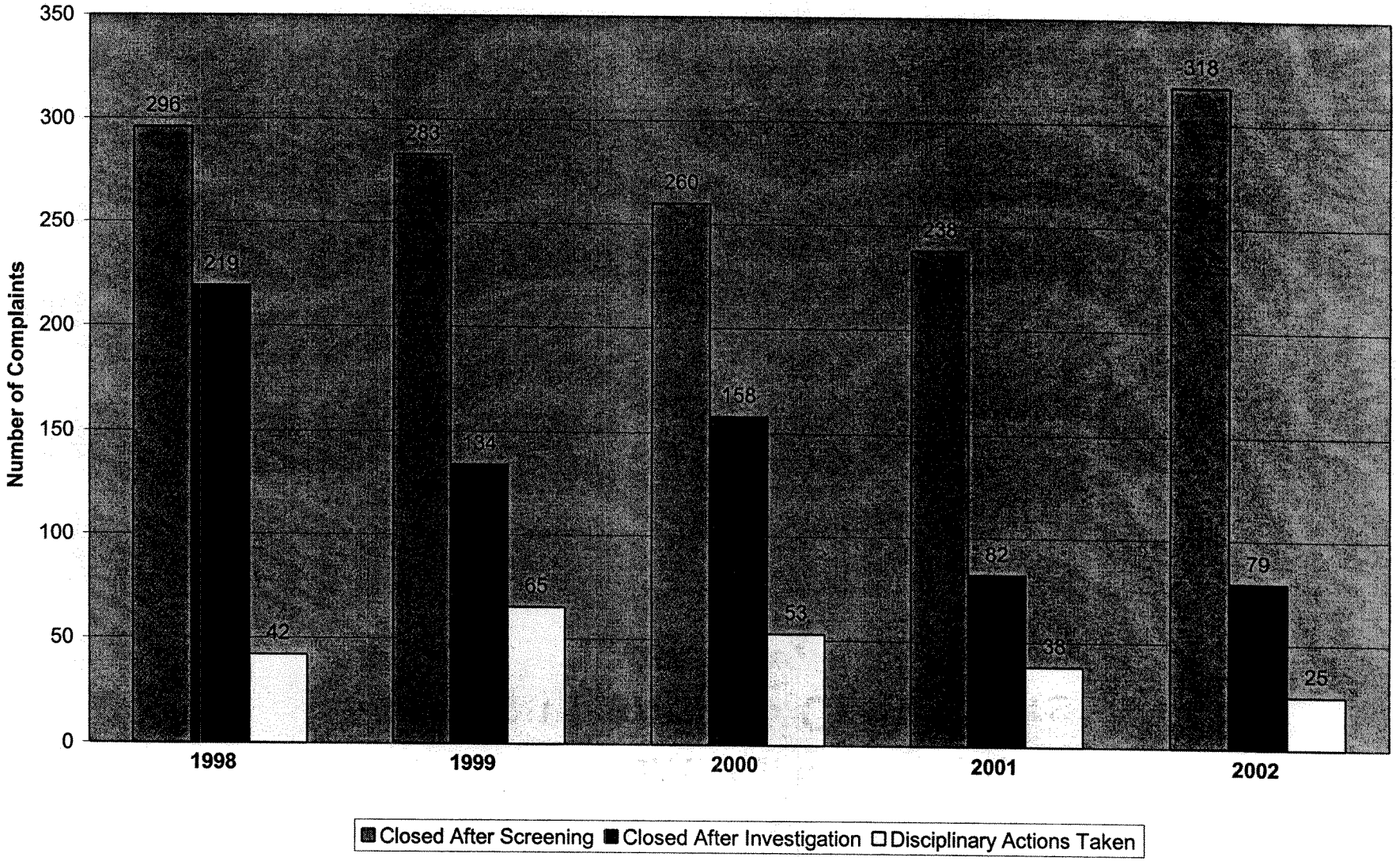
Complaints Handled by MEB 1998-2002



WISCONSIN
CITIZEN ACTION

Testimony of Carolyn Castore of Wisconsin Citizen Action on Senate Bill 226 and Senate Bill 227 to the Senate Committee on Health, Children, Families, Aging and Long-Term Care Senator Carol Roessler, Chair

Good morning, I am Carolyn Castore, the legislative director of Wisconsin Citizen Action.

As the state's largest public-interest voice, representing 85,000 household members and 200 diverse citizen groups, Wisconsin Citizen Action reflects its members deep and intense concerns about the state of health care in Wisconsin. Our members want to see the state acting fairly and efficiently to insure that the quality of health care is uniformly high, that the tiny-- but destructive-- minority of incompetent or negligent professionals are weeded out, and that all citizens have access to justice and accountability.

