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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
Lynn Klemmer, Carol Kujawa, Brenda Kurtti, Respondents.	:	LS0402092NUR

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Veterinary Examining Board.

The Division of Enforcement and Administrative Law Judge are hereby directed to file their affidavits of costs with the Department General Counsel within 15 days of this decision. The Department General Counsel shall mail a copy thereof to respondent or his or her representative.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 9th day of December, 2004.

Jacqueline Johnsrud, RN
Board Member
Board of Nursing

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
LYNN M. KLEMMER, R.N., CAROL J. KUJAWA, R.N., BRENDA KURTTI, R.N., RESPONDENTS.	:	LS0402092NUR

PROPOSED DECISION AND ORDER

The parties to this action for purposes of §227.53, Wis. Stats., are:

Mr. Steven P. Sager
Sager, Colwin, Samuelsen & Associates, S.C.
201 South Marr Street
P.O. Box 2068
Fond du Lac, WI 54936-2068

Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A hearing in the above-captioned matter was held on July 27 and September 8, 2004, before Administrative Law Judge Jacquelynn B. Rothstein. The Division of Enforcement appeared by attorney Jeanette Lytle. Attorney Steven P. Sager appeared on behalf of Lynn M. Klemmer, Carol J. Kujawa, and Brenda K. Kurtti.

Based on the entire record in this case, the undersigned administrative law judge recommends that the Board of Nursing adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Lynn M. Klemmer, R.N., (dob 4/28/55) is duly licensed as a registered nurse in Wisconsin (License # 76816). Her lic was first granted on August 29, 1980.

2. Ms. Klemmer's latest address on file with the Department of Regulation and Licensing is 2332 Ashland Street, Oshkos Wisconsin.

3. Carol J. Kujawa, R.N., (dob 4/13/39) is duly licensed as a registered nurse in Wisconsin (License # 35829). Her licer first granted on November 16, 1959.

4. Ms. Kujawa's latest address on file with the Department of Regulation and Licensing is 655 W. 19th Avenue, Oshkosh Wisconsin.

5. Brenda K. Kurtti, R.N., (dob 2/3/61) is duly licensed as a registered nurse in Wisconsin (License # 101823). Her licer was first granted on November 16, 1959.

6. Ms. Kurtti's latest address on file with the Department of Regulation and Licensing is 1595 Villa Park Drive, Oshkosh, Wisconsin.

7. At all relevant times related to this matter nurses Klemmer, Kujawa, and Kurtti were employed at Mercy Medical Cent Oshkosh, Wisconsin.

8. On December 24, 1996, Baby C.L. was born and placed in a special care nursery at Mercy Medical Center due to a murmur and hypoglycemia. The treating physician ordered oxygen therapy, cardio-respiratory monitoring, and an intrav solution of 10% Dextrose for the infant.

9. To obtain the Dextrose solution, hospital policy required the entry of a mnemonic into a computer. The nurse who ord

solution contacted the pharmacy for the mnemonic because she could not recall what it was. She was given the reques information, but the incorrect mnemonic was entered into the computer. As a result, 10% Dextran with 5% Dextrose v solution delivered to the nursery. This error was not noticed before the solution was administered to Baby C.L. or befo day shift ended on December 24, 1996.

10. Ms. Klemmer, who worked the evening shift on December 24, 1996, assisted the treating physician in starting an intrav (IV) line on Baby C.L.

11. Once the IV line was established, Ms. Klemmer started the infusion of the 10% Dextran with 5% Dextrose solution wit noticing the medication error. Ms. Klemmer worked the remainder of the evening shift without noticing the medication

12. Ms. Kurtti followed Ms. Klemmer on the night shift which began on December 24, 1996, and concluded on Decembe 1996. During that shift, she administered a bolus through the IV to Baby C.L., in response to a doctor's order, but did notice the medication error on her shift.

13. Ms. Kujawa worked the next shift, beginning at 7:30 a.m. on December 25, 1996. At 11:30 a.m . she changed Baby (IV bag and noticed the medication error. Ms. Kujawa immediately ordered a bag of Dextrose, changed the IV solutio contacted the physician on-call.

14. Baby C.L. was flown by helicopter to another hospital for a transfusion. He recovered with no apparent permanent eff

15. Nurse Klemmer failed to check the intravenous bag of solution to ensure that it contained the right medication prior to in its infusion on Baby C.L.

16. Nurse Kurtti failed to check Baby C.L.'s intravenous bag of solution at the beginning of her shift to ensure that it was th correct medication being administered.

17. Nurse Kujawa failed to check Baby C.L.'s intravenous bag of solution at the beginning of her shift to ensure that it was correct medication being administered.

18. A minimally competent registered nurse should check an intravenous bag of solution to ensure that it contains the right medication prior to initiating its infusion on a patient.

