Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 9/29/05 **Meeting Type:** Working Session

Location: 328 NW State Capitol

Committee Member	Present	Absent	Excused
Representative Curtis Gielow, Chair	☒	☐	☐
Representative Mike Huebsch	☒	☐	☐
Representative Ann Nischke	☒	☐	☐
Representative Jason Fields	☒	☐	☐
Representative Bob Ziegelbauer	☒	☐	☐
Mr. David Strifling	☒	☐	☐
Ms. Mary Wolverton	☒	☐	☐
Dr. Clyde "Bud" Chumbley	☒	☐	☐
Mr. David Olson	☒	☐	☐
Mr. Ralph Topinka	☒	☐	☐

Totals: 11 0 0

John Reinemann

John Reinemann
Task Force Clerk

S:\Medical Malpractice task force\Attendance Sheet.doc

cont. Pt. 3

Packet distributed to TF members via E-mail

To be discussed @ hearing 9/29/05. Part of Public Record.

cont.

BAY AREA
MEDICAL CENTER

September 27, 2005

The Honorable Curt Gielow
State Representative
Room 316 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952

Dear Representative Gielow:

Thank you for the opportunity to suggest a legislative approach that may be considered in helping restore the favorable medical malpractice environment that Wisconsin has enjoyed. The approach I am suggesting is one of many that the task force will consider, and I certainly do not presume that this approach alone would provide a complete fix. That being said, please allow me to outline the following alternative.

LEGISLATIVE ALTERNATIVE

Attorney Fee Reform in Conjunction with Caps on Non-economic Damage Awards.

Replace Wisconsin's statutory limits on attorney contingency fees in medical malpractice actions with California's statutory limits on attorney contingency fees.

Current Wisconsin Contingency Fee Limits
Current Wisconsin law limits contingent fees to 1/3 of the first $1 million recovered, 25% of the first $1 million recovered if liability is stipulated within 180 days of filing of the original complaint and not within 60 days of first day of trial, and 20% for amounts exceeding $1 million recovered. The law allows a judge to exceed these amounts in exceptional circumstances. These contingency fee amounts are in addition to compensation to the attorney for the reasonable costs of prosecution of the claim. Wis. Stat. §655.013

Current California Contingency Fee Limits
Current California law limits contingency fees in medical liability cases to 40% of the first $50,000 recovered, 33.3% of the next $50,000, 25% of the next $500,000, and 15% of any amount on which the recovery exceeds $600,000. The limitations apply regardless of whether the recovery is by settlement, arbitration, or judgment. "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the claimant and the attorney's office-overhead

costs or charges are not deductible disbursements or costs for such purpose. Cal. Bus. & Prof. Code § 6146(a).

Rationale:

A contingency fee, in conjunction with cap reform, places more money in the hands of injured plaintiffs.

One reality of medical liability cases is that injured plaintiffs pay a significant portion of awards to their attorneys in the form of contingency fees. In general negligence cases, these fees are frequently 33% or more of a jury award or settlement. Wisconsin law places a high upper limit on what an attorney may charge in medical malpractice cases. However, other states such as California have enacted attorney fee reform to place more of an award in the hands of the injured plaintiff.

Under Wisconsin's current contingency fee limits, if an injured plaintiff receives a one million dollar award, the attorney's professional fees may be no more than $333,333. Note that professional fees do not include costs such as for filing fees and expert witnesses. Under California's contingency fee limits, that same plaintiff would pay only $221,667 in attorney professional fees—a difference of $111,666. For a five million dollar award, the Wisconsin attorney fees amount to $1,333,333, while California's attorney fees would be $821,667. This is a difference of $311,666 or over 8% of what the plaintiff would ultimately receive as an award after payment of Wisconsin attorney fees. A $500,000 award yields an additional $30,000 in attorneys fees owed under the Wisconsin system as compared to the California system.