Protecting the health and well-being of Wisconsin's 5.3 million citizens is supposed to be the overriding mission of the Medical Examining Board.

This is a serious task. The human cost of improper medical care is incalculable to the victims and their families. Further, the careless or negligent conduct of a mere ***5% of doctors accounts for 54% of all judgments*** in malpractice cases, according to the watchdog group Public Citizen.

However, by even the most charitable measurements, the Medical Examining Board has compiled a record that clearly indicates that it has fallen far short of this mission:

The Medical Examining Board ranks **49th** among such state bodies in the rate of discipline for doctors in the US.. according to a report issued by Public Citizen report on March 27, 2003.

The MEB actually imposes discipline in fewer than one out of 10 complaints. That's right, over 90% are dismissed without any sanctions, based on a review of data from 1998 to 2002 provided by the MEB itself.

Even in some instances when other doctors have complained of negligence by their colleagues, the MEB closed the case without taking any disciplinary action.

Most recently, the case of Peter Bollig shows an appalling lack of aggressiveness. Imagine –in the context of the MEB already imposing no sanctions in 90% of cases—the prosecutor asking for dismissal of charges when the investigation showed the he prescribed a contraindicated medication. If that conduct meets "the standard of care," every citizen in Wisconsin is in very serious jeopardy.

The need for reform of the Medical Examining Board is obvious and urgent, yet the Legislature last session failed to act on an eminently modest and sensible package of recommendations put together by a legislative council.

Essentially, the reform package contained in SB 226 and SB 227 would expand public representation, give the Board more authority: to take decisive action, and create greater public access to doctors' records in terms of their practice. All of these are vitally needed.

At the same time, a stronger MEB is no substitute for insuring that all Wisconsin citizens—regardless of age or marital status—be covered under our state's medical malpractice laws when a wrongful death occurs. The courthouse doors must be open to all citizens.

Finally, the Examining Board must re-discover its mission of protecting Wisconsin health consumers rather than reflexively trying to shield doctors from even the most minimal of sanctions, like merely requiring additional education. It is now tragically obvious that that Medical Examining Board has lost its way and forgotten that its role must be to insist on high-quality health care and see itself as accountable to all of Wisconsin's citizens, not simply doctors.

Thank you.

WISCONSIN DEPARTMENT OF
REGULATION & LICENSING

Scott McCallum
Governor
Oscar Herrera
Secretary

1400 East Washington Avenue
PO Box 8935
Madison WI 53708-8935
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TTY: 608-267-2416

30 NOVEMBER 2001

JEANINE MARIE KNOX
1820 N 40TH ST
MILWAUKEE WI 53208

RE: 01 MED 182

Dear Ms. Knox:

The purpose of this letter is to inform you of the results of the review of the complaint filed by you.

The details of your complaint, including information which may have been obtained by us, were reviewed and discussed by a screening panel. Screening panels generally include legal staff, investigative staff and members of the relevant profession.

Based on the screening panel's review and evaluation of your complaint, a decision has been made not to proceed any further with this complaint. However, your complaint will be retained on file in the Division of Enforcement for future reference.

The process of evaluating complaints is often difficult and complex, involving legal issues and professional or technical evaluation. While it may be disappointing to learn a decision has been made that your complaint will not be pursued further, we want to assure you that the decision was made only after serious consideration of the complaint made and the issues you raised.

Because of the volume of complaints screened each year, it is not possible for the panel to review this matter again unless **new, relevant information** can be provided which may have influenced the panel's evaluation of the case if the panel had been aware of that information when the complaint was initially evaluated. Any information of that nature should be provided **in writing** to my attention at the above address.

Thank you for bringing this matter to our attention.

With respect,

Dennie Petersen

Dennie L. Petersen
Administrative Staff Supervisor
Deputy Records Custodian
Division of Enforcement

OFFICE HOURS BY APPOINTMENT ONLY
OFFICE PHONE 444-7787

RESIDENCE PHONE 355-5937

DAVID E. AMOS. M.D., S.C.
FAMILY PRACTITIONER
5800 WEST BURLEIGH STREET
MILWAUKEE, WISCONSIN 53216

TESTIMONY OF DR. DAVID AMOS
Submitted to the Assembly Judiciary Committee
February 21, 2002

Dear Assembly Judiciary Committee Members:

I would like to provide written testimony regarding an injustice that occured from medical malpractice that lead to the death of Beverly McIntyre. I am here to support Senate Bill 193/Assembly Bill 638. My name is Dr. David Amos. I practice general medicine in Milwaukee at 5800 West Bureligh Street, my phone number is (414) 444-7787.

