a civil forfeiture for unprofessional conduct that constitutes negligence in treatment.

b. Description of Bill

Senate Bill 317 gives the MEB authority to assess a forfeiture of not more than \$1,000 for each violation against a credential holder found guilty of unprofessional conduct; the authority to assess the civil forfeiture does not extend to a violation that constitutes negligence in treatment.

12. Reports to MEB of Reports to NPDB

a. Background

The Special Committee extensively discussed the nature and frequency of information received by the MEB concerning actions taken against credential holders in other contexts that may indicate possible unprofessional conduct on the part of the credential holder. Both state and federal law were reviewed in this regard. The Special Committee learned that federal law contains extensive reporting requirements on actions against or concerning physicians and that, under federal law, the reports must also be made to the MEB. The Special Committee learned that recent evidence suggests that compliance with the federal reporting requirements is low.

The Special Committee concluded that, rather than requiring additional or duplicative reports at the state level, a state penalty should be created for failure to submit reports to the MEB as required under federal law.

Under current law, the federal Health Care Quality Improvement Act [42 U.S.C. ss. 11111 to 11152] requires certain entities to report information on physicians to the NPDB. Specifically, 42 U.S.C. s. 11131 requires entities (including insurance companies) which make payment under an insurance policy or in settlement of a malpractice action or claim to report information on the payment and the circumstances of the payment to the NPDB. Boards of medical examiners (in this state, the MEB) must report actions which suspend, revoke or otherwise restrict a physician's license or censure, reprimand or place a physician on probation; physician surrender of a license also must be reported. [42 U.S.C. s. 11132.] In addition, under 42 U.S.C. s. 11133, health care entities (which include hospitals, health maintenance organizations, group medical practices and professional societies) must report to the NPDB: professional review actions which adversely affect the clinical privileges of a physician for longer than 30 days; the surrender of a physician's clinical privileges while the physician is under investigation or in return for not investigating the physician; or a professional review action which restricts membership in a professional society.

Federal regulations require the information on malpractice payments to be reported to the NPDB within 30 days of a payment, and simultaneously to the board of medical examiners. [45 C.F.R. s. 60.5 (a).] A payor is subject to a fine of up to \$10,000 for each nonreported payment.

Federal regulations require health care entities to report adverse actions to the board of medical examiners within 15 days (which, in turn, has 15 days to forward the report to the NPDB). [45 C.F.R. s. 60.5 (c).] The penalty for not complying with these reporting requirements is a loss of the immunity protections under the Health Care Quality Improvement Act.

b. Description of Bill

Senate Bill 317 creates a state requirement that reports on medical malpractice payments and professional review actions by health care entities that under federal law are submitted to the NPDB must be submitted to the MEB in accordance with the time limits set forth under federal law. An individual or entity who violates this requirement is subject to a forfeiture of not more than \$10,000 for each violation.

13. Indication of Certain Therapeutic-Related Deaths on Death Certificate

a. Background

The Special Committee reviewed the functions and duties of coroners and medical examiners. It was suggested by the Milwaukee County medical examiner that it might be useful, for disciplinary purposes, that the MEB and other state health care credentialing authorities be notified when a coroner or medical examiner determines that a death was therapeutic-related. Currently, there is no provision or requirement for a coroner or medical examiner to indicate a therapeutic-related death on a death certificate.

Under current s. 69.18 (2) (d) 1., Stats., if a death is the subject of a coroner's or medical examiner's determination under s. 979.01 or 979.03, Stats., the coroner or medical examiner or a physician supervised by a coroner or medical examiner in the county where the event which caused the death occurred is required to complete and sign the medical certification part of the death certificate and mail the death certificate within five days after the pronouncement of death or present the certificate to the person responsible for filing the death certificate within six days after the pronouncement of death.

Further, s. 69.18 (2) (f), Stats., provides that a person signing a medical certification part of the death certificate must describe, in detail, on a form prescribed by the state registrar, the cause of death; show the duration of each cause and the sequence of each cause if the cause of death was multiple; and, if the cause was disease, the evolution of the disease.

b. Description of Bill

Senate Bill 317 provides that when a coroner or medical examiner receives a report of a death under s. 979.01, Stats., and subsequently determines that the death was therapeutic-related, the coroner or medical examiner must indicate this determination on the death certificate. The bill creates a definition of "therapeutic-related death" based on the definition contained in the instruction manual on completing the death certificate published by the State of Wisconsin. The definition includes three types of therapeutic-related deaths: death resulting from complications of surgery, prescription drug use or other medical procedures performed or given for disease conditions; death resulting from complications of surgery, drug use or medical procedures performed or given for traumatic conditions; or death resulting from "therapeutic misadventures," where medical procedures were done incorrectly or drugs were given in error. The bill requires the state registrar to revise the death certificate to include a space in which determinations of therapeutic-related deaths may be recorded. Finally, the bill requires the coroner or medical

examiner who determines that a death is therapeutic-related to forward this information to the DRL.

Under the bill, these provisions first take effect on the first day of the sixth month beginning after publication.

B. SENATE BILL 318

1. Background

Early in its deliberations, the Special Committee learned that the DRL intends to include on its website information on completed disciplinary actions against physicians. In addition, the Special Committee heard from the Bureau of Health Care Information, DHFS, regarding DHFS's efforts to implement that portion of 1997 Wisconsin Act 231 which requires DHFS to prepare an annual consumer guide to assist consumers in selecting health care providers and health care plans. In response, members of the Special Committee expressed interest in determining whether more legislative direction concerning information on individual physicians provided by the state for the public should be considered.

The Special Committee reviewed a Massachusetts law that directs the Massachusetts Board of Registration in Medicine (the Massachusetts counterpart to the MEB) to collect certain information to create individual profiles on physicians in a format created by the board for dissemination to the public. [Annotated Laws of Massachusetts, General Laws, ch. 112, s. 5 (1998 Cumulative Supplement).] That directive resulted in an initiative known as "Massachusetts Physician Profiles." Under that initiative, information on over 27,000 individual physicians licensed to practice medicine in Massachusetts is available to the public from the Massachusetts Board of Registration in Medicine home page. The Committee also received general information on recent legislative activity in connection with state regulatory boards for health care providers educating consumers in obtaining information necessary to make decisions about health care practitioners.

The Special Committee concluded that it is desirable to have information on individual physicians available at one source for the convenience and utility it affords the public. Further, because the DRL intends to provide information on its website on state disciplinary actions against physicians, inclusion of more comprehensive information will better balance the information provided by the state. Providing information on individual physicians should enhance the public's ability to choose physicians and the public's confidence in physicians.

2. Description of Bill

Senate Bill 318: (a) directs the MEB to make available for dissemination to the public, in a format established by the MEB, specified information concerning a physician's education, practice, malpractice history, criminal history and disciplinary history; and (b) requires administrative rules of DHFS to include procedures affording health care providers the opportunity to

correct health care information collected under ch. 153, Stats. If enacted, Senate Bill 318 would take effect on the 1st day of the 12th month beginning after its publication.

The provisions of the bill relating to information on individual physicians are based on the Massachusetts law cited above. The bill requires the following information on physicians to be made available to the public:

a. Names of medical schools attended and dates of graduation; graduate medical education; and eligibility status for any specialty board certification and certification by any specialty board.

b. Number of years in practice or first year admitted to practice; location of primary practice setting; identification of any translating services that may be available at the primary practice location; names of hospitals where the physician has privileges; indication whether the physician participates in the Medical Assistance program and in the Medicare program; and, optionally, education appointments and indications whether the physician has had a responsibility for graduate medical education within the preceding 10 years.

c. A description of any felony conviction within the preceding 10 years.

d. A description of any final board disciplinary action taken within the preceding 10 years, including action taken by a licensing board of another jurisdiction that has been reported to the MEB.

e. A description of Medical Assistance program decertification or suspension within the preceding 10 years that is required to be reported to the MEB under s. 49.45 (2) (a) 12r., Stats. Under that section, DHFS is required to report any Medical Assistance decertification or suspension if the grounds include fraud or a quality of care issue.

f. A description of any loss or reduction of hospital staff privileges or resignations from hospital staff within the preceding 10 years that is required to be reported to the MEB under s. 50.36 (3) (b) and (c), Stats. Under that section, hospitals are required to report both a loss or reduction of hospital staff privileges or resignation from hospital staff due to reasons that include the quality of or ability to practice and a loss or reduction of hospital staff privileges or resignation from hospital staff for 30 days or more as a result of peer investigation for reasons that do not include the quality of or ability to practice.

g. A description of any disciplinary action taken by a health maintenance organization, limited service health organization, preferred provider plan or managed care plan within the preceding 10 years that is required to be reported to the MEB under s. 609.17, Stats. Under the bill, if the MEB determines that a reported action is the result of a business or economic decision and does not involve conduct by the physician that appears to relate to possible unprofessional conduct or negligence in treatment, the board may omit that action from the information made available to the public.

h. A description of any action taken by an insurer against a physician within the preceding 10 years that is required to be reported to the MEB under s. 632.715, Stats. Under that section, an insurer is required to report any action taken by it against a physician if the action relates to unprofessional conduct or negligence in treatment by the physician. Again, the MEB may withhold reporting the action to the public if the board determines that the action was done for business or economic reasons.

i. A description of any exclusion from participation in the Medicare program and federally approved or funded state health care programs within the preceding 10 years that is required to be reported to the MEB by the federal Department of Human Services under 42 C.F.R. s. 1001.2005.

j. A description of any medical malpractice claims paid by the patients compensation fund or other insurer within the preceding 10 years that is reported to the MEB under s. 655.26, Stats., and a description of any amount of settlement or award to a claimant in a medical malpractice action within the preceding 10 years that is required to be reported to the MEB by the director of state courts under s. 655.45, Stats.

k. Any other information required by the MEB by rule.

The information that is made available to the public under the bill must be reported in nontechnical language. Dispositions of paid medical malpractice claims must be reported in a minimum of three graduated categories, indicating the level of significance of the amount of the award or settlement. Information concerning paid medical malpractice claims must be given context by comparing the physician's medical malpractice judgment awards and settlements to the experience of other physicians in the same specialty. Information concerning medical malpractice settlements must include the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

The bill requires the MEB to utilize links to other websites that contain information on individual physicians that the board is otherwise required to provide.

The bill expressly provides that physicians are required to provide any information requested by the MEB that the MEB determines is necessary to comply with the section. The MEB is required to provide a physician with a copy of the information about him or her prior to its initial release and prior to the inclusion of any change in the information. A physician must be given a reasonable time to correct factual inaccuracies that appear in the information before the information is released to the public. Information that is made available by the MEB under the provisions of the bill is not an exception to the hearsay rule under s. 908.03 (8), Stats., and is not self-authenticating under s. 909.02, Stats.

The MEB by rule is required to determine whether and the extent to which the provisions of the bill apply to a physician who holds a temporary license to practice medicine and surgery.

Under the bill, the costs incurred by the DRL to implement the draft are funded by a surcharge on physicians' biennial license renewal fees. The DRL is directed to determine the amount necessary to fund its costs and include that amount in the department's biennial recommendation for changes in license renewal fees to cover costs funded by the fees.

Finally, Senate Bill 318 expressly requires that DHFS rules relating to health care information under ch. 153, Stats., include procedures affording health care providers the opportunity to correct health care information. Currently, the DHFS is directed to promulgate administrative rules, with the approval of the Board on Health Care Information, to, among other things, establish procedures under which health care providers are permitted to review, verify and comment on health care information collected under ch. 153, Stats. [s. 153.75 (1) (b), Stats.] Under s. 153.45 (5), Stats., DHFS may not release any health care information that is subject to those rules until there is compliance with the verification, comment and review procedures.

DD:rv;jal

APPENDIX I

JOINT LEGISLATIVE COUNCIL

s. 13.81, Stats.

