2003-04 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Senate Committee on Health, Children, Families, Aging and Long Term Care

(SC-HCFALTC)

Sample:

Record of Comm. Proceedings … RCP

- 03hrAC-EdR_RCP_pt01a
- 03hrAC-EdR_RCP_pt01b
- 03hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- *03hr_sb0227_pt03*

- *Miscellaneous … Misc*
- **

- *Record of Comm. Proceedings … RCP*
- **

Jim Doyle
Governor

Donsia Strong Hill
Secretary

WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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Madison WI 53708-8935
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Statement on Bill Draft SB 227

Before The

COMMITTEE ON HEALTH, CHILDREN, FAMILIES, AGING AND LONG TERM CARE

Senator Carol Roessler, Chair

September 4, 2003
411 South, State Capitol

Statement of Secretary Donsia Strong Hill
Representing the Department of Regulation and Licensing

For Information Only

Good morning Chairwoman Roessler and members of the Committee. My name is Donsia Strong Hill and I am the Secretary for the Department of Regulation and Licensing. I am appearing today to comment on SB 227.

This bill contains provisions that the Department supports. In fact, this Administration has already implemented several of the bill's provisions. However, the bill also contains provisions that would be problematic if adopted.

Establishment of priority disciplinary cases.

This provision requires the Department to establish a priority system that gives the highest priority to those cases that have the greatest potential to adversely affect public health, safety and welfare. The provision also requires that the Department give special consideration to those cases that involve death, serious injury, substantial damages or sexual abuse of a patient or client.

I agree that cases should be prioritized. Some cases are more immediately important to public safety than others. Staff resources must be allocated to prosecutions that will provide the greatest degree of protection to Wisconsin citizens.

In addition, in the past, staff did not receive sufficient specific direction regarding which cases should be pursued first. Some staff members were individually determining which cases to pursue. This has changed under my leadership.

I have already directed that the highest priority be given to those cases that affect health, safety and welfare and that this mandate is being implemented. The Deputy Secretary and I are being briefed on every case currently open that exceeds the Department's existing case process

timelines to ensure that case priorities are being followed and that staff resources are being allocated appropriately. We will continue this practice until all such cases have been resolved.

Current law already imposes time limits for initiating disciplinary actions against physicians. (Wis. Stat. s. 448.02(3)). The law requires that a disciplinary action where a death has occurred be initiated within one year after initiating an investigation, and that a disciplinary action in all other medical cases be initiated within three years. As a result, these cases must receive priority treatment. In addition, I believe these mandates will create a significant need for increased resources in the near future.

Promulgate rules for identifying professionals who may warrant evaluation.

We have concerns about this provision. First, existing statutes already require that certain information be reported to the Department. For example, Wisconsin Statutes require that the Department receive claims paid reports that identify physicians who have had claims paid on their behalf by a malpractice insurance carrier (See Wis. Stat. ss. 632.715 and 655.23). When the Department receives this information, a complaint is recorded and an investigation is conducted. The Department also receives notice when there are losses or reductions in staff privileges (Wis. Stat. ss. 50 and 609). When cases are screened, the screening panels also review a history of past complaints against the health care provider.

Second, establishing other types of identifiers may violate concepts of due process and equal protection particularly if they are based on criteria that involve gender, age and race.

In addition, implementing this provision might violate the privacy rights of individuals who would be subject to having their otherwise protected medical records reviewed with no clear indication of any violation on the part of the health care provider.

Notwithstanding the foregoing, tools which would help in developing a system of markers to identify licensees warranting evaluation can only be made available through legislative changes.

For example, DUI convictions as well as convictions relating to any illegal drug related incident may be early indicators of behavior that could lead to unprofessional conduct by a practitioner. These convictions are not required to be reported to any of the examining boards or the Department. In addition, any plea bargain down from such a charge or a charge for which the factual basis would suggest relationship to unprofessional conduct may also be an early indicator deserving of report to a credentialing authority.

Notice to health care professionals, complainants, patients and clients and the health care professional's place of practice.