Ms. McIntyre was under the care of a physician in my office by the name of Dr. Gloria Abacan. She was seen on August 17, 2000. Her blood urea nitrogen was 25 and the creatinine was 1.6. At that time the creatinine level was already high and Dr. Abacan did nothing about it.

Ms. McIntyre saw Dr. Abacan again on August 23, 2000. At that time she was sent to the hospital for a cat scan of the lungs, also a serum creatinine was ordered. The result at that time was 4.5. The level of the creatinine was up more than 4 fold but she again did nothing about it. And worse yet she prescribed cefzil, a dose of 500 mg 2 x daily for 10 days - the medical charts showed Ms. McIntyre was allergic to pencilin. As a result of this prescription she developed acute allergic reaction and the medicine worsened her renal disease. The medicine cefzil can be toxic to the kidney when given in full dose. Again, Dr. Abacan never followed up with Ms. McIntyre on the abnormal findings of her creatinine level.

On September 28,2000, Ms. McIntyre went to the emergency room at St. Joseph Hospital, she had developed severe generalized edema. Her blood urea nitgrogen went up to 181 with a creatinine of 10.9 requiring emergency dialysis. She was in a very serious condition, all of this could of been prevented with proper treatment and diagnosis.

I am ashamed that an associate of mine demonstrated such negligence. I am asking you to support Senate Bill 193/Assembly Bill 638 that would allow this family to have justice. Please vote favorable on this important piece of legislation. You all now have the chance to stand for justice and to the right thing. I am providing testimony today because I have to stand for **truth** and **justice**. I hope and pray that you will also.

Sincerely,

David E. Amos, MD

David E. Amos MD

Testimony of Kathy Bollig on
Senate Bill 226 and Senate Bill 227
to the
Senate Committee on Health, Children, Families, Aging and Long-Term Care
Senator Carol Roessler, Chair
September 4, 2003

My name is Kathy Bollig and I am a resident of Cottage Grove. I want to thank Sen. Roessler for holding this hearing and providing the opportunity for the public to comment on the need for reforming the Medical Examining Board.

As a nursing assistant and the daughter-in-law of the late Peter Bollig, I feel a special need to speak out on the urgency of providing Wisconsin families with a strong and impartial watchdog for the medical profession. I believe that Senate Bills 226 and 227 are steps in the right direction, and will help to shape a Board that is more objective and consumer friendly.

At the same time, I want to stress that even a more aggressive MEB will not fill a critical loophole in Wisconsin law that closes the courthouse door to two important categories of families when they lose a loved one due to improper medical care:

- the children of divorced or widowed parents—like Peter Bollig—and
- the parents of children over age 18.

There is no simple substitute for having our day in court on the needless loss of a beloved family member. That is why passing the Family Justice Bill, SB 187, is so essential.

OK - Verbalized in SB 187

In the meanwhile, as I can attest from personal experience based on what our family has gone through, the Medical Examining Board desperately needs a new direction and a new sense of mission: to protect the health consumers of Wisconsin.

Let me briefly relate the tragedy that has dominated our family life for the past 21 months. My father-in-law Peter Bollig was admitted to Mile Bluff Medical Center-Hess Memorial Hospital, Mauston, Wisconsin on December 22, 2001 complaining of chest pains and vomiting. But when my husband Jim and I saw him that evening, he said everything was "ok" and he was going home tomorrow.

The following morning, we went back and could see that my father-in-law's condition was actually getting much worse. Jim was very vocal that he wanted him transferred. At 10:00 a.m., we were repeatedly requesting that my father-in-law be transferred to a Madison hospital. Peter could not breathe while lying down and was obviously getting worse. However, Dr. Leon Radant saw no need to transfer Jim's father. At 1:00 p.m. something sparked the doctor to transfer Peter to Madison. They must have realized something was very wrong because they called Med Flight first, but they weren't flying.

It then took them two hours to find an ambulance, another hour to staff it and two plus hours to get him to Madison.

Upon arrival at Meriter Hospital in Madison, my father-in-law was immediately diagnosed and tests run to confirm he was having a heart attack. He went straight to surgery and made it through. However the surgeon told the family there was so much heart damage that he would not make it. Peter Bollig passed away on Christmas Day 2001. He was 70-years-old. We buried him on our wedding anniversary, December 28.

We later found out that when Peter arrived at Hess Memorial, his myoglobin level was 311.1. The normal range is approximately 116.2. This extremely elevated level should have alerted the doctor that something was not right and to keep a close eye on Jim's dad. The staff did not bother to repeat this test until 5:55 a.m. the next morning. At that time the lab test shows the myoglobin level had risen to 2252.2! Also, all other cardiac enzymes had elevated substantially during this time frame.