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**DISCIPLINE OF HEALTH CARE PROFESSIONALS,
SPECIAL COMMITTEE ON**

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STUDY ASSIGNMENT: The Committee is directed to study procedures for imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards identified by the Special Committee, for the purpose of ensuring that such procedures are effective, fair and consistent. The Special Committee shall report its recommendations to the Joint Legislative Council by May 1, 1999. [Based on Assembly Amendment 3 to Assembly Substitute Amendment 1 to 1997 Assembly Bill 549.]

Established and Chairperson appointed by a June 24, 1998 mail ballot; members appointed by a September 4, 1998 mail ballot.

16 MEMBERS: 2 Senators; 5 Representatives; and 9 Public Members.

LEGISLATIVE COUNCIL STAFF: Don Dyke, Senior Staff Attorney; Laura Rose, Senior Staff Attorney; and Kathy Follett, Administrative Staff.

State of Wisconsin
JOINT LEGISLATIVE COUNCIL

Special Committee on Discipline
of Health Care Professionals
Senator Joanne Huelsman
Chairperson



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April 15, 1999

TO: MEMBERS, JOINT COMMITTEE ON FINANCE

FROM: Senator Joanne Huelsman, Chairperson, Special Committee on Discipline of Health Care Professionals

The Joint Legislative Council's Special Committee on Discipline of Health Care Professionals is directed to study procedures for the imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards, for the purpose of ensuring that such procedures are effective, fair and consistent. To date, the Special Committee has held six meetings.

Among the topics reviewed by the Special Committee are: (1) recent efforts of the Department of Regulation and Licensing (DRL) to enhance the efficiency and effectiveness of the credential holder disciplinary process; and (2) the provisions of 1997 Wisconsin Act 311, which contains a variety of provisions relating to regulation of physicians by the Medical Examining Board (MEB) and the DRL. The Governor's biennial budget, 1997 Senate Bill 45 and 1997 Assembly Bill 133, contains two appropriation requests that relate to these topics.

One of the budget appropriations provides \$541,000 PR for 5.0 project paralegal and 2.0 project regulation compliance investigator positions in order to extend the enforcement pilot project in the department's Division of Enforcement until June 30, 2001. The Joint Committee on Finance originally approved the pilot project and provided funding and authorization for the seven positions beginning October 1, 1998, to temporarily increase DRL enforcement staff. The pilot project was established in order to assist the Division of Enforcement in moving cases more quickly through the "legal action stage" of the complaint handling process. The "legal action" stage follows the investigative stage and only the more serious cases in which there is evidence of a violation tend to progress to this stage. The stage involves determinations as to the appropriate method of resolving a case and if the case cannot be resolved at this stage, the case moves to the formal hearing stage.

During its deliberations, the Special Committee learned that the enforcement pilot project has been successful in expediting the handling of cases through the legal action stage, thereby

reducing the number of disciplinary cases pending legal action. The expedient handling of disciplinary cases by the DRL is very important for an effective discipline process and for public confidence in that process. The Special Committee concluded that it is important to continue the pilot project and therefore supports the extension of the project included in the biennial budget bill.

Another DRL provision in the biennial budget bill appropriates \$278,100 PR to:

3. Maintain a toll-free telephone number, pursuant to 1997 Wisconsin Act 311, to receive reports of allegations of unprofessional conduct, negligence or misconduct involving a physician; and

4. Fund positions authorized under Act 311 for the purpose of providing staff to the MEB (1.5 program assistant positions and 1.5 legal assistant positions).

The enactment of 1997 Wisconsin Act 311 addressed a number of concerns regarding the physician disciplinary process and reflected the importance that the Legislature and the public give to that process. The Special Committee concluded that additional staff for the MEB will enhance the efficiency and fairness of the physician disciplinary process and that the toll-free telephone number will enhance public access to and confidence in that process. Therefore, the Special Committee supports the recommended funding to complete the implementation of the provisions of Act 311.

On behalf of the Special Committee on Discipline of Health Care Professionals, I urge members of the Joint Committee on Finance to carefully consider the Special Committee's support of the above budget provisions as the Finance Committee engages in its difficult task of recommending a budget for consideration by the full Legislature.

Thank you for your attention to this matter.

JH:wu:kjf;kjf;rv

COMMITTEE MATERIALS

Staff Materials

1. Staff Brief 98-3, *Overview--State Discipline of Health Care Professionals* (September 29, 1998)
2. Memo No. 1, *Department of Regulation and Licensing: Ad Hoc Enforcement Advisory Committee Recommendations* (October 7, 1998).
3. Memo No. 2, *Massachusetts Law on Individual Physician Profiles* (December 10, 1998).
4. Memo No. 3, *Information From the Federation of State Medical Boards of the United States, Inc.* (December 10, 1998). (Attachments distributed to Committee Members only.)
5. Memo No. 4, *The Health Care Quality Improvement Act* (December 11, 1998).
6. Memo No. 5, *Purpose of Medical Examining Board; Definition of "Unprofessional Conduct" on Part of Physicians* (January 12, 1999).
7. Memo No. 6, *Issues Relating to Medical Examiners: Death Certificate Completion and Reporting to the Medical Examining Board* (January 12, 1999).
8. Memo No. 7, *Department of Regulation and Licensing Biennial Budget Requests of Interest* (January 12, 1999).
9. Memo No. 8, *Issues Relating to Medical Examining Board Disciplinary Procedure* (January 12, 1999).
10. Memo No. 9, *Required Reporting and Records Provided to the Medical Examining Board* (January 13, 1999).
11. Memo No. 10, *Crimes Information Provided to the Department of Regulation and Licensing* (March 2, 1999).
12. Memo No. 11, *Draft Revision of Section 146.38, Stats., Prepared by State Medical Society of Wisconsin Working Group* (March 3, 1999).
13. Memorandum, *Comments From Committee Member Mary Wolverton on Drafts Before the Committee* (April 20, 1999). (Distributed to Committee Members only.)

Other Materials

1. Presentation of Marlene A. Cummings, Secretary, Wisconsin Department of Regulation and Licensing (October 8, 1998). (Distributed to Committee Members only.)

2. Pamphlet, *Statewide Physician Health Program--Compassionate assistance for Wisconsin physicians* (December 1997).
3. Handout, *Agreement by the State Medical Society of Wisconsin and the Medical Examining Board for a Statewide Impaired Physician Program* (September 12, 1984).
4. Testimony submitted by Walter R. Schwartz, M.D., Medical Examining Board (October 8, 1998).
5. Testimony submitted John C. LaBissoniere, State Medical Society of Wisconsin (October 8, 1998).
6. Testimony submitted by Mark L. Adams, General Counsel, State Medical Society of Wisconsin (October 8, 1998).
7. Booklet, *Passport to Excellence, Visiting Fellowships*, University of Wisconsin (UW)-Madison Continuing Medical Education (undated). (Distributed to Committee Members only.)
8. "Diagnoses and the Autopsies Are Found to Differ Greatly," *The New York Times* (Wednesday, October 14, 1998).
9. Flow chart of hospital disciplinary process, submitted by Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison (undated).
10. Form, *Madison (Wisconsin) Hospitals Medical Staff Application*, submitted by Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison (undated).
11. Handout, *Physician Monitoring in the Health Plan Setting*, submitted by Steven Baker, M.D., Senior Medical Director, and Wendy Potochnik, R.N., Director, Quality Management PrimeCare Health Plan, Inc. (November 18, 1998).
12. Testimony submitted by Don C. Prachthausser, Wisconsin Academy of Trial Lawyers (November 18, 1998).
13. Testimony submitted by George M. Mejicano, M.D., and Thomas C. Meyer, M.D., Office of Continuing Medical Education, Madison (November 18, 1998).
14. Handout, *Monitoring Physician Quality*, submitted by Richard Roberts, M.D., Professor of Family Medicine, UW-Madison Medical School (November 18, 1998).
15. Testimony submitted by Donald R. Rittel, Department of Regulation and Licensing (December 18, 1998).
16. Executive Summary: *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, Task Force on Health Care Workforce Regulation, Pew Health Professions Commission (October 1998).

17. Newspaper articles relating to the revocation of Dr. M. Terry McEnany's medical license, *Leader-Telegram* (February 7, 1999).
18. Letter, from Arthur Thexton, Prosecuting Attorney, Department of Regulation and Licensing (February 24, 1999).
19. Letter, from Barbara A. Rudolph, Ph.D., Director, Bureau of Health Information, Department of Health and Family Services (March 1, 1999).
20. Article, *FTC jumps on ads touting wonders of unproven care*, American Medical News (February 8, 1999). (Distributed to Committee Members only.)
21. Memorandum, *Fiscal Estimates for WLCS: 0015/P1*, from Gail Riedasch, Budget Manager, Department of Regulation and Licensing (March 4, 1999).
22. Materials distributed at the request of Public Member Candice Freil.
23. Draft letter to Joint Committee on Finance (March 10, 1999). (Distributed to Committee Members only.)
24. Letter to Joint Committee on Finance (April 15, 1999). (Distributed to Committee Members only.)
25. Chart, *Complaints Pending 1988-1998*, distributed by the Medical Examining Board (undated). (Distributed to Committee Members only.)

Public input important, doctor says

BILLS
from Page 1

bills in September for introduction to the Legislature.

One of the bills would increase public oversight of the system by adding an additional two public members to the state Medical Examining Board, which is responsible for overseeing the state's licensed medical professionals. It also would give the board more power to be proactive in stopping potentially dangerous doctors from practicing.

"The objective was to make discipline tighter," said state Rep. Gregg Underheim, R-Oshkosh, who predicted at least some of the proposed legislation would become law. Underheim was vice chairman of the special committee.

The other bill would require the board to make a variety of information about doctors — including data on their education, malpractice record, criminal background and disciplinary history — available to the public. The plan is modeled after the system in Massachusetts, where such information is easily accessible via telephone or the Internet.

The Leader-Telegram detailed the Massachusetts system in a July 1998 story contrasting it with the limited information available to the Wisconsin public at that time.

"If that passes, I would hope consumers would make use of the information on the Internet to learn more about physicians they might see," Hulseman said. "People do have to take some of their health care into their own hands."

The public information bill would provide the public one-stop shopping for data now available only in pieces from multiple sources within state government.

"At least the one bill would give people a place to go to find out about a doctor's background," said Barbara Schultz, a Menomonee woman who served on the special committee. "The way it is now most people don't even know where to look."

Schultz, who acknowledged being somewhat disappointed the bills don't provide for even tougher regulation of doctors, said committee members cited Leader-Telegram stories about questionable doctors in Eau Claire as evidence for why the doctor discipline system should be strengthened.

Hulseman said the bills likely will be introduced and referred to a committee after the next legislative

session begins Jan. 25. She hopes they could be approved by one house in February and the other in March.

"I think the bills are a step toward trying to ensure quality health care and information for consumers," she said. "I would not expect them to be too controversial."

In fact, the State Medical Society has endorsed most of the concepts in the bills, said Colleen Wilson, the group's legislative counsel, noting that doctors have an interest in maintaining a properly functioning medical board.

"A couple bad apples spoil the whole bunch, and doctors don't want their profession's reputation tarnished," Wilson said.

One element the group opposes is a requirement that coroners or medical examiners indicate all deaths they deem therapeutic-related on death certificates and forward that information to the State Department of Regulation and Licensing. State Medical Society officials believe death certificates are not scientifically reliable and thus would prefer that coroners report any questions about a death to the medical board, she said.

Schultz, whose daughter died four years ago as a result of what she alleges was medical error, is a big proponent of the proposal to add two public members to the medical board. That would mean five of the board's 15 members would be from the public, with the other 10 being doctors.

"I think we need more normal people on these boards," Schultz said. "The doctors can get so caught up in the statistics that they don't realize all this stuff affects real people."

Public members fulfill a watchdog role and ensure medical boards aren't just composed of doctors regulating their colleagues, said Rebecca LeBuhn, executive vice president of the Citizen Advocacy Center, a Washington, D.C.-based group that provides training and support for public members of health care regulatory boards.