Under the Department's current procedure, complainants are informed when a complaint is received and when an investigation or case is closed. With respect to health related cases, approximately 1,600 notices of complaints received are sent to complainants annually. If the

To Carol From Camille Solberg

P.01

Hispanic Heritage Month
September 15 - October 15, 2003

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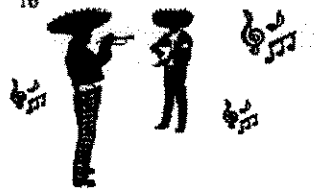
SEPTEMBER	15 **LIVE MARIACHI MUSIC** *Mariachi San Francisco* **KICK OFF** Multicultural Education Center 11:30 a.m. – 1:00 p.m.	16 	17 **SALSA AND MERENGUE** Dance Lessons Instructor: Rosalita Villa Professional Dancer Upper Gym, Kolf Sports Center 5:30 p.m – 7:00 p.m.	18 **PRESENTATION** *"Costa Rica: Cultural Aspects and its People"* Presenter: Marco Mena Professor, Foreign Languages Reeve Memorial Union, Wisconsin Room 5:30 p.m – 7:00 p.m.	19 ***"Mi casa es su casa" during September 15 - October 15, 2003. Join us as we celebrate the sounds, aromas and cultures of mi gente during Hispanic Heritage Month.*** 	20 **FLAMENCO PERFORMANCE** Dance Performance Estampa Chicago, Illinois *Fall Fest on the Fox* – Downtown Oshkosh 1:00 p.m. – 2:00 p.m.
	22 **MEETING** HISPANIC CULTURES UNITED Everyone is Welcome Library, Multicultural Education Center 6:00 p.m. 7:00 p.m.	23 **PRESENTATION** *"Domestic Violence in the Latino Community"* Presenter: Nedda Lopez, Case Worker Milwaukee's Women's Center Library, Multicultural Education Center 6:00 p.m. – 7:00 p.m.	24 **MI COCINA** Puerto Rican Cooking Demonstration Chef: Beatriz Contreras Financial Aid Director Kitchen, Multicultural Education Center 11:30 a.m 1:00 p.m.	25 **LATIN ORCHESTRA & DANCE LESSONS** Hector Silvera y su Orquesta Instructor: Miguel Mendez, Professional Dancer SalsaChicago.com, Chicago, Illinois Reeve Memorial Union, Titan Underground 2:00 p.m. – 4:30 p.m.	26 **21st Annual United States Hispanic Leadership Conference** September 26 – 28, 2003 Chicago, Illinois USHLI	
	29 **SALSA LESSONS** Animation Instructor: John Rosales, Professional Dancer Social Dance Studios in Minnesota Terrace Room, Gruenhagen Conference Center 8:00 p.m – 10:00 p.m.	30  OCTOBER	1 *"Hispanic Americans: Honoring our Past, Surpassing our Present and Leading our Future"* 	2 **DANCES FROM CENTRAL AND SOUTH AMERICA** CASS Program Fox Valley Technical College Appleton, Wisconsin Titan Lounge, Gruenhagen Conference Center 5:30 p.m. – 7:00 p.m.	3 **KARATE DEMOSTRATION** Self-Defense Workshop Instructor: Bill Soto Martial Arts America, Appleton, Wisconsin Aerobic Studio, Scott Hall 5:30 p.m. – 7:00 p.m.	4 **FOURTH ANNUAL DIA DE LOS PADRES** HCU Parents & Family Potluck HISPANIC CULTURES UNITED Everyone is Welcome Library, Multicultural Education Center 1:00 p.m. – 3:00 p.m.
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	13 **SPANISH HOUR** "Hora de Conversacion" Join HCU members for chocolate caliente con pan dulce Multicultural Education Center 11:30 a.m. 1:00 p.m.	14 **TANGO LESSONS** Tango Nada Mas Instructors: Bob Dronski & Kathleen Kreher Professional Dancers Terrace Room, Gruenhagen Conference Center 5:00 p.m. – 6:30 p.m.	15 **QUINCEAÑERA PROGRAM** "Dinner and Presentation" Facilitator: Susana Valtierra Music by: Guillermo Ruiz Reeve Memorial Union, Room 202 5:30 p.m. 8:00 p.m.			