In response to this appalling level of treatment, we decided to file a complaint with the Medical Examining Board. As I noted above, we had no recourse within the legal system because of the loophole in Wisconsin law, so all of our hopes were riding on the ability of the Medical Examining Board to examine all the evidence and come up with a just resolution.

So my husband filed a complaint against Dr. Leon Radant with the Department of Regulation and Licensing (DRL) on January 7, 2002. (see attachment.) But the hearing and final ruling did not take place until July 23, 2003.

We had been initially encouraged about the possibility for justice when the DRL staff investigated my husband's complaint and learned that Dr. Radant had given my father-in-law a drug that was ***"contraindicated"*** by his heart condition and ongoing hypertension. In other words, my father-in-law was given the wrong drug, which worsened his condition and may have played a part in his death.

We also felt vindicated that the DRL complaint supported our own feelings that the doctor and hospital had failed to properly care for my father-in-law.

However, our faith in the MEB's commitment to consumer protection and justice has been shattered my recent events. On the morning on July 23, 2003 Jim happened to call the investigator, Celina Kobs, and was shocked to learn the MEB was going to be acting on the case that very morning at 10:45 a.m. Since Jim was working hundreds of miles away, I immediately arranged to attend. I was told the meeting was open to the public. Ruth Simpson of the Wisconsin Academy of Trial Lawyers also quickly shifted her schedule to attend the MEB meeting.

However, when we attempted to attend the MEB session on Dr. Radant, we were told it was a closed session and not open to the public and asked to leave. We complied. But we later discovered that Dr. Radant and his attorney were allowed to attend the meeting.

The next day my husband called back the DRL and learned the MEB had dismissed our complaint against Dr. Radant because of a precedent set in some case with supposedly almost identical facts, had also been dismissed by the MEB. (In fact, one of the main failings noted in the precedent-setting case involving Dr. James Deming's failure to

administer a sufficiently large dose of the ***correct*** drug and that an administrative law judge ruled in favor of sanctioning the doctor.)

Our family's treatment by the MEB, when we suffered the shattering loss of a precious member of our family, raises many questions, to put it mildly.

First, why were we never even officially notified about the MEB hearing? → Is this typical?

Second, why weren't Ruth Simpson and I allowed to attend the MEB meeting?

Third, we learned that the prosecutor in the case, Gilbert Lubcke, had moved to dismiss the complaint against Dr. Radant earlier this summer. Why were we never informed that the DRL was virtually abandoning its prosecution of my father-in-law's case? Why didn't the MEB prosecutor see that there is a vital distinction between prescribing too little of the proper drug and prescribing a contraindicated drug likely to cause severe harm? I know that the MEB rejected Mr. Lubcke's motion for dismissal, but didn't that motion clearly signal to the MEB that the case was disposable in the prosecutor's eyes? In our view, the evidence was very strong, but the prosecution was weak and half-hearted at best.

As a nursing assistant, I find it incredible that the DRL would make an initial finding that Dr. Radant acted carelessly in giving out contraindicated medication and failing to respond adequately the deterioration in condition, but then the MEB brushed it aside and just dismissed the case. Where is the justice in that?

In the wake of the loss of my father-in-law, which has deeply touched everyone in our family, we have tried just about every conceivable forum to try and get justice . But we have had the door slammed in our faces each time.:

- Jim talked with the local district attorney's office about criminally charging Dr. Radant, but they have refused to prosecute him, saying this is a matter for the civil courts.
- Of course, we cannot pursue the case in the civil courts either. Jim has spoken to numerous attorneys about suing Dr. Radant, but because of Wisconsin' peculiar double standard on medical malpractice, but as an adult child Jim cannot bring a wrongful death claim against the doctor for his dad's death.
- Our only remaining hope was the Medical Examining Board process. Once again our dream of justice for Peter Bollig was crushed.

So, I ask again, where do we now go to find justice for my father-in-law and for all of our family members who were so painfully affected?

I believe that SB 226 and SB 227 will result in a more balanced Medical Examining Board and more public accessibility, and hopefully a renewed commitment to protecting consumers. But I also feel strongly that these bills will only be a down payment on the more fundamental steps needed to assure justice for all in Wisconsin, such as passage of the Family Justice Bill.

Thank you so much.