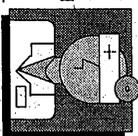
"The good ones often change the agenda," sometimes in such an important way as by shifting the focus from requiring continuing education credits to ensuring continuing competence, LeBuhn said.

While some disciplinary judgments seem to require the expertise of other doctors, Dr. James Esswein, a former medical board member from Cameron, agreed that the input of public members is important.

"We as physicians can look at something and con-

Proposed Legislation

A Wisconsin Legislative Council committee developed two bills this year involving the discipline of health care professionals. The bills, approved in September by the Joint Legislative Council for introduction to the Legislature, are expected to be considered by legislators in the spring session. Following are highlights of the provisions:



Doctor discipline bill

■ Adds two public members to the Medical Examining Board resulting in a 15-member board with five public members, nine medical doctor members and one member who is a doctor of osteopathy.

■ Authorizes the MEB to summarily limit any credential issued by the board pending a disciplinary hearing.

■ Authorizes the MEB to assess a fine of not more than \$1,000 for each violation against a credential holder found guilty of unprofessional conduct (not including negligence in treatment).

■ Requires the Department of Regulation and Licensing to develop a system for identifying health care professionals who, even if not the subject of a specific allegation of unprofessional conduct, may nonetheless warrant further evaluation and possible investigation.

■ Provides that when a coroner or medical examiner receives a report of a death and determines that it was therapeutic-related, the coroner or medical examiner must indicate that determination on the death certificate and forward the information to the DRL.

Public information bill

■ Directs the MEB to make available for dissemination to the public specified information concerning a physician's education, practice, malpractice history, criminal history and disciplinary history.

■ Requires state government to include procedures affording health care providers the opportunity to correct health care information.

Source: Wisconsin Legislative Council

Staff graphic by Kathy Nelson

sider it an accepted complication," he said. "But a public member may look at the same thing and be horrified."

Linquist can be reached at 833-9209, (800) 236-7077 or eric.linquist@ecpc.com.

Experience prompts fight to change malpractice law

DISCIPLINE
from Page 8A

Department of Regulation and Licensing documents indicate that a nurse told a state investigator she noticed a smell from Rankin that night but couldn't say for sure if it was from alcohol or something else, such as his cologne. While she couldn't state that Rankin was intoxicated, the nurse said something seemed different than usual about Rankin that night and noted that he fumbled with a collar device he was putting on Merle Fitzgerald.

"I think the state should be much more aggressive in protecting the public on these cases," said Michael Wagner, the Menomonee attorney who filed the complaint on behalf of the Fitzgeralds. "It seemed like (regulators) didn't take the complaint seriously. If that's any evidence of how the system works, then it doesn't work very well."

Temby, of the Division of Enforcement, said disciplining doctors is a challenge because it's often difficult to prove they provided incompetent care and they are entitled to the same due process rights as everyone else in a democratic society.

Donna Fitzgerald said the experience left her disappointed the medical board didn't take any action against Rankin, especially considering the extensive list of malpractice cases against him.

"Why hasn't anything been done with this guy?" she asked. "I don't think he should be allowed to practice anymore. Enough lives have been ruined already."

An unfortunate consequence of all the questions about doctor discipline is that those doubts can cause some people to lose faith in the entire medical establishment.

That's certainly true for Christine Cryson, whose tragic experience scarred her attitude about health care — probably forever. Barring major changes in the regulatory system, she expects to remain extremely suspicious of all medical providers.

"It's hard for me to tell people to trust doctors because we don't," she said. "We don't go to the doctor unless we absolutely have to."

Milosevic still holding onto Serbia despite opposition

LOOK NO FURTHER,

Medical board reviews all consumer complaints

DISCIPLINE
from Page 1

state Medical Examining Board's obligation to protect the public, said River Falls osteopathic physician Glenn Hoberg, chairman of the medical board.

"We review all complaints very closely and try to be as fair to the doctor as possible because he has a tremendous amount invested in this," Hoberg said. "We also try to give consumers a fair shake."

State gets low ranking

Public Citizen, a Washington, D.C.-based consumer watchdog group, reported that statistics show the balance of power has shifted too much in favor of doctors in Wisconsin.

The group said Wisconsin ranked 45th among the 50 states last year in terms of the rate of serious disciplinary actions per 1,000 licensed doctors. Public Citizen, which classifies license revocations, surrenders, suspensions and probation/restrictions as serious disciplinary actions, reported that Wisconsin has ranked in the lower half of states throughout the 1990s.

Wisconsin took 29 such actions in 1998, a rate of 2.24 per 1,000 doctors, or 40 percent lower than the average rate of 3.76 nationwide, according to the report based on data from the Federation of State Medical Boards. The top state was Alaska, with 15.4 serious actions per 1,000 doctors.

"There's not a shred of evidence that better doctors practice in one state or another," so the natural conclusion is that most states do a better job than Wisconsin of protecting the public from bad doctors, said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group, in an interview.

"These data raise serious questions about the extent to which patients in many states with poorer records of serious doctor discipline are being protected from physicians who might well be barred from practice in states with boards that are doing a better job of disciplining physicians," Wolfe wrote in the report. "It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top 10 performances."



McEnany

State Department of Regulation and Licensing Secretary Marlene Cummings said she thought the Public Citizen rankings were unfair to Wisconsin because they don't count license limitations — such as not allowing a doctor to do a certain kind of surgery — in the probation/restrictions category.

"We think that's a pretty strong form of discipline," she said.

Cummings also said she believes that Wisconsin regulators are better than their counterparts in other states at screening out poor doctors who seek licenses, and that the state's medical profession does an exceptional job of getting rid of problematic doctors through the peer



Staff photo by Dan Reiland

Donna and Merle Fitzgerald of Mondovi were disappointed when the state Medical Examining Board failed to discipline Eau Claire neurosurgeon Thomas V. Rankin after they filed a complaint about him, disclosing his criminal record for sales tax fraud in Pennsylvania.

Response criticized

While the story about Rankin's application deceit prompted a state investigation, consumer advocates said the resulting inaction raises serious questions about the effectiveness of doctor discipline and license application screening in Wisconsin.

The medical board has taken no action against Rankin, although it has reviewed three complaints, three malpractice settlements and one \$450,000 jury award against the surgeon. Board members also are aware Rankin lied to them on his license application and was sued for malpractice five times in Florida and once in Pennsylvania before moving his practice to Wisconsin, where he has been hit with 26 more malpractice claims.

During his six years in Wisconsin, 61 percent of the state's 84 licensed neurosurgeons had no claims, and 93

Fourteen months after Merle was injured in a car accident and bypassed a proposed surgery by Rankin, Merle is doing well but still wears a soft neck brace for certain activities.

than others," Hoberg said, explaining that the medical board may take little or no disciplinary action in cases that appear to be isolated mistakes by doctors with good records. "They're basically good doctors, so we don't want to take them out of commission for life."

In such cases, the board often views requiring further education as a more productive form of discipline than license suspension or revocation, he said.

"There's no question that when physicians make mistakes, they can have a big impact," said Jack Tandy, administrator of the state Division of Enforcement. "But that begs the question: Do we discipline people whenever they make a mistake?"

"The answer, as directed by the Legislature, is a resounding no. The Legislature has determined we should discipline license holders when they show negligence or fail to meet the minimum standards of competency but not when they just make a mistake."

But Christine Czyzson argued Martin's limited punishment shows the flaw in a system where a medical board made up of mostly doctors is in charge of disciplining other doctors.

"They won't do anything to one of their own," she said. "We can see (the process) was all for the doctor and not for the people."

Hoberg claimed that perception isn't true because doctors have an interest in maintaining a good reputation for their profession. "We doctors don't want bad doctors working in our hospitals with us, either," he said.

The Czyzsons sued the hospital and Martin, who they said hasn't spoken with them since the ill-fated surgery, for damages. The case was settled out of court. "For those who think we got a lot of cash, I say I'd trade places with you any day," Christine Czyzson said. "No amount of money could ever replace my son."



Rankin

Death spawns activism

After enduring the death of her daughter in 1995 as a result of what she alleges was medical error, Barbara Schultz of Menomonie set out to do what she could to hold doctors accountable for their actions.

Schultz, along with Patsy Miller of Menomonie, led the fight to change the state's medical malpractice law by raising the wrongful-death award cap to \$500,000 for a minor and \$350,000 for an adult.

The Schultz family is suing Dr. Roger Narwick, Red Cedar Clinic and their insurance companies for the death of Lindsey Schultz, who was a seventh-grader when she died after Narwick performed surgery to remove her appendix.

Narwick, who since has retired, hasn't been disciplined by the medical board for the case, Schultz said, adding that the investigation remains open.

"Something should have been done," she said. "I think doctor discipline in Wisconsin is terrible."

Barbara Schultz also served on a Legislative Council committee that helped develop a pair of bills intended to make more information about doctors accessible to the



Wolfe said "would be more discipline, not complaining about how statistics are computed."

Of the 536 complaints the state medical board reviewed in 1998, 53 percent of the cases were closed without discipline after review by an initial screening panel, 40 percent were closed without discipline after an investigation and 8 percent were closed after a formal disciplinary action.

The most common form of discipline involved placing some sort of limitation or condition upon the license holder. On the more severe end of the scale, the tally included zero license revocations, six surrenders and two suspensions.

Lawsuits have impact

The number of disciplines might be higher if so many people didn't immediately decide to sue after a poor experience, Cummings said, suggesting that more consumers should file complaints with the Department of Regulation and Licensing instead of running to a lawyer.

In some cases, the agency never hears details about potential violations of medical standards because out-of-court settlements may stipulate that the person suing a doctor pledge not to file a complaint with the agency, she said.

"This is a complaint-driven agency; it's not a police agency," said Patrick Brazz, director of the state's Bureau of Health Professions. "The only way we can act is if someone files a complaint."

At the other end of the scale, the medical board receives a fair number of frivolous complaints about actions that don't merit discipline, such as a doctor who failed to say hello or act friendly, Hoberg said. Still, the board reviews all consumer complaints and cases involving malpractice insurance payments.

The doctor discipline system has attracted particular attention this year in Eau Claire, where two high-profile cases of problematic surgeons have resulted in 49 malpractice claims.

A Leader-Telegram investigation revealed in February that Dr. M. Terry McElhany — the heart surgeon hired in 1993 to launch the cardiac surgery program at Luther Hospital/Middlefort Clinic — had reached an illegal, secret deal with California hospital officials to cover up his suspect medical record and allow him to practice in Wisconsin.

McElhany surrendered his California medical license after that state's medical board — responding to a complaint by a whistleblower — accused him of unprofessional conduct and incompetence in patient care. McElhany, the target of 23 malpractice claims since coming to Wisconsin, then surrendered his Wisconsin license after the medical board launched an investigation in response to the California action.

The Leader-Telegram also reported this year that Thomas V. Rankin, a neurosurgeon who has practiced at Sacred Heart Hospital since 1993, has been the target of at least four times as many malpractice claims as any other Wisconsin neurosurgeon during his tenure in Eau Claire. In September the paper detailed how Rankin lied on his Wisconsin medical license application to avoid

Supreme Court

Sacred Heart is conducting its normal peer review process of Rankin but hasn't restricted his surgical privileges, so the only thing preventing Rankin from practicing is that he voluntarily went on vacation in July and hasn't returned, hospital officials acknowledged. He also has vacated his Sacred Heart office.

As for Rankin's license application, state officials said they only do criminal background checks on doctor candidates who acknowledge having criminal records. "I'm sure some people do avoid telling us about their criminal records," Brazz said. "But if we did more criminal background checks, it would take even longer to license people, and we already get complainants that it takes too long."

James Esswein, a Cameron family practice doctor who served on the medical board from 1989 to 1997, said he didn't know if misrepresentations about criminal records were a significant problem. But when it was pointed out that the state does thousands of criminal background checks on gun buyers every year, Esswein said he couldn't see why the board couldn't conduct them too as an additional level of protection for the public.