One example of how attorney fee reform would affect an actual plaintiff can be seen in the case of Tim and Sean Kaul. On August 30, 2005, a representative of the Wisconsin Academy of Trial Lawyers testified to the Task Force and referred to the case of the Kauls as an example of why the representative believed there should not be caps on non-economic damages. What was not discussed was the impact of attorney fees on what the Kauls ultimately receive as a successful plaintiff.

When one looks at what the Kauls ultimately receive from a jury award after attorney costs rather than simply at the amount of the jury award, the Kauls would actually receive 0.86% *more* of an award after attorney fees are deducted if their award were subject to California's reasonable attorney fees and a $550,000 cap on non-economic damages rather than Wisconsin's current attorney fee limits and no cap on non-economic damages. Thus, a non-economic damage cap of $550,000 in conjunction with attorney fee reform would put the Kauls in a better position after attorney fees are deducted than they are under Wisconsin's current medical liability status quo.

California's system has not closed the court room doors to injured plaintiffs.

Some argue that reducing contingency fee arrangements will close the courtroom doors to plaintiffs because attorneys will be unwilling to take on cases at lower contingency rates. A 2004 RAND study of California's medical liability reforms speculates that this may be the case, however the study offers no data to support this speculation. Rather, according to data from the National Practitioner Data Bank, when one compares the average number of paid medical malpractice claims per capita in California and Wisconsin from 1991-2004, California with its attorney fee reform has averaged 3.22 more claims per 100,000 population per year than Wisconsin. Clearly, this data shows that California's attorney fee reform has not had the chilling effect on legitimate claims that the RAND study imagines.

California's experience with damage caps, in conjunction with its attorney fee limits, has shown that such reforms produce a stable medical liability system.

Finally, California has a stable medical liability system, as evidenced by the findings of numerous scientific studies.

In addition to this suggested approach, I would also like to lend my support to the alternatives that were recommended by my fellow task force member and colleague Ralph Topinka. I know that Ralph has spent a great deal of time researching and considering a number of different options, and I believe that his suggestions are well thought out and certainly could provide restoration of our previous favorable medical malpractice environment.

Thank you for the opportunity to submit my recommendations. I appreciate being a part of this assembly task force, and I look forward to supporting the recommended solutions.

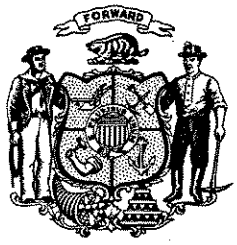
Sincerely,

BAY AREA MEDICAL CENTER

David A. Olson
President and CEO

dao:kac

END



END

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
Web Address: oci.wi.gov

September 27, 2005

The Honorable Curt Gielow
State Representative
Chair – Medical Malpractice Insurance Task Force
316 N State Capital
Hand Delivered

Dear Representative Gielow:

When I appeared before the Medical Malpractice Task Force on September 8, 2005, I was asked about a LAB report. Let me take this opportunity to get back to you and the other members of the Task Force on the issue of the Fund being "overly conservative" in its reserving. On July 7, 2005, the Fund received the Tillinghast Second Opinion on the Milliman Actuarial Analysis as of September 30, 2004. That second opinion found the Fund reserve "to be reasonable, but conservative" [p.3]. The report also noted that conservatism is appropriate because; the coverage offered is unlimited; there is uncertainty with respect to investment results; there could be contingent liabilities; and if the Fund ran out of money there is no easy source of additional funds.

I would also like to take the opportunity to emphasize that the Fund has been a noted success in helping make Wisconsin medical malpractice market a viable environment where companies compete for business, doctors receive affordable coverage, and patients receive the protections. No other state in the union can attest to this success. Specifically:

- The medical malpractice marketplace in Wisconsin is the most stable anywhere in the country. Providers pay the least amount of premium, including Fund assessments, to receive the most coverage available anywhere in the United States.

- The approximately 20 companies now writing in medical malpractice coverage in Wisconsin create a competitive market for primary coverage. The first layer of coverage is available to any licensed physician practicing in Wisconsin at rates that are simply not available in comparable states.