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST LEON J. RADANT, M.D. RESPONDENT.	COMPLAINT ( )

Division of Enforcement
02 MED 001

Celina Kobs, an investigator for the Wisconsin Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, Madison, Wisconsin, upon information and belief, complains and alleges as follows:

1. Leon J. Radant, M.D., Respondent herein, 1040 Division Street, Mauston, Wisconsin, 53948, was born on 6/19/51 and is licensed and currently registered to practice medicine and surgery in the state of Wisconsin, license #21582, said license having been granted on 7/5/78.

2. Respondent specializes in family practice.

3. Respondent, at all times relevant to this complaint, practiced medicine at the Hess Memorial Hospital in Mauston, Wisconsin.

4. Peter Bollig, the patient herein, was born on 11/24/31. He had a history of hypertension.

5. On 2/22/01 at approximately 1710, the patient presented at the emergency room at the Hess Memorial Hospital in Mauston, Wisconsin with active chest pain which had persisted for approximately 1 ½ hours prior to his arrival at the emergency room. He reported that he had felt light-headed, had vomited and had been diaphoretic. He rated his chest pain as 5/5 with aching in his arms. He was not experiencing shortness of breath or pain radiating into his arms.

6. The emergency room physician, Dr. Logan, obtained a medical history, performed a physical examination of the patient in the emergency room, ordered laboratory tests and obtained an EKG and a chest x-ray. Dr. Logan's physical examination disclosed a blood pressure of 132/82, a pulse of 88 with a regular rhythm and a respiratory rate of 20. The patient's chest was clear to auscultation. The chest x-ray showed minimal pulmonary vascularization and a normal heart shadow. Dr. Logan read the EKG as demonstrating myocardial ischemia with some ST-T wave depression.

7. Dr. Logan initiated treatment of the patient in the emergency room. At 1715 on 12/22/01, he administered aspirin. He also initiated IV heparin and nitroglycerin at 9 cc/hr. which he increased to 12 cc/hr. at 1750. He also placed the patient on oxygen at 2 L/min. by nasal cannula resulting in an oxygen saturation of 99%. When the patient's blood pressure

dropped to 80/50 at 1800, Dr. Logan reduced the nitroglycerin to 9 cc/hr. and administered a fluid bolus.

8. At 1840 on 12/22/01, Dr. Logan arranged for the admission of the patient to the Hess Memorial Hospital, acute care room. The patient was admitted to the hospital on an acute myocardial infarction protocol.

9. Dr. Logan continued to manage the patient's care in the hospital until the on-call physician, Dr. Ness, assumed responsibility for the patient at approximately 0800 on 12/23/01. Dr. Logan, while he had responsibility for the patient, continued to adjust the patient's nitroglycerin and continued to provide oxygen to the patient by nasal cannula. The patient remained essentially stable while under Dr. Logan's care.

10. The on-call physician, Dr. Ness, assumed responsibility for management of the patient at approximately 0800 on 12/23/01 when the nurse contacted him to report that the patient's oxygen saturation level had dropped to 79% on 3 L/min. of oxygen by nasal cannula. The nurse also reported that the patient had developed course rhonchi. At that time, the patient's blood pressure was 103/41, his pulse was 68 and his respiratory rate had increased to 40 respirations per minute.

11. Dr. Ness arrived at the hospital shortly after 0800 on 12/23/01 to evaluate the patient. At that time his orders included Lasix 40 mg by IV route. The Lasix was started at 0830 on 12/23/01. Dr. Ness also ordered a chest x-ray that was obtained at 0840 on 12/23/01. The chest x-ray showed pulmonary vascular congestion that had worsened significantly from the time that the previous chest x-ray was taken in the emergency room on 12/22/01. Dr. Ness was of the opinion that the patient was developing congestive heart failure and pulmonary edema. Dr. Ness increased the oxygen administered to the patient to 4 L/min. by nasal cannula.

12. Respondent was the patient's primary care physician and he assumed responsibility for the management of the patient when he arrived at the hospital at approximately 1000 on 12/23/01.

13. When the Respondent arrived at the hospital at approximately 1000 on 12/23/01, he had a face-to-face meeting with Dr. Ness during which the Respondent and Dr. Ness discussed the patient's condition.

14. Respondent, based upon his assessment of the patient and a review of the patient's record, was of the opinion that the patient had an anterior wall myocardial infarction with congestive heart failure and acute pulmonary edema.

15. At 1000 on 12/23/01, Respondent increased the oxygen delivered to the patient by placing him on a nonrebreather mask at 12 L/min. The patient's oxygen saturation increased to 87%. At 1020 on 12/23/01, the patient's oxygen saturation level increased to 91% on the nonrebreather mask at 15 L/min.