Board's power limited
The Rankin case illustrates a key shortcoming with the medical board's disciplinary power, said Hoberg, the panel's chairman. "We have the power that as soon as we see something like that to say there's a problem here, and we're going to pursue it," Hoberg said. "But then the doctor gets a lawyer, and it's out of our hands."

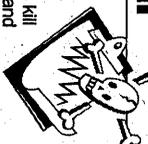
At the point a doctor challenges the board's proposed discipline, the case shifts to the court system and ultimately is decided by a judge or jury — a process that can take years to complete, he said. When the matter is tied up in court, "then we can't stop him from practicing. It's a terrible frustration," Hoberg said.

Esswein agreed that the ability of a savvy defense attorney to delay disciplinary action was one of his major frustrations as a medical board member. He recalled two particularly disturbing examples. In one case, it took the board 1½ years to stop a doctor with communicable tuberculosis from practicing. The other case involved a surgeon who was operating on patients who didn't need surgery and causing permanent injuries. It took several years before the board was able to suspend the surgeon's license.

Overall, however, those within the regulatory system stressed that they believe most Wisconsin doctors do a good job and the process for disciplining the few exceptions works adequately. "I think Wisconsin does a very good job of disciplining doctors," Cummings said, noting that her department's Division of Enforcement has made changes recently to ensure that it responds more quickly to complaints and no longer has cases that remain open for years.

Area doctor reprimanded
Gwen Martin, the doctor who operated on Cyscown's baby July 31, 1996, at Lakeview Medical Center in Rice

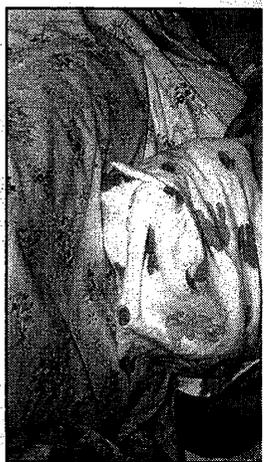
Leading Causes of Death



The Institute of Medicine recently reported that studies estimate medical mistakes kill between 44,000 and 98,000 hospitalized Americans a year. Even using the more conservative estimate, that makes medical mistakes the eighth-leading killer of Americans.

Causes	Deaths (1997)
1. Heart disease	726,974
2. Cancer	539,577
3. Stroke	159,791
4. Lung disease	109,029
5. Accidents	95,644
6. Pneumonia/flu	86,449
7. Diabetes	62,636
8. Medical mistakes	44,000
9. Suicide	30,535
10. Kidney disorders	25,331

Staff graphic by Kathy Nelson



Contributed photo

Christine Cyscown's joy over the birth of her son, Kellen, in 1996 quickly turned to sorrow when the boy died from an overdose of pain medication after stomach surgery three weeks later. The state Medical Examining Board reprimanded the doctor who wrote the prescription.

Lake, was the only west-central Wisconsin doctor disciplined this year by the medical board, which determined that morphine overdose was the cause of Kellen Cyscown's death early the following morning. The board found that Martin prescribed more than twice the appropriate dose for a baby and that she was negligent by not halting all morphine and returning to the hospital to examine the patient after a nurse informed her the patient's breathing had slowed.

The board also ruled Martin was negligent less than two months later when she was supposed to staple a female patient's rectum to the end of her colon but instead mistakenly stapled the woman's intestine to her vagina. The error forced the patient to undergo corrective surgery.

Martin's punishment was a reprimand on her record and an order to pay \$1,300 toward the cost of investigating and prosecuting the cases. She avoided an order to seek further education by voluntarily attending two pain management conferences. After Kellen's death, Lakeview Medical Center ceased doing infant surgery. Christine Cyscown called the discipline a "slap on the wrist."

"That's nothing," she said. "How many people see her permanent record? I want people to know what she did because it's her fault. I don't know what due punishment is, but I know what she got isn't enough for what she did."

Martin and Marshfield Clinic-Indianhead Center in Rice Lake, where she practices, accepted the discipline as a fair compromise with the medical board regarding an unfortunate incident, said Reed Hall, general counsel for Marshfield Clinic.

"We think a public reprimand was more than adequate," Hall said. "We looked at her entire career and thought this was an isolated situation. We have full confidence in her abilities as far as her continued care and treatment of patients."

In a letter to the Cyscowns after the case closed, Department of Regulation and Licensing prosecuting attorney Arthur Thevonen told the rural Ladysmith couple the decision to settle the case with a reprimand wasn't easy but seemed like the most prudent strategy considering how difficult it is to prove a doctor didn't use reasonable caution.

"I think a reprimand is a significant discipline," Hoberg said. "It will be on their record every time they apply for a new job. They constantly explain this for the rest of their life, and that's a horrible thing." Determining the appropriate punishment is tricky because medicine is a difficult profession in which some errors and bad outcomes are inevitable. "It's not an exact science. Some doctors are better

spring. An improved discipline system would benefit the public because doctors would raise their standards if they expected to face consequences for poor performance, Schultz said.

Continued weak discipline, by contrast, likely would result in more negligence and more unnecessary patient deaths, she said, explaining that the ultimate goal of her efforts is "to help prevent another little girl from dying."

Potential problem averted

Donna Fitzgerald's close encounter with the health care system began Oct. 9, 1998, when her husband, Merle, was transferred to Sacred Heart Hospital after a car accident in which he broke several vertebrae, fractured his skull, punctured a lung and cracked four ribs.

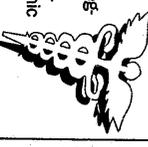
After waiting more than four hours for Rankin to show up after midnight, Donna Fitzgerald said she and her husband agreed the neurosurgeon looked disheveled, seemed impaired and smelled strongly of alcohol. After Rankin, the hospital's sole neurosurgeon at the time, recommended that he operate on Merle at 8 a.m. the next day, the Mondovi couple requested a transfer to Luther Hospital, where Merle was treated without surgery by former Luther neurosurgeon Robert Narozky.

"I thank my lucky stars I went back to the intensive care unit that night because I wasn't close enough to smell the alcohol at first," Donna Fitzgerald said. "I can't help wondering what would have happened if I hadn't gotten to the hospital in time." Even some Sacred Heart staff members told the couple at the time they were making a good decision by seeking the transfer, she said.

However, the medical board dismissed the Fitzgeralds' complaint in May without any action, citing a lack of evidence. Rankin couldn't be reached for comment, but his attorney told investigators Rankin never has had a problem with alcohol impairment.

See DISCIPLINE, Page 9A

Protecting the Public



The Pew Health Professions Commission warned in a report released last year that the system for regulating health-care professionals — because of its conflicting policies of protecting both consumers and the economic interests of health-care workers — has serious shortcomings. Recommendations for improving regulation offered by the commission, headed by former Sen. George Mitchell, included:

- Requiring individual professional boards to be more accountable to the public by significantly increasing their public members, ideally to at least a third of each board's membership.
- Requiring states to make health-care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.
- Having states require policy oversight and coordination of professional regulation through consumer-dominated boards or central agencies.
- Having Congress establish a national policy advisory body that would research, develop and publish national scopes of practice and continuing competency standards.

■ Having states require boards to provide relevant information about health-care practice licenses to the public in a comprehensible manner.

Staff graphic by Kathy Nelson

TO: Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Barbara Schultz
Menomonie, WI
Member of the Special Committee on Discipline of Health Care Professionals

DATE: February 16, 2000

RE: Public Hearing of Physician Discipline
Senate Bill 317 & 318

The State Medical Examining Board is here to protect the public from bad health care providers. But, whom are they protecting if it takes 7 years to resolve a case, and then require either more education, a removal of license, or simply to pay a fine. The disciplinary actions need to be done in a more timely manner and impose stricter disciplinary actions to be more effective in protecting the public. Wisconsin ranked a low 45th of the 50 states last year for serious disciplinary actions. As I served on this Legislative Council Study Committee last year, it was frustrating to listen to doctors on the committee refuse to admit there even is a problem. I am here to testify in favor of Senate Bill 317 & 318.

My 13-year-old daughter, Lindsey, died 4 years ago during a routine appendectomy from medical negligence. I know the pain one feels of taking your child to the hospital and going home without her. I know how shock consumes the body and your mind goes numb. A grieving family does not think about any questions that should be asked: What about an autopsy? What phone numbers are available to call? What happened? Who do I report this to? The citizens of Wisconsin need and deserve legislation that would help protect them and their loved ones from medical mistakes. Tougher discipline is one way of raising the medical standards, if the doctors expected to face consequences for poor performance.

This bill does not solve all the problems that were addressed at the committee hearings, but it is a start. We need this bill as a beginning to strengthen the disciplinary process. Please read the Eau Claire Leader article on "Discipline Prescription." This is the third large article on bad doctors and how the disciplinary process is not working as is. If we want to protect the public from such questionable doctors, state and nationwide, peer review records should be made available to the Medical Examining Board if needed during their investigations. Doctors, nurses and other hospital personnel should have a duty and exercise their right to help protect the public. They should also be able to help make their workplace a safer one. The peer review issue which is not in this bill would make this a stronger and more effective piece of legislation.

I would like to address a few of the issues that I feel are important.

- When there is an unexpected medical related death that occurs, there should automatically be an investigation. The families should be advised that an autopsy

would be recommended. When a coroner or medical examiner receives a report of a death and determines that it was therapeutic-related (medical misadventure), the coroner or medical examiner must indicate that determination on the death certificate and forward the information to the Department of Regulation and Licensing. This is a critical issue. Any wrongful death, including medical, should prompt some type of investigation.

- Adding two public members to the Medical Examining Board is very important. This would ensure that some cases the medical professionals might consider acceptable, would be investigated because the public members disagreed. I think Dr. James Esswein, a former medical board member said it best in the Eau Claire Leader story "We as physicians can look at something and consider it an accepted complication, but a public member may look at the same thing and be horrified."
- When there is an investigation, the victim or victim's family should be informed of and be able to be a part of any negotiations or hearings that may take place. This may speed up the process. Lindsey's case has never been closed. The two lawyers are still trying to negotiate. I think if the victim/family would be involved a solution would take place sooner,
The quicker we can get these cases done, the quicker that doctor will get back to work doing a better performance with his patients.

As I close, remember the general public does not have a clue as to what their options are, yet alone where to call, and what questions to ask, if an emergency arose. The patient needs to be able to find a hospital /medical clinic and expect there should be quality health care and that you and your loved one will be taken care of. This is not too much to ask.

Please vote for Senate Bill 317 and 318, in full, and consider strengthening it by adding the peer review process issue. Thank you for your time.

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**Presentation of
Paul E. Sicula
on behalf of the
Wisconsin Academy of Trial Lawyers
on
Senate Bill 317 and Senate Bill 318
to the
Senate Committee on Health, Utilities, Veterans and Military Affairs
Senator Rodney Moen, Chair
February 16, 2000**

Good afternoon, Senator Moen and members of the committee. My name is Paul E. Sicula, the legislative representative of the Wisconsin Academy of Trial Lawyers. On behalf of the Academy, I thank you for the opportunity to appear here today in support of Senate Bills 317 and 318.

The Wisconsin Academy of Trial Lawyers (WATL), established as a voluntary trial bar, is a non-profit corporation organized under the laws of the state of Wisconsin, with approximately 1,000 members located throughout the state. The objectives and goals of WATL are the preservation of the civil jury trial system, the improvement of the administration of justice, the provision of facts and information for legislative action, and the training of lawyers in all fields and phases of advocacy.

We are very pleased to support Senate Bills 317 and 318, the work product of the Legislative Council's Special Committee on Discipline of Health Care Professionals. The bills include a number of incremental improvements to the disciplinary process of the Medical Examining Board (MEB) and to the consumer's ability to make informed decisions about health care providers.

The bills contain positive steps to advance three very important goals: (1) speed up and focus the disciplinary efforts of the MEB and the Department of Regulation and Licensing; (2) increase the range of sanctions available to the MEB; and (3) make more

information available to consumers and increase participation by consumers, both those inside and outside the complaint process.