Sponsored by Hispanic Cultures United, Division of Academic Support.
Co-Sponsored by the Foreign Language Department and Financial Aid.

All events are free, unless specified, and are open to the public.

For further information, call the Multicultural Retention Programs at the University of Wisconsin Oshkosh at (920) 424-3081.

Quinceañera Program is **FREE** to the first 50 UW Oshkosh students with ID; sign up in Dempsey 146 by **October 9, 2003**. Non-Students must pay $10.00.

THE UNIVERSITY OF WISCONSIN OSHKOSH

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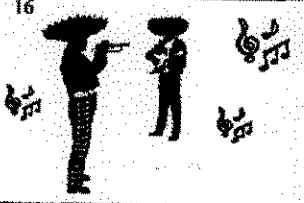
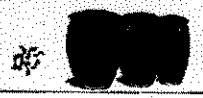
SEPTEMBER 15 **LIVE MARIACHI MUSIC** *Mariachi San Francisco* **KICK OFF** Multicultural Education Center 11:30 a.m. – 1:00 p.m.	16 	17 **SALSA AND MERENGUE** Dance Lessons Instructor: Rosalita Villa Professional Dancer Upper Gym, Kolf Sports Center 5:30 p.m – 7:00 p.m.	18 **PRESENTATION** *"Costa Rica: Cultural Aspects and its People"* Presenter: Marco Mena Professor, Foreign Languages Reeve Memorial Union, Wisconsin Room 5:30 p.m – 7:00 p.m.	19 ***"Mi casa es su casa" during September 15 - October 15, 2003. Join us as we celebrate the sounds, aromas and cultures of mi gente during Hispanic Heritage Month.*** 	20 **FLAMENCO PERFORMANCE** Dance Performance Estrompa Chicago, Illinois *Fall Fest on the Fox* – Downtown Oshkosh 1:00 p.m. – 2:00 p.m.
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complainant were also the victim, he/she would be notified during the course of the investigation.

Department staff notifies a health care professional when a case or an investigation is closed. The Department does not routinely notify the individual against whom the complaint is filed when the case is opened because such notice might impede the investigation. A routine part of each case investigation is, however, an interview of, or other contact with, the person being investigated.

The Department issues approximately 2,500 closeout letters annually.

Information regarding the health care professional's place of practice may not be readily available. The provider may change health care facilities and fail to notify the Department. Additionally, notification to the provider's place of practice may cause needless harm to the reputations of those who are named in the complaint. The mere filing of a complaint may ultimately mean nothing. However, the damage to reputation will have been done.

Opportunity for Patients and Clients to Confer Concerning Discipline

I have issued a directive to Department staff stating that, generally, it is Department policy to provide victims of alleged unprofessional conduct with the opportunity to provide information and to observe proceedings in the prosecution of cases. Specifically, staff have been directed to contact and interview victims, and to consider the victim's viewpoint in determining the resolution of cases. It is important that the Department retain flexibility in determining the appropriateness of the circumstances of victim contact.

Establishment of Disciplinary Procedure Time Guidelines

The Department has a timelines policy adopted by the previous administration that is fairly stringent. Depending upon the complexity of the case, screening is required to be conducted within 45- 60 days of receipt of the complaint; the investigation is to be conducted within 90-180 days after the completion of screening; any legal action must be taken within 90-180 days after the completion of the investigation; and the hearing stage must be conducted within 90 to 180 days after a formal complaint is filed by the Division of Enforcement.

These timelines are not always met. This is due to a number of factors, including the failure of hospitals or other facilities to timely respond to requests for health care records, uncooperative or hard to find witnesses, case loads and practice related time constraints of volunteer board members and most importantly, limited staff resources. While the Department has subpoena power as a practical matter it is rarely used because the remedy for non-compliance is not usually timely or certain. Nonetheless, we are in the process of reviewing whether these timelines should be adjusted.

In addition, the Division of Enforcement has been actively addressing the backlog of cases inherited by this Administration. Specific deadlines have been set for the completion of older cases. The first deadline was met. Others are on target.