16. At approximately 1018 on 12/23/01, Respondent wrote orders for Furosemide 80 mg IV, Metolazone 2.5 mg by mouth and Atenolol 25 mg by mouth. All of these drugs were to be administered immediately. Respondent also continued nitroglycerin at 6 cc/hr.

17. Atenolol is a beta blocker and is contraindicated in the acute myocardial infarction patient who is experiencing congestive heart failure, pulmonary edema and hypotension.

18. Furosemide and Metolazone are diuretics and, in the amounts ordered by the Respondent, represent more aggressive diuretic therapy than had been initiated by the Dr. Ness when he ordered Lasix 40 mg by IV route at approximately 0800 on 12/23/01.

19. At 1115 on 12/23/01, the patient's blood pressure was 110/68, his pulse was 124 and his respiratory rate was 44. The patient was sitting up because it had become more difficult to breathe even though he was receiving oxygen by nonrebreather mask at 15 L/min.

20. Respondent came to the hospital to evaluate the patient at 1145 on 12/23/01. At this time, the patient's blood pressure had dropped to 96/80, his pulse was 96 and his respiratory rate was 40. His oxygen saturation was 90% on the nonrebreather mask at 15 L/min. of oxygen.

21. The patient's condition continued to deteriorate after 1145 on 12/23/01. At 1200 on 12/23/01, the patient's blood pressure was 96/58, his pulse was 91 and his respiratory rate was 40. At 1220, the patient's blood pressure had fallen to 75/48, his pulse was 77 and his respiratory rate was 40 with an oxygen saturation level of 96% on the nonrebreather mask. When the patient would attempt to lie down, he would become dusky and diaphoretic. He was engaging in purse lip breathing.

22. At 1221 on 12/23/01, the patient's oxygen saturation level on the nonrebreather mask was 94%, his blood pressure had dropped to 68/48, his pulse was 68 and his respiratory rate was 38. At 1223, the patient's blood pressure was 70/58. The patient had only minimal urine output.

23. After 1230 on 12/23/01, the patient's vital signs, oxygen demands and clinical appearance were consistent with the patient's deteriorating condition.

24. Respondent re-evaluated the patient at 1420 on 12/23/01 and made the decision at that time to transfer the patient to Meriter Hospital, a tertiary care center, in Madison, Wisconsin for further diagnosis and treatment. Respondent contacted a cardiologist at Meriter Hospital to make arrangements for the patient's admission. Respondent's preference was to transport the patient by helicopter but adverse weather conditions dictated that the transport be by ground ambulance.

25. The patient departed Hess Memorial Hospital at 1635 and arrived at Meriter Hospital at 1843 on 12/23/01.

26. Upon arrival at Meriter Hospital, the patient was in sevère respiratory distress and was emergently intubated. An intra-aortic balloon pump was utilized to stabilize the patient's blood pressure. An echocardiogram demonstrated left ventricular hypertrophy with evidence of

a large inferior and posterior infarction with a suggestion of severe mitral insufficiency and significant systolic flow reversal in the pulmonary veins. Coronary arteriography demonstrated the occlusion of a large circumflex vessel. The LAD and right coronary arteries were open but of very small caliber. Angioplasty was attempted to open the circumflex artery but the procedure was not successful. A transesophageal echocardiogram demonstrated severe mitral insufficiency probably due to papillary chordal dysfunction and possibly due to a ruptured cord. Surgery was performed for a mitral valve replacement and saphenous vein grafts from the aorta to the patient's left anterior descending and his obtuse marginal branch. Following the surgery, the patient's hypoxia and cardiac function continued to worsen and the patient died on 12/25/01. The final diagnosis included cardiogenic shock secondary to acute myocardial infarction with acute ischemic mitral regurgitation and severe coronary artery disease.

27. At the time of the above-referenced events, Hess Memorial Hospital was not a tertiary care center and did not have the evaluation or monitoring capabilities or treatment modalities necessary to adequately evaluate, monitor or treat the patient's condition.

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

a. Respondent ordered Atenolol 25 mg at 1018 on 12/23/01 when the drug was contraindicated by the patient's congestive heart failure and pulmonary edema.

b. Respondent failed to respond to the patient's deteriorating condition at or about 1230 on 12/23/01 by either consulting with a cardiologist to determine the future course of treatment or, if he elected not to consult with a cardiologist, to transport the patient to a tertiary care facility for further assessment and appropriate treatment not available at Hess Memorial Hospital.

29. Respondent's conduct created the following unacceptable risks to the health, welfare and safety of the patient:

a. The order for Atenolol created the unacceptable risk of exacerbating the patient's congestive heart failure, pulmonary edema and hypotension.

b. The failure to consult a cardiologist or to transport the patient to a tertiary care center created the unacceptable risk that the patient would not have available to him technology and medical expertise for further evaluation, monitoring and treatment that may be appropriate to address his medical condition, thereby, placing the patient at unacceptable risk of further deterioration and death.