WATL has been very active in the legislative deliberations on medical malpractice and the medical disciplinary process for more than 20 years. As advocates for those injured due to carelessness, we strongly believe the medical malpractice system is needed to hold health care providers accountable for injuries caused by their carelessness. That accountability includes paying injured patients and their families for the harm done to them.

While our members serve their clients' interests directly, the medical disciplinary process is needed to serve the public at large. We believe a strong disciplinary system is necessary to set standards for licensure, hold providers accountable for other activities that may not come under the legal system, and protect the public from providers who pose a danger to society. The two systems – the civil justice system and the disciplinary system – should be considered complementary and not duplicative. Each serves its own function.

We want to emphasize again our strong commitment to strengthening the medical disciplinary system because weeding out “problem” physicians will help hold down malpractice insurance payouts and, more importantly, may prevent future needless injuries. Studies in several states, including Wisconsin, have shown that a small percentage of physicians account for a large percentage of the malpractice payouts.¹ Research has also shown malpractice claims history does have a predictive value of future claims. I have attached a copy of “The Relationship Between Physicians’ Malpractice Claims History and Later Claims: Does the Past Predict the Future?” published in the *Journal of the American Medical Association* of November 9, 1994. In the article, the authors conclude:

Claims history had predictive value, even with only unpaid claims. Small paid claims were better predictors than unpaid claims, large paid claims were better predictors than small paid claims, and multiple paid claims were better predictors than single paid claims. Claims history of all kinds is a reasonable statistical measure, e.g., for the screening purposes of the National Practitioner Data Bank.

That is why the work of the MEB is so important. As an organization, we have been critical – highly critical, at times – of the MEB. We have often viewed the MEB’s

¹ In Wisconsin’s closed claim study, the top ten physician defendants, ranked by total dollars paid out, accounted for 2.4% of the claims and 23% of the total indemnity payments. Office of the Commissioner of Insurance, “WHCLIP: Preliminary Report on Medical Malpractice in Wisconsin,” IP 13-92.

activities, especially as they relate to the quality of care cases that we deal with, to be too timid, too slow, and too lenient.

Our greatest complaint about the work of the MEB and our strongest suggestion for improvement relate to speeding up the complaint handling and investigative process. Often it is months after a medical malpractice claim is paid – long after the files have been put into storage – before lawyers for injured consumers hear from the MEB about looking at the files. Another complaint is that sometimes the MEB seems intent on “reinventing the wheel” in those cases, even when tens of thousands of dollars have already been spent investigating and litigating a case. It seems logical to ask that there be some way found to speed up this process and also to use whatever information has been developed during the medical malpractice civil case to speed up and help in the investigation and prosecution of these cases.

Senate Bill 317 addresses these concerns in Sections 3 and 4 by requiring that reports currently sent to the National Practitioner Data Bank be sent to the MEB and by formalizing the Department’s current process of establishing priorities and completion deadlines. We believe these are both positive steps.

SB 317 also contains two other provisions we believe are very important to improving the disciplinary process: (1) adding two more public members to the MEB; and (2) requiring death certificates to contain an indication whether a death is “therapeutic-related.” Both of these provisions are aimed at opening the process to consumers. The death certificate information, in particular, will help consumers who find themselves dealing with the tragic loss of a loved one.

We also want to strongly support Senate Bill 318 because it will make a great deal of important information available to consumers. The process is modeled after a Massachusetts profiling system that has been very successful. While much of the discussion in the special committee centered on the medical malpractice information that will be included in the physician profile, that is only a small part of the profile. The importance of the profile is in giving a complete picture of the physician’s training and practice, all in one place. It should provide a type of “one-stop” source for consumers.

As far as the medical malpractice information to be included, it is important to remember that much of it is already available to consumers who take the time to search it out. Currently, three different state departments have some of the information. The MEB can tell a consumer if a formal complaint has ever been considered on a certain provider; the Medical Mediation Panels System can tell a consumer if a Request for Mediation has ever been filed (but not necessarily how the case turned out); and the Patients

Compensation Fund can tell a consumer whether the Fund has ever paid a claim on behalf of a health care provider. Three different inquiries and the consumer still may not have a complete picture. SB 318 will not necessarily provide more information about medical malpractice claims, but it will make the inquiry easier and more readily available to consumers.

Finally, since the time the special committee completed its work, important public information has come out about the level of medical errors that occur all too frequently in our health care system. I have attached an article entitled "Medical Errors Said to Kill Tens of Thousands" from the November 30, 1999 *Milwaukee Journal-Sentinel*. It describes an important Institute of Medicine report that said anywhere from 44,000 to 98,000 Americans die in hospitals every year from medical mistakes. I have also attached a four-part series on medical mistakes that ran in September in the *Philadelphia Inquirer*.

The *Philadelphia Inquirer* series is particularly relevant to your consideration of SB 317 and 318 because it duplicates many of the important discussions the special committee had during its meetings. The problem of medical errors is called "by far the number one problem" in health care, by one of the country's most respected researchers. The series describes how patients and their families are often kept in the dark about errors in a story entitled "Mum is Often the Word When Caregivers Stumble." It also describes the positive results that occur when the secrecy is lifted, in a story entitled "Accepting Responsibility, by Policy." It describes the "culture of denial" that exists within the health care system, the inadequacy of the peer review system, and the stories of many consumers who suffer first from medical errors then suffer greater indignities from a system that fosters denial and cover-up.

As the series points out, there is nothing unusual about the hospitals it describes. The types of errors and the way the system handles them occur all over America. We know from experience they happen in Wisconsin.

These bills represent some positive steps that Wisconsin can take to face up to the problems of medical errors and give greater public attention to them. Thank you for the opportunity to appear in support of these bills, and I would be happy to answer any questions you may have.

The Relationship Between Physicians' Malpractice Claims History and Later Claims

Does the Past Predict the Future?

Randall R. Bovbjerg, JD, Kenneth R. Petronis, MS, MPH

Objective.—To investigate whether an association exists between physicians' past and subsequent claims of medical malpractice, particularly whether a history of even unpaid claims (\$0) or small claims (<\$30 000) predicts subsequently higher rates of claims, especially large paid claims (≥\$30 000) (all in 1990 dollars).

Data.—All medical malpractice claims closed in the state of Florida from January 1975 through August 1988 (N=20 016, 92% involving physicians), matched with the American Medical Association's Physician Masterfile on all practicing physicians in the state of Florida during that period. Claims history was automated into physician-year claims files, then partitioned into a baseline period (1975 through 1980) and a subsequent period (1981 through 1983). Inconsequential claims were excluded, ie, cases closed without a named claimant and without expense for investigation (30.4% of raw claims).

Methods.—Descriptive analysis of all physician claims; odds ratio analysis of physicians in practice throughout both periods (N=8247), comparing claims experience in baseline vs subsequent period, adjusted for specialty of practice.

Results.—For all consequential physician claims, 60% were unpaid claims, 17% were small paid claims, and 23% were large paid claims. The 8247 continuously practicing physicians had a total of 6614 claims, averaging 0.9 per year, but 59.2% of physicians had no claims in 9 years, only 13.4% had any paid claims, and 7.2% had multiple paid claims. Less than 8% of physicians had any large paid claims during the baseline period, and less than 7% had any in the subsequent period. Physicians with any baseline claims (whether paid or unpaid, small or large, single or multiple) had elevated odds of subsequent claims (whether defined as any claims, any paid claims, any large claims, or multiple claims) relative to physicians with no baseline claims. With a baseline of all small claims, the adjusted odds ratio for any subsequent claim was 2.84 (95% confidence interval [CI], 2.32 to 3.49), for any subsequent paid claim was 2.97 (95% CI, 2.34 to 3.77), for all large subsequent claims was 2.42 (95% CI, 1.76 to 3.33), and for subsequent multiple claims was 2.83 (95% CI, 2.08 to 3.86). Even having a single unpaid baseline claim approximately doubled the odds.

Conclusions.—Claims history had predictive value, even with only unpaid claims. Small paid claims were better predictors than unpaid claims, large paid claims were better predictors than small paid claims, and multiple paid claims were better predictors than single paid claims. Claims history of all kinds is a reasonable statistical measure, eg, for the screening purposes of the National Practitioner Data Bank.

(JAMA. 1994;272:1421-1426)

THE PREDICTIVE value of data on liability claims has received considerable attention.¹⁻⁵ The federal National Practitioner Data Bank on physicians⁶⁻⁸

contains information on individual physicians' paid malpractice claims, among other things. The question has arisen whether this information has any value for predicting future claims or problems with medical quality (*Am Med News*. November 16, 1992:1).⁹ In particular, should the data bank include small paid claims (currently included) and unpaid claims (currently excluded)? Congress itself evidently had some doubts, for in establishing the data bank it asked for an analysis of these questions.¹⁰ The data bank's administrators recognized the importance of this issue,¹¹ which has also received attention at the highest levels of the Department of Health and Human Services (*Am Med News*. November 16, 1992:1).¹²

See also p 1453.

Herein, we examine the value of unpaid and small claims in predicting the occurrence, size, and number of future claims. The predictive value of any claims and of only large claims was also examined for comparison.

DATA AND METHODS

Data

We obtained data concerning the malpractice claims experience of all Florida medical providers, notably including physicians. The main database used for this project, for reasons of speed and economy, was a previously created file of physician-year experience for 1975 through 1988.⁵ This file merged information from two primary data sources. The first source was the Florida Medical Professional Liability Insurance Claims file, an archival-style file that contains information on all medical li-

From the Urban Institute, Health Policy Center, Washington, DC.

Reprint requests to the Urban Institute, 2100 M St NW, Washington, DC 20037 (Mr Bovbjerg).

ability claims closed in Florida from January 1975 through August 1988, organized by year of closure. All Florida insurers and self-insurers are required by law to complete and submit a standardized form with information concerning every claims file closed by the carrier, whether there was ever any formal demand for payment or lawsuit, or any payment made. The data-reporting form was expanded for claims reported since October 1985. This file does not contain any information regarding physicians who had no claims. This archival file contains 20 016 claims, mainly involving physicians.

The second data source was the American Medical Association's Physician Masterfile. It contains descriptive and demographic information about all physicians. It allowed us to include physicians with no claims and to add characteristics for all physicians actually in practice during the study period. The preexisting analysis file used in the present analyses resulted from a merge of these two data sources.⁵

This database consists of annual records by year of exposure/occurrence for every physician in Florida. It is important that the closure year claims data have been converted to occurrence year data, so that the odds of having a claim based on that year's exposure can be calculated. For each year, there is a record for each physician listed as being in practice in the state of Florida. For those with no claims, the file contains only physician data. For those with one or more (paid or unpaid) claims, the year's record totals the number of claims each faced and the total amount of indemnity paid on their behalf. Hence, each database record contained a yearly summary of each physician's liability experience (including zero).

Preliminary descriptive analyses used the full Florida closed-claim database. Prospective analyses of physicians' claims used a database that included only the 8247 physicians who were continuously in practice (and hence had exposure to malpractice claims) in Florida during the entire study period (1975 through 1983). Physicians without continuous exposure normally either began practicing or retired during the period in question. They were not included because the main goal of these analyses was to describe how physicians' early claims experience related to their subsequent experience; a bias would have been introduced into the analysis if physicians exposed during only part of the study period were included. To analyze this relationship prospectively, the data were divided into a baseline period (occurrences in calendar years 1975 through

1980) and a subsequent period (occurrences in calendar years 1981 through 1983). The baseline was judgmentally made longer to equalize numbers of claims in each period, given that claims frequency was lower in the earlier period.

Data from post-1983 occurrences are omitted because claims may be submitted and paid long after the occurrence date. The 1983 cutoff allowed almost 5 years of runoff before the end of observation in 1988. A 5-year runoff includes about 85% of all reported claims and 80% of paid claims, according to a mid 1970s national near-census of claims.¹³ We verified that more than 80% of Florida claims occurring in 1975 also closed within 5 years, based on follow-up for the 14 years of experience available. Including more recent occurrence years would have shortened the runoff and omitted too many unclosed claims for those years, disproportionately the slower-closing, larger, more serious claims of particular interest for the analysis.¹³⁻¹⁵ Alternatively, increasing the runoff by limiting the study to a shorter period (eg, 1975 through 1983) would have substantially hurt the sample size and widened confidence intervals.