Panels of Experts: Alternative Health Care Practitioners

The current screening panels consists of Board members and a Division of Enforcement attorney.

The Committee may wish to consider requiring that one member of every board be a professional who practices an alternative form of health care in a specific area.

Expansion of board membership to include more public members.

In my view, additional public members may not fully address the perceived problems with the Medical Examining Board. Public members often defer to professionals on every board. Increasing the number of public members may not alone affect that dynamic. The committee may want to consider including other professionals representing other disciplines or perspectives such as a nurse, or an alternative health care practitioner as required members.

Imposition of forfeitures and expanding summary suspension provisions to limit licenses

These are enforcement tools that might be useful.

Therapeutic related death

At a minimum these complaints would require the collection of significant medical records and an analysis of those records. Many would require investigation. It is very difficult to project the number of open cases that would result. The result could also vary greatly from coroner to coroner.

Closing

The ideals contained in this legislation are ones that we can and, for the most part, do support. At this point, the effectiveness of the goals of this legislation and the processes currently in place at the Department will continue to be constrained unless the fees collected are adjusted. This Department is funded solely by the fees paid by the self-regulated professions. These fees have simply not kept pace. Last spring the Department engaged Grant Thornton to conduct a fee study. The fee study indicated that most fees should be slightly raised to accomplish our mandate. Unfortunately, the Joint Committee on Finance declined to implement the fee changes. I think the worthy goals of this legislation, much of which is in place in some form in the Department, suggest that the fee change proposal deserves a second look. We'd appreciate any support the committee can provide in this effort.

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SEPTEMBER 4, 2003
PUBLIC HEARING
SENATE BILLS 226 AND 227

Senator Robson

- She asked if anyone has been hurt because a doctor was not disciplined for a previous act. **CR SAID WE CAN LOOK INTO THIS.**

Senator Jauch

SB 227

- Senator Jauch questioned to what extent do we have a problem? What is in place to measure improvement? He wants more info. on the scope of the problem. He is not convinced that we have people out there that the state knows are bad and are practicing. He further stated, "Yes, some improvements are necessary. Yes, the MEB is holding people accountable."
- He questions the language that requires investigation of those who may warrant investigation. **CR ASKED LAURA ROSE TO LOOK AT TESTIMONY ETC. FROM THE 1999 LEG COUNCIL COMMITTEE. CR WANTS TO KNOW WHAT INFORMATION WAS BEHIND THE SUGGESTION OF THIS LANGUAGE BY THE COMMITTEE.**

Secretary Hill, Department of Reg .and Lic.

SB 226

- She did provide written testimony.
- There is a National Practitioners Website which is only available to those who are in the system. She wonders why states haven't gotten together to gain assess to this database rather than each creating their own.
- Massachusetts paid $200,000 in 1996 to develop its site.
- The Secretary received from Mass. a step by step process on how they implemented their website.

SB 227

- **THE HIGH PRIORITY MANDATE IN THE BILL IS ALREADY BEING IMPLEMENTED.**
- **STATUS OF CASES: PRE 1976: THERE WERE 7, NOW THERE ARE NONE. PRE 1999 THERE WERE 44 AND NOW THERE ARE 29. PRE 2001, THERE WERE 177 NOW THERE ARE 122.**
- **POSSIBLE ADDITION, ALLOW INFO TO BE OBTAINED FROM COURTS ETC. THAT MAY DEMONSTRATE UNPROFESSIONAL CONDUCT.**
- The Dept. of Reg. and Lic. Does have timelines in place for completing cases, however, sometimes these are not always met due to the following: (a) delay in getting info. from a hospital. (b) Lack of resources.

- The Grant and Thorton fee study deserves a second look.
- It is not difficult to file a claim against a doctor. There is a one page complaint form on the DRL website which people can download from their computer free of charge.
- The DRL is working with DHFS to enter a Memorandum of Understanding regarding sharing information on professionals. EX: Folks who have not paid child support- DRL could remove professional lic.
- **CR ASKED THE DRL TO FIND OUT HOW THE STATE CAN FLAG PROFESSIONALS WHO HAVE OWI'S ETC. (FOR EITHER PRACTITIONER LICENSE REMOVAL OR FURTHER INVESTIGATION).**
- The avg. length of time to complete a case from the time it is filed, opened and then closed is discussed on page three of DRL's SB 227 written testimony.