30. A minimally competent physician, to avoid or minimize the unacceptable risks:

a. Would not have ordered Atenolol at 1018 on 2/23/01 while the patient was experiencing congestive heart failure and pulmonary edema.

b. Would have, by 1230 on12/23/01, consulted with a cardiologist to determine the future course of treatment or transported the patient to a tertiary care center equipped to adequately evaluate, monitor and treat the patient's condition.

31. Respondent's conduct as herein described was unprofessional conduct contrary to Wis. Stats. sec. 448.02(3), and Wis. Admin. Code sec. MED 10.02(2)(h) in that he engaged in conduct that tended to constitute a danger to the health, welfare and safety of the patient.

WHEREFORE, the Complainant demands that the disciplinary authority hear evidence relevant to matters alleged in the Complaint, determine and impose the discipline warranted and assess the costs of the proceeding against the Respondent.

Dated this 17th day of December, 2002.

Celina Kobs

Celina Kobs, Investigator
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Celina Kobs, being first duly sworn on oath, deposes and says that she is an investigator for the State of Wisconsin, Department of Regulation and Licensing, Division of Enforcement, and that she has read the foregoing Complaint and knows the contents thereof and that the same is true to her own knowledge, except as to those matters therein stated on information and belief and as to such matters, she believes them to be true.

Celina Kobs

Celina Kobs
State of Wisconsin
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Subscribed and sworn to before me
this 17th day of December, 2002.

Notary Public
My Commission is Permanent

Gilbert C. Lubcke
Attorney for Complainant
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935
State Bar no. 1014414

Compl212

Keeping Wisconsin Families Safe

www.watl.org

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Presentation of
Scott Froehlke
on behalf of the
Wisconsin Academy of Trial Lawyers
on
Senate Bill 226 and Senate Bill 227
to the
Senate Committee on Health, Children, Families, Aging
and Long-Term Care
Senator Carol Roessler, Chair
September 4, 2003

Good morning, Senator Roessler and members of the committee. My name is Scott Froehlke, legislative representative for 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 226 and 227.

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 226 and 227, the work product of the Legislative Council's Special Committee on Discipline of Health Care Professionals from 1998-99. WATL had two representatives serve on the Special Committee, attorneys Keith Clifford and Susan Rosenberg. Several years have lapsed since the bills were first introduced,

but WATL believes the ideas presented in the bills deserve the Legislature's immediate attention and would like to thank Senator Roessler for reintroducing the bills. 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. It also means individuals need access to the courts to uphold their rights. Right now access to the courts is being denied to numerous individuals and the Legislature needs to address that important issue through the Family Justice Bill, SB 187.

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. In an article entitled, "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) 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.

This predictive future claim quality was shown again in a March 5, 2000 article in the *New York Daily News*, which reviewed the 15 most sued doctors in New York. The article stated,

> According to the national database, 79% of the New York doctors who [each] made 10 malpractice payments were not disciplined in any way. Nationwide, the figure is 64%. The pattern holds for [New York's] 15 most sued practitioners. Five have never been disciplined, six were hit with professional charges and were permitted to stay in practice, one was suspended from podiatry for five years and three lost licenses. The effect of failing to crackdown is stunning, because they are a powerful driving force behind medical malfeasance nationwide. Making three malpractice payments is rare — only 1% of the nation's doctors have crossed that line, according to the national database. But those doctors account for 24% — or $5.6 billion — of the money paid to aggrieved patients.

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

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[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.

We have recently raised several concerns with the Department of Regulation and Licensing (DRL) about whether the MEB is responsive to citizen complaints. After meeting with Secretary Strong Hill and members of her staff, the department has taken steps to ensure injured patients and their families are kept informed of department proceedings and can, if at all possible, attend disciplinary hearings. We think these are major improvements and thank Secretary Strong Hill and the DRL staff for their prompt action.

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 MEB's investigation and prosecution of these cases.

Senate Bill 227 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 227 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 citizens. The death certificate information, in particular, will help individuals who find themselves dealing with the sudden tragic loss of a loved one by a medical error.

We also want to strongly support Senate Bill 226 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 226 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. 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. That is why SB 226 and 227 are particularly relevant for your prompt attention and consideration.

These bills represent some positive steps that Wisconsin can take to face up to the problems of medical errors and provide greater public information and accountability for 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.