- For patients who successfully prove a malpractice claim, (close to 90% of the claimants do not), the process of actually recovering an award is much more predictive than in other jurisdictions.

- Medical malpractice insurance is available to any licensed physician who wants to practice in Wisconsin. If a doctor cannot secure coverage in the private market, that doctor can secure first dollar coverage in WHCLIP, Wisconsin's residual pool.

- During the past several years as other states have announced alarming rate increases and problems with availability of malpractice coverage, the assessments of doctors and other healthcare providers participating in the Wisconsin Fund have been reduced by 50%. Assessments have fallen from $40 million to less than $20 million in the last two years.

In 2005 the *Ferdon* decision removal of 'caps' on non-economic damages increased the exposure of the Fund to essentially unlimited liability for non-economic damages. The long-term cost of such increased exposure can be actuarially estimated and assessments adjusted accordingly to ensure adequate reserving for liabilities to be paid in the future. The Fund is well able to manage, through its contracted vendors, such a change in the risk environment.

It has been suggested that one option for a workable solution to continue to control the cost of medical malpractice insurance is that the Fund now begin coverage at $500,000 per occurrence/$1,500,000 annual aggregate. This would be a return to the coverage levels of the early 1990s. The threshold or point, at which the Fund starts paying claims, has increased over time. The threshold history is; $200,000 (1975 – 1987); $300,000 (1987 – 1988); $400,000 (1988 – 1997); $1,000,000 (1997 to present).

In the interests of finding workable outcomes let me observe that if $500,000/$1,500,000 were to be the statutory amounts now required, health care providers would obtain primary medical malpractice insurance from private insurance companies in those amounts. A reduction in the liabilities placed in the private market will not impact the administration of the Fund. As risk shifts to the Fund, payments to the Fund would increase while payments to private insurers would decrease. The bottom line for such a policy change is that the Fund through its Board of Governors has successfully made such changes before and has conservatively managed its reserves to ensure the continued financial viability of the Fund.

The Injured Patients and Families Compensation Fund has been remarkably successful in fulfilling the charge of supporting a viable medical malpractice environment in the state. As the Task Force considers alternatives, lowering the threshold to $500,000/$1,500,000, should be one option for the task force's consideration.

Thank you for the opportunity to speak to the Task Force. If you need any further information on the Fund please feel free to contact me.

Sincerely,

Jorge Gomez
Commissioner

END

END

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, *Governor*
Jorge Gomez, *Commissioner*

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
Web Address: oci.wi.gov

September 27, 2005

The Honorable Curt Gielow
State Representative
Chair – Medical Malpractice Insurance Task Force
316 N State Capital
Hand Delivered

Dear Representative Gielow:

When I appeared before the Medical Malpractice Task Force on September 8, 2005, I was asked about a LAB report. Let me take this opportunity to get back to you and the other members of the Task Force on the issue of the Fund being "overly conservative" in its reserving. On July 7, 2005, the Fund received the Tillinghast Second Opinion on the Milliman Actuarial Analysis as of September 30, 2004. That second opinion found the Fund reserve "to be reasonable, but conservative" [p.3]. The report also noted that conservatism is appropriate because; the coverage offered is unlimited; there is uncertainty with respect to investment results; there could be contingent liabilities; and if the Fund ran out of money there is no easy source of additional funds.

I would also like to take the opportunity to emphasize that the Fund has been a noted success in helping make Wisconsin medical malpractice market a viable environment where companies compete for business, doctors receive affordable coverage, and patients receive the protections. No other state in the union can attest to this success. Specifically:

- The medical malpractice marketplace in Wisconsin is the most stable anywhere in the country. Providers pay the least amount of premium, including Fund assessments, to receive the most coverage available anywhere in the United States.

- The approximately 20 companies now writing in medical malpractice coverage in Wisconsin create a competitive market for primary coverage. The first layer of coverage is available to any licensed physician practicing in Wisconsin at rates that are simply not available in comparable states.