Senator Welch

SB 227

- **HE IS CONCERNED ABOUT INVESTIGATING THOSE WHO WARRANT CONCERN. ARE THERE SPECIFIC THINGS WE ARE LOOKING AT?**
- **THE CORONER LANGUAGE ALSO CONCERNS HIM.**
- **CR DOES NOT THINK THE LANGUAGE IS OUT OF THEIR SCOPE OF PRACTICE BUT WILL REVIEW FURTHER.**

Senator Roessler

- **CR HAS CONCERNS ABOUT FUNDS DEDICATED FOR INTENDED DISCIPLINES ACTUALLY BEING USED FOR THOSE DISCIPLINES. EX: IF THE DENTAL HYGIENISTS FEE IS INCREASED, CR WANTS TO MAKE SURE THAT THOSE FUNDS ACTUALLY SUPPORT THE DENTAL HYGIENIST DISCIPLINE.**

Gary Radloff, DHFS

- DOA and WHA are working on a contract relating to physician data. If this bill moves forward, we need to discuss this with HFS.
- **CR ASKED FOR AMENDMENT DIRECTION FROM GARY.**
- **SHE SAID THAT THE END OF THE MONTH IS THE DEADLINE TO HAVE ALL PIECES OF THIS BILL IN PLACE.**

Dr. Werch, WI Medical Society

- He submitted written testimony.
- **CR WILL BE DELIBERATE IN HAVING A LINK ON DRL WEBSITE TO WI MED. SOCIETY.**

SB 227

- He really likes privatization section.
- MEB given greater flexibility…he likes this.
- He thinks that OWI's, prescriptions for narcotics etc. should cause a red flag.
- Expressed concerns about the coroner section. **CR SAID THIS MAY BE A SEPARATE BILL.**
- The WI Med Soc. Website on physician data had 163,000 hits.

SCOTT FROEHLKE

- His contact, Keith Clifford, is very knowledgeable and will be helpful in remembering events of 1999 Leg Council Committee.

Scott said he'll provide info.

Wisconsin Medical Society

Your Doctor. Your Health.

DATE: September 4, 2003

TO: Senator Carol Roessler, Chair, Senate Health Committee
Members, Senate Health Committee

FROM: Paul Wertsch, MD, President, Wisconsin Medical Society

RE: SB 227: Physician Discipline
Testimony For Information Only

Once again, good afternoon Chairperson Roessler and members of the committee. I am Dr. Paul Wertsch, here to testify as president of the Wisconsin Medical Society and its more than 10,000 members on Senate Bill 227. This testimony is for information only, regarding our thoughts on the positives and negatives of the bill.

Several provisions in SB 227 have merit.

Prioritizing Disciplinary Cases: The provision requiring the Department of Regulation and Licensing (DRL) to establish a system to prioritize disciplinary cases makes good intuitive sense. At a time when resources are limited and everyone is trying to control government spending, it makes the most sense to address serious problems first.

Allowing Medical Examining Board Greater Disciplinary Flexibility: The ability to limit a credential holder to specific practices appears to be a natural evolution in discipline. It would be a good way to increase fairness to credential holders while making it easier for the MEB to levy a sanction that need not be as draconian as a blanket license suspension.

Other portions of the bill, including sections establishing broader notification requirements when a complaint is filed and soliciting the advice of credentialing authorities regarding the creation of the new statutory sections, are also meritorious.

The Society does have some concerns over other parts of the bill.

Investigating Those Who "May" Warrant Evaluation: The provision requiring DRL to set up a procedure to identify licensees warranting evaluation, even though there is no specific allegation of any wrongdoing, is particularly troublesome. We applaud the Legislative Council Committee's hopes that the MEB could somehow become a proactive as well as reactive entity. Any such proactive attempts, however, must be evidence-based, and should focus on attributes that have been shown to impact patient outcomes. Until that evidence emerges, we question the efficacy of such a proactive effort.