All dollar amounts in our data were adjusted to 1990 dollars. This adjustment was made using the fixed-weighted price indexes for personal consumption expenditures published each July in the Survey of Current Business (US Department of Commerce, Bureau of Economic Analysis). Malpractice average payments were rising above this index rate during this period,¹⁶ but we could not control for changing severity of injury, which at least in Florida jury awards was also rising.¹⁷ Moreover, data bank thresholds have been discussed in flat dollar terms, unadjusted for objective extent or severity of injury of the case.

Methods of Analysis

We first conducted a descriptive analysis of the distribution of indemnity awards. We tabulated frequencies (and accompanying percentages), by categories of total indemnity, for each time period and for all medical providers, for physicians only, and for four classes of physician specialty.

The main analysis focused on consequential claims, ie, those involving an actual request from a claimant or insurer expenses of investigation. Those without a claimant or investigation are considered a kind of nonclaim of little importance for analysis and for policy. Insurers and self-insurers vary in what they consider a claim and hence in what types of incidents are reported to the

state, so this definition standardized claims for analysis across reporting entities, consistent with the practice of other studies.¹⁴

The analysis used odds ratios (ORs) to measure the association of baseline claims experience with subsequent experience, controlling for physician specialty within the four classes defined by the American Medical Association: general practice, medical specialties (eg, internal medicine and gastroenterology), surgical specialties (eg, obstetrics/gynecology and ophthalmology), and other specialties (eg, psychiatry and emergency medicine). We judgmentally moved anesthesiology from other specialties to surgical specialties on the grounds that anesthesia accompanies surgery and shows similar patterns of liability claims. Individual specialty categories could not be used because there were insufficient numbers of physicians in many of the specialties.

Consequential claims experience was classified as follows for both the baseline and subsequent periods: none (no claims), all unpaid (every claim disposed at \$0), all small (every claim closed at <\$30 000), all large (every claim closed at ≥\$30 000), and indeterminate (payments were an unknown combination of multiple claims under and over \$30 000). The figure of \$30 000 was chosen because it is often proposed as the threshold amount for removing smaller claims from the data bank. California's required reporting uses this payment threshold, and it was also backed as a minimum by the American Medical Association and by former Department of Health and Human Services Secretary Louis Sullivan during his last months in office (*Am Med News*. November 16, 1992:1).

For our study's categorization, a physician with only one claim during 1 year of physician exposure is known to have had a claim equal to that year's cumulated dollar payments, which may be unpaid, small, or large. A physician with two (or more) claims is known to have all unpaid claims if total payments were \$0 and to have had all small claims if the total dollars are under \$30 000. However, a physician with two claims and payments more than \$30 000 falls in the indeterminate category, even if the total is \$1 million because it is possible that one of the two was settled at less than \$30 000. "Indeterminate" is literally true, but most physicians in this category probably faced claims predominantly more than \$30 000. Most claims are large, and the physician-year totals were generally large in the indeterminate category.

An additional OR analysis classified claims experience by number rather than

Table 1.—Distribution of Malpractice Claims in Florida, 1975 Through 1983, by Total Indemnity (1990 Dollars)*

Total Indemnity 1975-1983	Physicians Only	General Practice	Medical Specialties	Surgical Specialties	Other Specialties	All Claims
Nonclaims	6059 (32.9)	728 (37.6)	1451 (37.5)	2980 (31.1)	900 (29.6)	6074 (30.3)
Unpaid claims	7440 (40.4)	715 (37.0)	1606 (41.5)	3875 (40.4)	1244 (41.0)	8301 (41.5)
\$1-\$999	132 (0.7)	16 (0.8)	17 (0.4)	65 (0.7)	34 (1.1)	143 (0.7)
\$1000-\$4999	513 (2.8)	43 (2.2)	76 (2.0)	273 (2.8)	121 (4.0)	578 (2.9)
\$5000-\$9999	536 (2.9)	67 (3.5)	64 (1.7)	299 (3.1)	106 (3.5)	604 (3.0)
\$10000-\$19999	660 (3.6)	67 (3.5)	120 (3.1)	364 (3.8)	109 (3.6)	757 (3.8)
\$20000-\$29999	312 (1.7)	34 (1.8)	49 (1.3)	155 (1.6)	74 (2.4)	376 (1.9)
\$30000-\$49999	489 (2.7)	51 (2.6)	74 (1.9)	274 (2.9)	90 (3.0)	564 (2.8)
\$50000-\$99999	655 (3.6)	62 (3.2)	120 (3.1)	369 (3.8)	104 (3.4)	760 (3.8)
\$100000-\$499999	1222 (6.6)	117 (6.0)	221 (5.7)	682 (7.1)	202 (6.7)	1388 (6.9)
\$500000-\$999999	265 (1.4)	25 (1.3)	43 (1.1)	165 (1.7)	32 (1.1)	291 (1.5)
≥\$1000000	148 (0.8)	9 (0.5)	30 (0.8)	89 (0.9)	20 (0.7)	180 (0.9)
Total	18431 (100.0)	1934 (100.0)	3871 (100.0)	9590 (100.0)	3036 (100.0)	20016 (100.0)
Nonclaims	6059 (32.9)	728 (37.6)	1451 (37.5)	2980 (31.0)	900 (29.6)	6074 (30.3)
Unpaid claims	7440 (40.4)	715 (37.0)	1606 (41.5)	3875 (40.4)	1244 (41.0)	8301 (41.5)
Small claims (<\$30000)	2153 (11.7)	227 (11.7)	326 (8.4)	1156 (12.1)	444 (14.6)	2458 (12.3)
Large claims (≥\$30000)	2779 (15.1)	264 (13.7)	488 (12.6)	1579 (16.5)	448 (14.8)	3183 (15.9)
Total	18431 (100.0)	1934 (100.0)	3871 (100.0)	9590 (100.0)	3036 (100.0)	20016 (100.0)

*Values are numbers (percentages).

Table 2.—Distribution of Malpractice Claims in Florida, 1975 Through 1980, by Total Indemnity (1990 Dollars)*

Total Indemnity 1975-1980	Physicians Only	General Practice	Medical Specialties	Surgical Specialties	Other Specialties	All Claims
Nonclaims	3599 (35.1)	419 (37.7)	807 (40.4)	1828 (34.2)	545 (30.4)	3601 (34.6)
Unpaid claims	4186 (40.8)	430 (38.7)	821 (41.1)	2192 (41.0)	743 (41.4)	4263 (41.0)
Small claims (<\$30000)	1094 (10.7)	137 (12.3)	137 (6.9)	580 (10.8)	240 (13.4)	1126 (10.8)
Large claims (≥\$30000)	1369 (13.4)	124 (11.2)	235 (11.8)	747 (14.0)	263 (14.7)	1412 (13.6)
Total	10248 (100.0)	1110 (100.0)	2000 (100.0)	5347 (100.0)	1791 (100.0)	10402 (100.0)

*Values are numbers (percentages).

dollars of claims: none (no claims), single unpaid (only one claim disposed at \$0), multiple unpaid (more than one claim closed at \$0), single small (only one claim closed at \$1 to \$29 999), single large (only one claim closed at ≥\$30 000), and multiple paid (more than one claim settled at ≥\$1, probably containing mainly large claims but not in every case).

Subsequent claims experience was related to baseline as follows: (1) any claim (all unpaid, all small, all large, or indeterminate) vs none; (2) any paid claim (all small, all large, or indeterminate) vs unpaid or none; (3) any large claim (all large or indeterminate) vs small or none; and (4) multiple claims (multiple unpaid or multiple paid) vs single or none.

We used ORs¹⁸⁻²⁰ to measure the relationship between baseline and subsequent experience. Where outcomes are infrequent, ORs approximate relative risks.^{19,20} The goal of the analysis was to quantify the value of payment size and number of payments as predictors of the occurrence, payment size, and number of later claims. All ORs were first calculated without adjusting for physician specialty type, but those presented herein were adjusted for physician specialty with use of the Mantel-Haenszel method.¹⁹ Estimates were accompanied by 95% confidence intervals to quantify their variability; intervals not contain-

ing the value 1.0 are statistically significant at the .05 level. This approach was consistent with that of parallel investigations by other investigators using different databases.^{21,22}

RESULTS

The study period included 20016 closed claims, of which 18431 (92%) involved physicians practicing at any time during these 9 years (Table 1). Slightly more than half of the physician claims were in the surgical specialties. Similar patterns in overall claims were found in both baseline and subsequent periods, except that the physician share of total claims dropped somewhat (10248 of 10402, declining to 8183 of 9614; Tables 2 and 3).

For the entire study period, 32.9% of claims against physicians and 30.3% of all claims were closed without a named claimant and without expense for investigation (Table 1). (These nonclaims were not used for OR analysis.) Unpaid claims constituted the largest single category—about 40% of all claims for both physicians and all providers. Small paid claims (<\$30 000) constituted 11.7% of claims against physicians, and large paid claims (≥\$30 000) constituted 15.1%. The distribution of awards by total indemnity was very similar across the four specialty classes. The most frequent cat-

egory of paid physician claims was \$100 000 to \$499 999 (6.6%, with 26.8% paid in all). Less than 1% of total claims by any category closed for \$1 million or more (1990 dollars).

The distributions of payments during the baseline period (Table 2) and the subsequent period (Table 3) were similar. However, claim size rose for most physician classes. Large physician claims were 13.4% in the baseline period, compared with 17.2% in the subsequent period. Similar increases occurred within all specialty classes, except "other specialties." Small claims against physicians also increased but by less, from 10.7% to 12.9%, across all specialty classes, except general practice, where the percentage of small claims decreased. Unpaid claims remained at the same percentage. Million-dollar payments for all physicians increased from 0.7% at baseline to 1.0% subsequently (data not presented). For medical specialties, million-dollar payments increased from 0.5% to 1.1%; other specialties had a decline from 0.8% to 0.5%. Moreover, physician claims per year increased (from 10248 for 6 baseline years to 8183 for less than 3 subsequent years; Table 3 vs Table 2). Consequential claims increased even more, as nonclaims against physicians decreased from 35.1% to 30.1% of the total.

Table 3.—Distribution of Malpractice Claims in Florida, 1981 Through 1983, by Total Indemnity (1990 Dollars)*

Total Indemnity 1981-1983	Physicians Only	General Practice	Medical Specialties	Surgical Specialties	Other Specialties	All Others
Nonclaims	2460 (30.1)	309 (37.5)	644 (34.4)	1152 (27.2)	355 (28.5)	2473 (25.7)
Unpaid claims	3254 (39.8)	285 (34.6)	785 (42.0)	1683 (39.7)	501 (40.2)	4038 (42.0)
Small claims (<\$30 000)	1059 (12.9)	90 (10.9)	189 (10.1)	576 (13.6)	204 (16.4)	1332 (13.9)
Large claims (≥\$30 000)	1410 (17.2)	140 (17.0)	253 (13.5)	832 (19.6)	185 (14.9)	1771 (18.4)
Total	8183 (100.0)	824 (100.0)	1871 (100.0)	4243 (100.0)	1245 (100.0)	9614 (100.0)

*Values are numbers (percentages).

Table 4.—Odds Ratios (ORs) for Incurring Any Claim, 1981 Through 1983

Baseline, 1975-1980 Claims	1981-1983 Claims		Specialty-Adjusted OR	95% Confidence Interval
	Any	None		
None	903	4886	1.00	Reference
All unpaid	431	918	2.33	2.03-2.67
All small	184	300	2.84	2.32-3.49
All large	173	310	2.57	2.09-3.15
Indeterminate	68	74	3.95	2.80-5.57
Total	1759	6488	...	...
None	903	4886	1.00	Reference
Single unpaid	303	714	2.15	1.84-2.51
Multiple unpaid	128	204	2.94	2.32-3.72
Single small	90	181	2.39	1.82-3.13
Single large	73	170	2.06	1.54-2.75
Multiple paid	262	333	3.45	2.87-4.15
Total	1759	6488	...	...