- For patients who successfully prove a malpractice claim, (close to 90% of the claimants do not), the process of actually recovering an award is much more predictive than in other jurisdictions.

- Medical malpractice insurance is available to any licensed physician who wants to practice in Wisconsin. If a doctor cannot secure coverage in the private market, that doctor can secure first dollar coverage in WHCLIP, Wisconsin's residual pool.

- During the past several years as other states have announced alarming rate increases and problems with availability of malpractice coverage, the assessments of doctors and other healthcare providers participating in the Wisconsin Fund have been reduced by 50%. Assessments have fallen from $40 million to less than $20 million in the last two years.

In 2005 the *Ferdon* decision removal of 'caps' on non-economic damages increased the exposure of the Fund to essentially unlimited liability for non-economic damages. The long-term cost of such increased exposure can be actuarially estimated and assessments adjusted accordingly to ensure adequate reserving for liabilities to be paid in the future. The Fund is well able to manage, through its contracted vendors, such a change in the risk environment.

It has been suggested that one option for a workable solution to continue to control the cost of medical malpractice insurance is that the Fund now begin coverage at $500,000 per occurrence/$1,500,000 annual aggregate. This would be a return to the coverage levels of the early 1990s. The threshold or point, at which the Fund starts paying claims, has increased over time. The threshold history is; $200,000 (1975 – 1987); $300,000 (1987 – 1988); $400,000 (1988 – 1997); $1,000,000 (1997 to present).

In the interests of finding workable outcomes let me observe that if $500,000/$1,500,000 were to be the statutory amounts now required, health care providers would obtain primary medical malpractice insurance from private insurance companies in those amounts. A reduction in the liabilities placed in the private market will not impact the administration of the Fund. As risk shifts to the Fund, payments to the Fund would increase while payments to private insurers would decrease. The bottom line for such a policy change is that the Fund through its Board of Governors has successfully made such changes before and has conservatively managed its reserves to ensure the continued financial viability of the Fund.

The Injured Patients and Families Compensation Fund has been remarkably successful in fulfilling the charge of supporting a viable medical malpractice environment in the state. As the Task Force considers alternatives, lowering the threshold to $500,000/$1,500,000, should be one option for the task force's consideration.

Thank you for the opportunity to speak to the Task Force. If you need any further information on the Fund please feel free to contact me.

Sincerely,

Jorge Gomez
Commissioner

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
One East Main Street, Suite 401

January 21, 2000
Madison, Wisconsin

RL 99-14

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

LEGISLATION ON DISCIPLINE OF HEALTH CARE PROFESSIONALS

CONTENTS

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

Also available at ***www.legis.state.wi.us/lc***

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
November 18, 1998
December 18, 1998
January 20, 1999
February 9, 1999
March 11, 1999
April 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 Prachthauser, Attorney, Murphy, Gillick, Wicht and Prachthauser, 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. Prachthauser 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 Massachusett'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 1

JOINT LEGISLATIVE COUNCIL

s. 13.81, Stats.

OFFICERS

Cochairperson
FRED A. RISSER
Senate President
5008 Risser Road
Madison 53705-1365

Cochairperson
CAROL KELSO
Assembly Representative
416 East Le Capitaine Circle
Green Bay 54302-5153