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

Sen. Leggs letter

Reporting "Complication"-Related Death Provisions are Vague: Requiring a Medical Examiner or Coroner to put in essence a "red flag" on a death due to "complications" from surgery, prescription drug use and the like is in our opinion extremely vague. For example, if a patient has an unexpected reaction to cardiac drugs, does that warrant a DRL notification? Or if post-surgery a patient get an infection that does not respond to normal, within-the-practice treatment? The existing language of SB 227 could be interpreted to say that any death not clearly "natural" could qualify as a complication."

We believe these concerns need to be addressed before the bill is given consideration to move forward.

Thank you again for the opportunity to testify today. The 10,000 physicians I am representing today believe that the main tenet of our Hippocratic oath – "do no harm" – is the most important guiding principle we bring to our work as physicians. The Society welcomes continued high standards to ensure that the trust between physicians and patients continues based on the highest quality and standards of care possible. As this committee and members of the legislature look to try to deal with problems, we hope you will continue to work with physicians and members of the Wisconsin Medical Society. We physicians always appreciate the strong working relationship with the legislature; I hope we can continue that collaboration during my year as president of the Society.

Web site

Physician Direct

163,000 Hits

HFS on Reg's 46

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 simply 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.

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 by 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?

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 severe 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

Jim Doyle
Governor

Donsia Strong Hill
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WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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September 26, 2003

OCT 13 2003

The Honorable Carol Roessler
Chair, Senate Health Committee
Room 8 South
State Capitol
P.O. Box 7882
Madison 53707-7882

Dear Senator Roessler:

The Medical Examining Board recently learned that Senate Bills 226 and 227 have been scheduled for Executive Session before the Senate Health Committee on October 7 at 10:00 a.m. Due to a full agenda for our September 24 meeting, we were unable to comprehensively evaluate the proposed legislation.

Because the bills have significant implications for the Medical Examining Board, we are requesting that the Committee delay the Executive Session until after the Board's meeting on October 22.

We appreciate your willingness to consider our request.

Sincerely,

Sidney Johnson, MD

Sidney Johnson, M.D.
Chair, Medical Examining Board

c: Secretary Donsia Strong Hill, Department of Regulation and Licensing

To: Senator Carol Roessler and Members, Senate Health Committee

From: Darold A. Treffert, M.D., Fond du Lac 9/10/03

Re: SB 226 & SB 227 regarding web site information and physician discipline

In view of my testimony on these two bills in the last legislative session on behalf of the Wisconsin Medical Examining Board (MEB), and some of our more recent discussions, I would like to share with you my perspectives on these bills in their present form. I just completed my second 4-year term on the MEB in July, 2003 and completed my one year term as Chair of the MEB in January, 2003. On 10/17/01 I testified, representing the MEB, in support of, with some suggested modifications, what were then SB 139 and SB 140. I am pleased to see some of those suggested modifications have been included in these two present bills. Because they have not yet been presented to the MEB, the MEB has not taken a formal position on SB 226 and SB 227 as yet but I presume MEB will consider both bills soon. I have been involved with the Department of Regulation and Licensing (DRL) even prior to my term on the MEB in that Senator Roessler and I both served on a special committee appointed by the Governor in 1986 to suggest changes to DRL at that time, and I am pleased to say many, although not all, of those changes have been implemented as well through the intervening years.

- **I support SB 226** which expands the information and availability of website information to the public regarding licensed physicians in a user friendly manner, with appropriate interfacing of DRL with other already existing sites.

- In that 2001 testimony I recommended adoption of the *Massachusetts model* website information, which I still favor, and I have recommended that model to DRL recently as well. In August, 2003 the Federation of Medical Boards published a paper summarizing this effort nationally, which I sent to you earlier, and I recommend that paper to the other committee members as well.