The OR analysis applied to the 8247 Florida physicians continuously in practice from 1975 through 1983 (Tables 4 through 7). They incurred 6614 consequential claims during these 9 years, not including nonclaims excluded from analysis. The analysis of these continuously practicing physicians hence covers 53.5% of consequential claims incurred by all physicians (6614/[18 431-6059] [the denominator equals the total claims in Table 1 less nonclaims]). Of the study cohort, 4886 physicians (59.2%) had no claims at all during the baseline period (Table 4), 2458 (29.8%) had any claim (paid or unpaid), 1109 (13.4%) had any paid claim, 625 (7.6%) had any large claims, and 927 (11.2%) had multiple claims. Subsequently, 1759 (21.3%) had any claim, 910 (11.0%) had any paid claim, 494 (6.0%) had any large claim, and 543 (6.6%) had multiple claims (calculated from Tables 4 through 7).

Tables 4 through 7 show the ORs for subsequent claim experience, given particular baseline experience. Only ORs adjusted for specialty class are presented; unadjusted ORs are uniformly higher (and are not presented). The odds of having any subsequent claim (paid or unpaid) were more than twice as high for physicians with any type of baseline claim than for physicians with no baseline claims (ie, none) (Table 4). Physicians with unpaid baseline claims (all unpaid, single unpaid, and multiple unpaid) were 2.15 to 2.94 times more likely to have any claim in the subsequent pe-

riod than those with no baseline claims. For physicians with a single small baseline claim, the OR was 2.39; for all small claims, the OR was 2.84. Physicians with a single large baseline claim had an OR of 2.06; those with all large baseline claims had an OR of 2.57. Physicians with indeterminate (multiple, mostly ≥\$30 000) or multiple paid claims during baseline were most likely to have any subsequent claim (ORs, 3.95 and 3.45). All ORs were statistically significant.

Table 5 depicts the ORs of experiencing any paid subsequent claim. For physicians with any type of baseline claim relative to none, adjusted ORs were all 1.85 or higher. For all unpaid baseline claims, the OR was 1.87 (1.85 for single unpaid and 2.04 for multiple unpaid) (Table 5, adjusted ORs). For all small baseline claims, the adjusted OR was 2.97; for single small baseline claims, the adjusted OR was 2.42; and for single large baseline claims, the OR was 1.92. The highest ORs for any paid subsequent claim were among physicians with indeterminate or multiple paid baseline claims (ORs, 4.46 and 3.57). All ORs were statistically significant.

Table 6 shows ORs for any large subsequent claim. Physicians with any type of baseline claim had ORs of at least 1.88 (Table 6, adjusted ORs). Physicians with all unpaid baseline claims had an OR of 1.89 (1.88 for single unpaid and 2.01 for multiple unpaid). Physicians with all small claims at baseline had an OR of 2.64; those with a single small claim had

an OR of 2.39. Physicians with indeterminate or multiple paid baseline claims had the highest ORs for subsequent large claims (3.87 and 3.42). All of these ORs were statistically significant. The category single large baseline claims was by far the smallest in the study (n=15) and had the only nonsignificant OR in the study.

Table 7 shows ORs for multiple subsequent claims. Physicians with any type of baseline claim were more than twice as likely to have multiple claims subsequently as were physicians with no baseline claims. The ORs for only unpaid claims at baseline (all unpaid, single unpaid, and multiple unpaid) ranged from 2.11 to 3.54 (Table 7, adjusted ORs). For a baseline of all small claims, the OR was 2.83; for a single small or a single large baseline claim, the OR was about 2.4. The highest ORs were for baselines of indeterminate or multiple paid claims (ORs, 6.83 and 4.05). All ORs were statistically significant.

Tables 4 through 7 show that physicians with any baseline claim, even a single small claim, have a statistically higher chance of experiencing any subsequent claims than physicians with no baseline claims. The ORs were uniformly lower after adjusting for class of physician specialty. In general, the physician class "other specialties" had higher ORs than the other three classes, which tended to have similar ORs. The adjusted OR, being a weighted average, gave less weight to "other specialties" than to the three lower-risk specialties and produced a lower estimate.

Companion OR studies involving data from New Jersey²¹ and Maryland²² also found predictive power in physicians' claims history.

COMMENT AND IMPLICATIONS FOR POLICY

First, our results suggest that malpractice claims remain relatively rare in the life of a physician, even in Florida, a very litigious state that ranks at the top of charts on premiums by specialty.²³ Among the 8247 physicians observed during almost 9 years in continuous practice, 59.2% faced no consequential claim whatsoever (ie, excluding those nonclaim case files in which no claimant came forward and the insurer spent no money on

investigation). Only 13.4% had any paid claims, and only 7.2% had multiple paid claims. Nonclaims declined as a share of total claims from 1975 through 1980 to 1981 through 1983. The cause of this rise in the percentage of consequential claims is unknown. It may reflect more accurate incident reporting by medical professionals or more litigious patients. The latter would be consistent with the observed rise in claims per physician-year. The distribution of award size shifted to become somewhat higher in the subsequent period, which means that the cost of paying malpractice claims increased faster than prices in general in the economy. To what extent more severe injuries might have been involved could not be determined.

Second, despite their rarity, malpractice claims have predictive power. The results strongly indicate that a Florida physician's early claims history is statistically related to subsequent claims history. Whether categorized by size in 1990 dollars (unpaid, small, or large) or by numerical frequency (single or multiple), having any baseline claims at all puts a physician at substantially higher risk of having subsequent claims of all categories. Again, whether measured by size or frequency, all results but one small category met the conventional .05 level of statistical significance.

Third, this predictive power makes claims history useful information for various purposes. Liability insurance underwriters have always been interested in claims history,²⁴ and there are good arguments for them to use it to "experience-rate" premiums and to decide whether an applicant for coverage is insurable.^{1,4,25-27} The use of claims history as part of quality monitoring is much more controversial,^{2,9,27} even though no one proposes that any action should be based solely on the existence of a reported paid claim.

It is not widely understood that data bank malpractice data are not gathered for their own sake but only as one input for peer review. Peer review was the prime focus of the Health Care Quality Improvement Act of 1986; it was put first, in Part A. Amid concern about undue legal intervention in peer review, notably from antitrust lawsuits,^{28,29} Congress recognized its value and sought to insulate it from most lawsuits (Act, §402). The data bank came second, in Part B, and paid malpractice claims are only one of three types of reportable information. Claims data are only available to bolster peer review and the actions of licensing boards; allowance of discovery in subsequent malpractice cases was eliminated by amendment, and data are not available to the public. Peer reviewers are not

Table 5.—Odds Ratios (ORs) for Incurring Any Paid Claim, 1981 Through 1983

Baseline, 1975-1980 Claims	1981-1983 Claims		Specialty-Adjusted OR	95% Confidence Interval
	Any Paid	Unpaid/None		
None	453	5336	1.00	Reference
All unpaid	204	1145	1.87	1.56-2.25
All small	113	371	2.97	2.34-3.77
All large	94	389	2.38	1.86-3.06
Indeterminate	46	96	4.46	3.06-6.48
Total	910	7337	...	...
None	453	5336	1.00	Reference
Single unpaid	148	869	1.85	1.51-2.26
Multiple unpaid	56	276	2.04	1.49-2.79
Single small	52	219	2.42	1.76-3.34
Single large	38	205	1.92	1.34-2.75
Multiple paid	163	432	3.57	2.89-4.41
Total	910	7337	...	...

Table 6.—Odds Ratios (ORs) for Incurring Any Large Claim (≥\$30 000), 1981 Through 1983

Baseline, 1975-1980 Claims	1981-1983 Claims		Specialty-Adjusted OR	95% Confidence Interval
	Any Large	Small/None		
None	241	5548	1.00	Reference
All unpaid	114	1235	1.89	1.49-2.39
All small	60	424	2.64	1.94-3.59
All large	53	430	2.42	1.76-3.33
Indeterminate	26	116	3.87	2.46-6.09
Total	494	7753	...	...
None	241	5548	1.00	Reference
Single unpaid	83	934	1.88	1.45-2.45
Multiple unpaid	31	301	2.01	1.35-3.00
Single small	29	242	2.39	1.58-3.63
Single large	15	228	1.38	0.80-2.37
Multiple paid	95	500	3.42	2.63-4.44
Total	494	7753	...	...

Table 7.—Odds Ratios (ORs) for Incurring Multiple Claims, 1981 Through 1983

Baseline, 1975-1980 Claims	1981-1983 Claims		Specialty-Adjusted OR	95% Confidence Interval
	Multiple	Single/None		
None	238	5551	1.00	Reference
All unpaid	141	1208	2.43	1.95-3.03
All small	63	421	2.83	2.08-3.86
All large	62	421	2.80	2.07-3.80
Indeterminate	39	103	6.83	4.58-10.20
Total	543	7704	...	...
None	238	5551	1.00	Reference
Single unpaid	90	927	2.11	1.63-2.72
Multiple unpaid	51	281	3.54	2.54-4.92
Single small	30	241	2.48	1.65-3.73
Single large	25	218	2.42	1.55-3.77
Multiple paid	109	486	4.05	3.14-5.23
Total	543	7704	...	...

to take malpractice payment(s) even as raising a presumption that malpractice actually occurred (Act, §427[d]). The relationship of claims data of the type reported herein to medical quality is only partly documented as a general matter³⁰; specific instances remain for targeted, case-by-case peer review to investigate.

Even so, the data bank has been controversial, especially for including small malpractice payments, alleged to be mainly nonmeritorious "nuisance claims"^{19,28} paid only to avoid costs of litigation and not because defendants failed to provide adequate care. Yet a baseline of one or more small claims has slightly more im-

fact than a history of large claim(s) in raising the odds of subsequent claims of all sizes (ORs, 2.39 to 2.97 vs 1.92 to 2.80). We strongly suspect, however, that indeterminate and multiple paid categories consist mainly of large claims and that their ORs are higher yet. The underlying intuition about claims size is that suspected mistakes can lead to either costly or noncostly claims, depending on other circumstances. There does not appear to be a category of physician subject only to small consequences. For instance, the lower-risk medical specialties as a class are more likely to have relatively smaller claims compared with the higher-risk surgical specialties, but for neither class of physicians does there seem to be a subclass subject only to small claims.

Among paid physician claims, about 44% were small, ie, less than \$30 000 in 1990 dollars (Table 1, 2153/2153+2779). This proportion rises to about 54% if small is defined as less than \$50 000. However, if only Florida practitioners with large paid baseline claims (\geq \$30 000) had been identified in our study, only 16.0% (53/494) of the physicians subsequently having any large claim could have been predicted in advance (Table 6). Some 35.2% (174/494) of all subsequent large claims occurred among physicians with all small or all unpaid baseline claims. It is difficult to see how the

data bank would be made more accurate by dropping small claims.

Unpaid claims are even more controversial. They are often not used for experience rating, for example,²³ and were intentionally omitted from the data bank. Yet even unpaid claims have substantial predictive power (adjusted ORs, 1.87 to 2.94), although less than small claims. For the period studied in Florida, the inclusion of unpaid claims (but not non-claims) would have somewhat more than doubled the number of claims to be reported (Table 1). However, adding unpaid claims would not add proportionately to reporting cost, as they contain less information to code. Most controversial of all, these results can be interpreted to support reporting claims as they open. Even though a newly opened claim's ultimate merits and size are clearly unknown, the mere fact of a claim does have predictive power, and this information has the virtue of being available long before claims are closed. Any such requirement, however, would add substantially to the number of claims reports (each very short). Including open claims only when multiple claims occur within a certain period may have more merit. Where a physician changed insurers, the subsequent company would need to know the physician's claims history, but insurers generally get histo-

ries for underwriting purposes in any case. Adjusted ORs for multiple unpaid baseline claims are similar to those for a single large baseline claim (OR ranges, 2.01 to 2.94 and 1.92 to 2.42, respectively). Another report suggests that almost all Maryland physicians who ultimately have a very large number of claims (five or more in 12 years) have three or more claims filed within a 3-year period,²² suggesting another way of limited "targeting" based on open claims.