SENATORS

BRIAN BURKE
2029 North 51st Street
Milwaukee 53208-1747

GARY R. GEORGE
1100 West Wells St., #1711
Milwaukee 53233-2326

CHARLES J. CHVALA
1 Coach House Drive
Madison 53714-2718

RICHARD GROBSCHMIDT
912 Lake Drive
South Milwaukee 53172-1736

ROBERT L. COWLES
300 W. Saint Joseph St., #23
Green Bay 54301-2048

JUDITH ROBSON
2411 East Ridge Road
Beloit 53511-3922

MICHAEL G. ELLIS
1752 County Road GG
Neenah 54956-9730

PEGGY ROSENZWEIG
6236 Upper Parkway North
Wauwatosa 53213-2430

JON ERPENBACH
2385 Branch Street
Middleton 53562-2808

DAVID ZIEN
1716 63rd Street
Eau Claire 54703-6857

REPRESENTATIVES

PETER BOCK
4710 West Bluemound Road
Milwaukee 53208-3648

SCOTT R. JENSEN
850 South Springdale Road
Waukesha 53186-1402

STEVEN FOTI
1117 Dickens Drive
Oconomowoc 53066-4316

SHIRLEY KRUG
6105 West Hope Avenue
Milwaukee 53216-1226

STEPHEN J. FREESE
310 East North Street
Dodgeville 53533-1200

MARLIN D. SCHNEIDER
3820 Southbrook Lane
Wisconsin Rapids 54494-7548

JOHN GARD
481 Aubin St., PO Box 119
Peshtigo 54157-0119

LORRAINE M. SERATTI
HC-2, Box 558
Florence 54121-9620

GREGORY HUBER
406 South 9th Avenue
Wausau 54401-4541

JEFF STONE
7424 West Forest Home Ave.
Greenfield 53220-3358

Jane R. Henkel, Acting Director, Legislative Council Staff
1 East Main Street, Suite 401, P.O. Box 2536, Madison, Wisconsin 53701-2536

APPENDIX 2

DISCIPLINE OF HEALTH CARE PROFESSIONALS, SPECIAL COMMITTEE ON

OFFICERS

Chairperson

JOANNE HUELSMAN
Senator
235 West Broadway, Ste. 210
Waukesha 53186-4832

Secretary

FRED A. RISSER
Senator
5008 Risser Road
Madison 53705-1365

Vice Chairperson

GREGG UNDERHEIM
Representative
1652 Beech Street
Oshkosh 54901-2808

REPRESENTATIVES

DAVID CULLEN
2845 North 68th Street
Milwaukee 53210-1206

FRANK URBAN
3645 Emberwood Drive
Brookfield 53005-2388

LORRAINE SERATTI
HC-2, Box 558
Florence 54121-9620

SHELDON WASSERMAN
3487 North Lake Drive
Milwaukee 53211-2919

PUBLIC MEMBERS

KEITH R. CLIFFORD
Attorney
Clifford & Reuter, S.C.
44 East Mifflin St., Ste. 800
Madison 53703-2800

JERRY NOACK
Director, Physician Assistant Program
UW-Madison Medical School
1300 University Avenue, Rm. 1050
Madison 53706-1532

BARBARA SCHULTZ
Owner
Appearances at Alma's
609 Crestview Drive
Menomonie 54751-4103

CANDICE FREIL
Vice President-Health Services
PrimeCare Health Plan
N8 W33847 Forest Ridge Dr.
Delafield 53018

RICHARD G. ROBERTS, M.D.
Professor, Dept. of Family Medicine
UW-Madison Medical School
777 South Mills Street
Madison 53715-1896

JANET SCHULZ
Vice President
Medical Staff Services
Waukesha Memorial Hospital
N8W29323 Windrift Lane
Waukesha 53188-9409

KERMIT NEWCOMER, M.D.
Retired Physician
Gunderson Clinic, Ltd.
N2028 Wedgewood Drive East
LaCrosse 54601-7175

SUSAN ROSENBERG
Attorney, Domnitz, Mawicke, Goisman & Rosenberg, S.C.
1509 North Prospect Avenue
Milwaukee 53202-2323

MARY K. WOLVERTON
Attorney, Peterson, Johnson & Murray, S.C.
733 N. Van Buren St., 6th Fl.
Milwaukee 53202-4705

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.

APPENDIX 3

State of Wisconsin

JOINT LEGISLATIVE COUNCIL

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

Committee Staff:
One East Main Street, Suite 401
P.O. Box 2536
Madison, WI 53701-2536
Telephone: (608) 266-1304
Fax: (608) 266-3830
Email: leg.council@legis.state.wi.us

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

APPENDIX 4

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. Prachthauser, 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.)