- SB 226 is to be funded by a surcharge on physician licenses. In my experience most physicians would not object to added licensure fees for this, (or other intensified disciplinary efforts of the MEB) **so long as** those revenues are **dedicated** and allocated ***specifically*** and ***only*** to those purposes and do not disappear indistinguishably into the budgets of DRL or the "general fund". Tied to any such 'surcharge' should be a requirement that DRL spend these additional monies only on the surcharge purpose. Bear in mind that no monies are allocated directly to the MEB to carry out its work, and it has no direct jurisdiction or control over any monies. Monies are instead allocated the DRL which then decides on allocations among the Boards. While MEB has sole statutory *authority* for licensing and discipline, it does not have control over any of the *resources* allocated to DRL and in an instance of a specific surcharge particularly there should be a requirement that DRL be able to account for direct allocation of those monies to the intended purpose, and only to that purpose.

- **I also support SB 227**, with some suggested modifications. Many of the provisions in this bill were supported by MEB in the prior version: having these provisions apply to all Health Care Professionals rather than just the MEB; adding public members while preserving the number of MD/DO members; extending Summary Suspension Hearings to *limiting* licenses, in instances of grave danger to public health and safety, along with the present authority to suspend the license in its entirety in those instances; adding forfeitures for certain credential holder violations; improved notification systems for both complainant and health care professional; and improved opportunity for complainants, and others where appropriate, to participate in the resolution process.

- In my view, the *"identification of health care professionals who may warrant evaluation"*, is still a difficult area as I testified last session on behalf of MEB, for the reasons that concerned MEB at that time—lack of identified and tested markers for such a *pro*active system; competing priorities over against already existing cases given limited resources; and costs of such a system (five full-time positions in the fiscal estimate of SB 139 in the last session). While the effort is noble in intent, implementation must await a sound, evidence-based marker system that is consistent, reliable, affordable and legally defensible. In fairness though, SB 227 does suggest only that DRL establish a *system* for such identification, and that any such system be *phased in* over time rather than be implemented fully, and immediately as the prior version (SB139) required. That is a useful change since there is merit in studying such a system, in conjunction and collaboration with the various professions and Boards, to see what might already reliably exist, before implementing any such system fully.

- Establishing, monitoring and requiring certain procedure time guidelines, and priorities, in fairness to both the complainant and the licensees, is also an admirable goal. DRL and MEB, for example, already have some such guidelines and priorities in place and the number of open MEB cases has dropped dramatically in recent years. The key sentence in this bill with respect to implementing any additional, meaningful priority system for MEB, however, is the one which reads: *"The priority system shall be used to determine which cases receive priority of consideration **and resources**....to most effectively protect the public health, safety and welfare"*(my emphasis added). If a priority system is to be implemented for the MEB that is an improvement over the present system, with an expectation of improved timelines for disposition of cases, then there must be adequate *dedicated* resources for the MEB for the same reasons outlined above: i.e. to be effective MEB, which has the statutory authority and responsibility for timely disposition of MEB cases, must also have sufficient investigative, attorneys

and supportive staff to carry out that mission promptly, and must have reasonable control over the assignment and utilization of those resources. In short, if Medical License fees are to be increased to support those activities, and the MEB is to be held accountable for more stringent timelines in processing cases, then there needs to be some assurance DRL will allocate and dedicate such resources to the MEB. No such procedure, or assurance presently exists. In fact, MEB is not directly involved in the budgeting process at all at the present time, nor is it directly involved in resource allocations or personnel assignments--(who works on what cases with which priority). Those determinations are made by DRL (Division of Enforcement) and not by the Medical Examining Board, even though MEB has statutory responsibility (and accountability) for the disciplinary process.

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DAROLD A. TREFFERT, MD

SEP 16 2003

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Darold Treffert, MD

From: "Darold Treffert, MD"
To: <Sen.Roessler@legis.state.wi.us>
Sent: Saturday, September 13, 2003 8:32 AM
Attach: SB 226 and SB 227 testimony.doc
Subject: Attn: Carol and Jennifer

Attached are my comments about SB 226 and 227. I hope they are helpful. I will be sending them by regular mail as well, along with my prior testimony on behalf of MEB (last session) and the minutes from the Leg Council regarding
therapeutic mis-adventures disscussions. I will share these comments and my prior testimony with Dr. Sid Johnson, present Chair of MEB since these bills will probably come up for discussion at this month's meeting. MEB has not reviewed these bills, nor taken a position on them as yet.