Finally, it should be noted that this analysis does not address the dollar cost of reporting compliance, nor does it seek to look behind the bald fact of claims outcomes to any estimate of true merit. Claims history is not a measure of technical medical competence and is certainly no measure of the value of a physician to society. However, it does indicate a measurable cost—the fiscal and emotional costs of resolving the malpractice claim. The predictive information inherent in claims, even small claims, could be used to reduce these costs.

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Medical errors said to kill tens of thousands

Report cites flaws in how hospitals function, sets goal of 50% reduction

By LAURAN NERGAARD
Associated Press

Washington — Medical mistakes kill anywhere from 44,000 to 98,000 hospitalized Americans a year, says a new report that calls the errors stunning and demands major changes in the nation's health care system to protect patients.

The groundbreaking report by the Institute of Medicine says there are ways to prevent many of the mistakes and sets as a minimum goal a 50% reduction in medical errors within five years.

The institute cited two studies that estimate hospital errors cost at least 44,000 and perhaps as many as 98,000 lives, but research on the topic is unable to be more precise.

Even the lower figure exceeds the number of people who die annually from highway accidents (about 43,450), breast cancer (42,300) or AIDS (16,500), the study says.

The problem is less a case of recklessness by individual doctors or nurses than it is the result of basic flaws in the way hospitals, clinics and pharmacies operate, the report says.

Doctors' notoriously poor handwriting too often leaves pharmacists squinting at tiny paper prescriptions. Did the doctor order 10 milligrams or 10 micrograms? Does the prescription call for the hormone replacement Premarin or the antibiotic Primaxin?

Too many drug names sound

Please see MISTAKES page 10

Mistakes/Thousands die in medical mishaps

From page 1

alike, causing confusion for doctor, nurse, pharmacist and patient alike. Consider the painkiller Celebrex and the anti-seizure drug Cerebyx, or Narcan, which treats morphine overdoses, and Norcuron, which can paralyze breathing muscles.

Medical knowledge grows so rapidly that it is difficult for health care workers to keep up with the latest treatment or newly discovered danger. Technology poses a hazard when device models change from year to year or model to model, leaving doctors fumbling for the right switch.

And most health professionals do not have their competence regularly retested after they are licensed to practice, the report says.

Indeed, health care is a decade or more behind other high-risk industries in improving safety, the report says. It points to the transportation industry as a model: Just as engineers designed cars so they cannot start in reverse and airlines limit pilots' flying time so they're rested and alert, so can health care be improved.

"These stunningly high rates of medical errors ... are simply unacceptable in a medical system that promises first to 'do no harm,'" wrote William Richardson, president of the W.K. Kellogg Foundation and chairman of the institute panel that compiled the report.

In recent years, researchers have begun coming up with ways to avert medical mistakes. Some hospitals now use computerized prescriptions, avoiding the handwriting problem and using software that warns if a particular patient should not use the prescribed drug. Many hospitals now mark patients' arms or legs — while they're awake and watching — to prevent removal of the wrong limb. Anesthesiologists made their field safer by getting manufacturers to standardize anesthesia equipment from one model to the next. The Food and Drug Administration is trying to prevent new drugs from hitting the market with sound-alike names.

But the Institute of Medicine concluded that reducing med-

ical mistakes requires a bigger commitment, and recommended some immediate steps:

■ Establish a federal Center for Patient Safety in the Department of Health and Human Services. Congress would have to spend some \$35 million to set it up, and it should eventually spend \$100 million a year in safety research, even building prototypes of safety systems. Still, that represents just a fraction of the estimated \$8.8 billion spent each year as a result of medical mistakes, the report calculates.

■ The government should require that hospitals, and eventually other health organizations, report all serious mistakes to state agencies so experts can detect patterns of problems and take action. About 20 states now require such reports, but how much information they require and what penalties they impose for errors varies widely, the report says.

■ State licensing boards and medical accreditors should periodically re-examine health practitioners for competence and knowledge of safety practices.

"Any error that causes harm to a patient is one error too many," said Nancy Dickey, past president of the American Medical Association, which already has started a National Patient Safety Foundation designed to address some of these issues.

But she cautioned that some of the changes will be difficult because doctors do face large liability for any mistake. "We may know to talk about a culture of safety, but we still live in an environment of blame," she said.

The Institute of Medicine is part of the National Academy of Sciences, a private organization chartered by Congress to advise the government on scientific matters.

The New York Times contributed to this report.

To read a four-part Knight Ridder series on medical mistakes that the Journal Sentinel ran in September, go to www.jsonline.com.



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Health care's deadly secret: Accidents routinely happen

First of four parts

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**By Andrea Gerlin
INQUIRER STAFF WRITER**



Walter Nawracay died after brain surgery.

The Medical College of Pennsylvania Hospital is a typical teaching hospital. It is known for cutting-edge research programs, for training medical students and newly graduated doctors, and for providing advanced medical care.

It is also representative of modern American hospitals in another respect: In the last decade alone, records show, hundreds of MCP Hospital patients have been seriously injured, and at least 66 have died after medical mistakes.

The hospital's internal records cite 598 incidents reported by medical professionals to the hospital administration in the last decade. In some of those cases, patients or survivors were never told that the injuries were caused by medical errors. None of the doctors involved in the incidents was subjected to disciplinary action.

For patients of all ages, serious injury and death caused by medical errors are well-known facts of life in the medical community. But they are rarely reported to the general public.

MCP Hospital's records came to light only because of bankruptcy proceedings last year, when its new owner publicly filed a detailed account of the 598 incidents reported at the facility from January 1989 through June 1998.

Those numbers mirror what is happening across the country. Lucian Leape, a Harvard University professor who conducted the most comprehensive study of medical errors in the United States, has estimated that one million patients nationwide are injured by errors during hospital treatment each year and that 120,000 die as a result.

That number of deaths is the equivalent of what would occur if a jumbo jet crashed every day; it is three times the 43,000 people killed each year in U.S. automobile accidents.

"It's by far the number one problem" in health care, said Leape, an adjunct professor of health policy at the Harvard School of Public Health.

In their study, Leape and his colleagues examined patient records at hospitals throughout the state of New York. Their 1991 report found that one of every 200 patients admitted to a hospital died as a result of a hospital error.

Researchers such as Leape say that not only are medical errors not reported to the public, but those reported to hospital authorities represent roughly 5 to 10 percent of the number of actual medical mistakes at a typical hospital.

"The bottom line is we have a system that is terribly out of control," said Robert Brook, a professor of medicine at the University of California at Los Angeles. "It's really a joke to worry about the occasional plane that goes down when we have thousands of people who are killed in hospitals every year."

Brook's recognition of the extent of hospital errors is shared by many of medicine's leaders.

The chief executive officer of the University of Pennsylvania Health System, William N. Kelley, also acknowledges that too many medical errors occur. "It is a major problem in this country that we have got to deal with better than we have," Kelley said.

In bankruptcy proceedings last year, Tenet Healthcare Corp. - which bought eight Philadelphia-area hospitals, including MCP, from the bankrupt Allegheny health system - publicly filed an account of medical errors reported at MCP from 1989 through the first half of 1998. Such documents, maintained by hospitals for legal and insurance reasons, are routinely kept confidential.

The Inquirer sent written requests seeking similar information from 34 other large hospitals in Philadelphia. Of 25 that responded, all declined to provide similar insurance reports, citing patient confidentiality. Tenet declined to provide comparable data for MCP since it acquired the hospital.

Contained in the MCP records is a history of one hospital's experience, providing an unprecedented glimpse into the extent and nature of hospital mistakes.

The cases run the gamut from benign to fatal, and involve patients whose health status ranged from young and vital to old and infirm. They include:

Four patients who died after they received too much medication, the wrong medication, or no medication.

Surgical "misadventures" during which patients' organs were punctured or blood vessels were pierced.

An epilepsy patient who died and another who was left paralyzed on one side after suffering brain hemorrhages during surgery by inexperienced and inadequately supervised residents. In those two cases, four doctors at MCP later signed a letter to a hospital administrator saying that mistakes by unsupervised surgical residents "resulted in the unfortunate death of one of our patients."

Two middle-age patients who died following cardiac emergencies - men who according to hospital records did not receive proper or timely treatment from emergency room residents. One man sat in the emergency room with dangerously elevated blood pressure for more than seven hours before dying of a heart attack.

An 18-year-old man who received the wrong type of blood in a transfusion after an automobile accident, and died after an apparent hemolytic reaction to the blood.

Eight surgical patients who required second operations to retrieve sponges, cotton or metal instruments left inside their bodies.

Inadequate intensive-care monitoring, which delayed response to a mother of two who had stopped breathing. She was left permanently brain-damaged.

The Allegheny Health, Education and Research Foundation, which owned MCP until November, declined to comment. Tenet, the hospital's current owner, declined to discuss specific cases and events at the hospital preceding its ownership.

A Tenet executive said the company is aggressive and systematic in monitoring the quality of care at the 130 hospitals it owns across the country. He said Tenet takes steps including conducting audits of hospitals to make sure they comply with laws and standard clinical practices; surveying its hospitals' performance; and reviewing adverse events on a case-by-case basis to determine whether to take action.

As of June 30, 1998, the date of the MCP report, the hospital's insurers had paid roughly \$30 million - excluding legal costs - in settlements or jury awards in 76 of the 266 cases that resulted in lawsuits. The figures include five cases settled for more than \$1 million each.

Lawyers for MCP, a 400-bed hospital in East Falls, have consistently denied the hospital's liability in lawsuits arising from errors. The hospital's own records suggest that its experience is no different from that of most hospitals in America. Medical-error experts from across the country to whom The Inquirer provided the report characterized the type and frequency of medical errors at MCP as typical of modern hospitals.

"I find nothing in there that's beyond the average," said Donald Berwick, a pediatrician who is president and chief executive officer of the Institute for Healthcare Improvement, a nonprofit organization based in Boston.

In addition, Philadelphia's medical malpractice lawyers, who devote their days to finding hospital mistakes, do not consider MCP Hospital out of the ordinary. "I've never heard anyone say 'don't let your relatives go to MCP,'" said Gerald A. McHugh Jr., who was president of the Philadelphia Trial Lawyers Association until June.

The MCP doctors who treated patients included in the report had a wide range of expertise. Some were first-year doctors-in-training, or residents, working under the supervision of attending doctors. Others were veteran faculty who had graduated at the top of their medical school classes and are regarded by their colleagues as among the most competent in their specialties.

None of the 40 doctors involved in some of the most serious mistakes at MCP was ever subjected to disciplinary action by the state Bureau of Professional and Occupational Affairs, according to an agency spokeswoman.

"Most people in health care really try hard, but they're human and they make mistakes," said Harvard's Leape, a coauthor of the "Harvard Medical Practice Study." Said Leape: "Physicians are not infallible."

Leape added: "No nurse or doctor wants to hurt somebody, and every nurse and doctor has hurt somebody. They don't want to do it again."

Because most medical mistakes do not go beyond hospital walls, experts say, an estimated 2 to 10 percent of all cases involving medical error result in lawsuits.

"Because of the surveillance climate in health care, the tendency is not to report errors, but to conceal them or explain them away," said Berwick.

The Inquirer also identified instances in which hospital staff did not tell patients or their relatives about errors in medical care - errors that staff viewed as serious enough to warrant informing hospital administrators. Those instances document how medical errors are sometimes concealed from patients through evasion and

deception.

Based on an examination of hospital and court records, as well as interviews with patients, doctors and lawyers, what follows are case studies of MCP patients who were listed in the records kept by the hospital.

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