MILWAUKEE JOURNAL-SENTINEL
NOVEMBER 30, 1999 PG. 1A

Medical errors said to kill tens of thousands

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

BY LAURAN NEERGAARD
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 antiseizure 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 medical 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.

Halbur, Jennifer

From: Asbjornson, Karen
Sent: Friday, August 29, 2003 3:27 PM
To: Halbur, Jennifer; Halbur, Jennifer
Subject: New Forward Contact Ownership and Assignment

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Owner: Halbur, Jennifer
Assigned: Halbur, Jennifer
Summary: DLR bills

Issue:
Position:
Status: Pending
Contact Type: E-mail
Description: -----Original Message-----
From: dtreffert@pol.net [mailto:dtreffert@pol.net]
Sent: Friday, August 29, 2003 9:21 AM
To: Carol.Roessler@legis.state.wi.us
Subject: Attn: Carol Roessler and Sara Jermstad

1. Is there a fiscal note as yet attached to the two DLR/MEB bills? Last time there were 12.5 positions attached to the one bill and 5 to the other. I see no reason why, if the web enhancement bill adopts the Massachusetts Board of Registration in Medicine Physician Profile (which I support and does include the information requested in this bill) why 5 positions would be needed.

2. Could you fax me, or e mail me, final versions of these two bills? 9/3 sent

3. Carol, as you know, I support the thrust of both these bills. I have completed my MEB term though, and if I were to testify, it would not be as a part of MEB as I did in the past. I guess I would be appearing simply privately. I'm not sure what weight that would carry, if any even though my past MEB terms, my role (along with you) in Hal Harlowes/Gov. Earl's task force, and past Presidency of WMS might be pertinent.

My real problem with these bills is not their content, but their implementation. MEB has always supported an increase in Dr. license

fees IF those monies were to go to MEB for the bill's stated purposes. Unfortunately MEB has the STATUORY AUTHORITY but not the RESOURCE AUTHORITY to carry out its work. All decisions--budget, personnel allocation, prioritie allocation among the boards and individual cases, hiring, firing,
supervision of employees--are all done by DRL, not MEB. Whether an investigator/attorney gets assigned to real estate, barbering, or MEB are decisions made entirely, and only, by DRL. Monies from Dr. license fees presently, and any new such monies, go the the 'department', not MEB. If you don't believe that, maybe you will have more success than I finding where in the DRL did the 3.5 positions approved two sessions ago 'specfically for MEB' go. I have tried to locate those 3.5 positions and have never been given a direct answer. They are somewhere in the 'black hole' of DRL, or even DOA. Personnel decisions are just as problematical, witness the employee you and I have corrresponded about previously. She is now part-time with different responsibilities

ASK

The answer? The best answer would be a separate MEB as was the case before Kellett, and is the case in a least 6 other states at present, and is the case with Atty's in Wisconsin (If DRL is good for all other professions why is the Bar not part of that more global effort?). A separate MEB is probably not likely though; I realize that although it would still, in my view, be the best option for true accountability. Failing that, at least DRL should sign on to the concept of DEDICATED RESOURCES, i.e. increased fees per profession to go directly to efforts with that profession. Before Oscar H. the department actively resisted such dedicated resources. Oscar H. supported the concept but was not around long enough to know where that would go, and there were no fee increases. I don't know where the new Secy. stands on that matter. DEDICATED RESOURCES would mean, as a minimum, MEB would be involved at least in the budgetary process, and in the decision making process regarding priorities which is NOT the case presently (with respect to assignment of attys/investigators/ALJ's etc).

So, in short, I support the thrust of these bills IF there is some honest attempt to have MEB involved in decision-making regarding resource allocation via dedicated resource allocatin. Otherwise MEB gets the heat and DRL gets the resources. The press never attacks DRL. They attack MEB and such scrutiny, and criticism, if fair if MEB has not just the statutory authority, but also resource allocation and prioritization to carry out its work as it sees necessary. If that were the case, Carol, I think you would see that MEB objectives, and Legislative objectives are the same and much of the criticism would be muted.

I hope the Sidney Wolf 'report card' is not used to justify these bills. That report card is flawed as I have written you, and in the Regulatory Digest, before. I have data on a much wider scale that shows Wisconsin to rank #8 in the nation (on 22 quality of care indicators) in quality of care (not 49th as HRG ranks it in discipline. If you put this broad-based quality of care chart next to HRG 'report card'--there is not correlation. I can fax you that side by side chart if you wish. While that report card may come up again by some, I would hope you wouldn't tie these efforts to

the flawed report.

Just some thoughts as to where I am on all of this a present. I'd appreciate seeing a fiscal note, and present versions of the bill.

Darold Treffert