Darold Treffert

Darold

Perhaps you could distribute my comments/testimony on 226 & 227 to the other committee members, and John Townsend, if you would please

DT

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Darold Treffert

To: Senator Carol Roessler and Members, Senate Health Committee

From: Darold A. Treffert, M.D., Fond du Lac 9/10/03

Re: SB 226 & SB 227 regarding web site information and physician discipline

In view of my testimony on these two bills in the last legislative session on behalf of the Wisconsin Medical Examining Board (MEB), and some of our more recent discussions, I would like to share with you my perspectives on these bills in their present form. I just completed my second 4-year term on the MEB in July, 2003 and completed my one year term as Chair of the MEB in January, 2003. On 10/17/01 I testified, representing the MEB, in support of, with some suggested modifications, what were then SB 139 and SB 140. I am pleased to see some of those suggested modifications have been included in these two present bills. Because they have not yet been presented to the MEB, the MEB has not taken a formal position on SB 226 and SB 227 as yet but I presume MEB will consider both bills soon. I have been involved with the Department of Regulation and Licensing (DRL) even prior to my term on the MEB in that Senator Roessler and I both served on a special committee appointed by the Governor in 1986 to suggest changes to DRL at that time, and I am pleased to say many, although not all, of those changes have been implemented as well through the intervening years.

- **I support SB 226** which expands the information and availability of website information to the public regarding licensed physicians in a user friendly manner, with appropriate interfacing of DRL with other already existing sites.

- In that 2001 testimony I recommended adoption of the *Massachusetts model* website information, which I still favor, and I have recommended that model to DRL recently as well. In August, 2003 the Federation of Medical Boards published a paper summarizing this effort nationally, which I sent to you earlier, and I recommend that paper to the other committee members as well.

- SB 226 is to be funded by a surcharge on physician licenses. In my experience most physicians would not object to added licensure fees for this, (or other intensified disciplinary efforts of the MEB) **so long as** those revenues are **dedicated** and allocated ***specifically*** and ***only*** to those purposes and do not disappear indistinguishably into the budgets of DRL or the "general fund". Tied to any such 'surcharge' should be a requirement that DRL spend these additional monies only on the surcharge purpose. Bear in mind that no monies are allocated directly to the MEB to carry out its work, and it has no direct jurisdiction or control over any monies. Monies are instead allocated the DRL which then decides on allocations among the Boards. While MEB has sole statutory *authority* for licensing and discipline, it does not have control over any of the *resources* allocated to DRL and in an instance of a specific surcharge particularly there should be a requirement that DRL be able to account for direct allocation of those monies to the intended purpose, and only to that purpose.

- **I also support SB 227**, with some suggested modifications. Many of the provisions in this bill were supported by MEB in the prior version: having these provisions apply to all Health Care Professionals rather than just the MEB; adding public members while preserving the number of MD/DO members; extending Summary Suspension Hearings to *limiting* licenses, in instances of grave danger to public health and safety, along with the present authority to suspend the license in its entirety in those instances; adding forfeitures for certain credential holder violations; improved notification systems for both complainant and health care professional; and improved opportunity for complainants, and others where appropriate, to participate in the resolution process.

- In my view, the *"identification of health care professionals who may warrant evaluation"*, is still a difficult area as I testified last session on behalf of MEB, for the reasons that concerned MEB at that time—lack of identified and tested markers for such a *pro*active system; competing priorities over against already existing cases given limited resources; and costs of such a system (five full-time positions in the fiscal estimate of SB 139 in the last session). While the effort is noble in intent, implementation must await a sound, evidence-based marker system that is consistent, reliable, affordable and legally defensible. In fairness though, SB 227 does suggest only that DRL establish a *system* for such identification, and that any such system be *phased in* over time rather than be implemented fully, and immediately as the prior version (SB139) required. That is a useful change since there is merit in studying such a system, in conjunction and collaboration with the various professions and Boards, to see what might already reliably exist, before implementing any such system fully.

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[illegible] coroner from mbe

- Needed stat. requirement in order to be able to report a suspicious death.
  - Dr. Jensen