19. A minimally competent registered nurse should check an intravenous bag of solution at the beginning of his or her shift t ensure that the correct medication is being administered.

CONCLUSIONS OF LAW

1. The Nursing Board has jurisdiction in this matter pursuant to §441.07, Wis. Stats.

2. By having failed to check the intravenous bag of solution for Baby C.L. as set forth in Findings of Fact 10-11 and 15, Ms. Klemmer engaged in unprofessional conduct contrary to § 7.04 (4), Wis. Admin. Code.

3. By having failed to check the intravenous bag of solution for Baby C.L. as set forth in Findings of Fact 13 and 17, Ms. Kujawa engaged in unprofessional conduct contrary to § 7.04 (4), Wis. Admin. Code.

4. By having failed to check the intravenous bag of solution for Baby C.L. as set forth in Findings of Fact 12 and 16, Ms. Kurtti engaged in unprofessional conduct contrary to § 7.04 (4), Wis. Admin. Code.

ORDER

NOW THEREFORE IT IS HEREBY ORDERED that Lynn M. Klemmer, Carol J. Kujawa, and Brenda K. Kurtti are **REPRIMANDED**.

IT IS FURTHER ORDERED that Ms. Klemmer and Ms. Kurtti take and successfully complete a course of study approved by the Board of Nursing related to the administration of medication, including intravenous solutions, within one year of the date on which this order is signed.

IT IS FURTHER ORDERED that Ms. Klemmer and Ms. Kurtti shall not work in a supervisory or charge nurse capacity for one year following the date on which this order is signed.

IT IS FURTHER ORDERED that the assessable costs of this proceeding be imposed upon Lynn M. Klemmer, Carol J. Kujawa, and Brenda K. Kurtti pursuant to sec. 440.22, Wis. Stats.

OPINION

On December 24, 1996, Baby C.L. was born at Mercy Medical Center (Mercy) located in Oshkosh, Wisconsin. Bec Baby C.L. was diagnosed with having a cardiac murmur and hypoglycemia, he was placed in a special care nursery at Mercy. C.L.'s treating physician ordered oxygen therapy, cardio-respiratory monitoring, and an intravenous solution of 10% Dextrose

To obtain the Dextrose solution for infants in the special care nursery, hospital policy required the entry of a mnemonic computer, typically done by a nurse. The nurse who ordered the solution contacted the pharmacy for the mnemonic because sh not recall what it was. She was given the requested information, but the incorrect mnemonic was nevertheless entered into the computer. As a result, 10% Dextran with 5% Dextrose was the solution delivered to the nursery. That error was not noticed b the solution was administered to Baby C.L. or before the day shift ended on December 24, 1996.

Lynn M. Klemmer, who is a registered nurse, worked the evening shift on December 24, 1996, at Mercy. That evenin assisted Baby C.L.'s treating physician in starting an intravenous (IV) line on the infant. Once the IV line was established, Ms. Klemmer started the infusion of the 10% Dextran with 5% Dextrose solution without noticing the medication error. She worke remainder of the evening shift without noticing the error.

Brenda K. Kurtti, who is also a registered nurse, followed Ms. Klemmer on the night shift, which began on December 1996, and concluded on December 25, 1996. During that shift, Ms. Kurtti administered a bolus through the IV to Baby C.L., response to a doctor's order, but did not notice the medication error on her shift.

Carol J. Kujawa, also a registered nurse, worked the next shift, beginning at 7:30 a.m. on December 25, 1996. At 11: she changed Baby C.L's IV bag and noticed the medication error. Ms. Kujawa immediately ordered a bag of Dextrose, chang IV solution, and contacted the physician on-call. Baby C.L. was subsequently flown by helicopter to another hospital for a transfusion. He recovered with no apparent permanent effects.

There is no dispute that the wrong intravenous solution was administered to Baby C.L. He was given 10% Dextran wit Dextrose when, in fact, he should have been given 10% Dextrose. At issue is whether the failure of nurses Klemmer, Kurtti, an Kujawa to notice that medication error means that their nursing practices fell below the minimally accepted standard of care wit profession.

Testifying on behalf of the Board of Nursing as an expert witness was Susan Yadro, an assistant clinical professor at th University of Wisconsin School of Nursing. Ms. Yadro has over thirty years of nursing experience, including having worked wi critically ill infants in various hospital settings. According to Ms. Yadro, when a nurse begins caring for a patient, it is her respon to assess that patient. As part of that assessment, a nurse must verify what medications have been ordered for a patient and wh medications the patient is actually receiving. The fact that another nurse may have initiated the medication intravenously does no obviate the responsibility of a subsequent treating nurse to do her own, independent assessment of a patient to ensure that the medication ordered is what the patient is truly receiving. Therefore, the standard of care requires that each nurse independently each patient and, if medications have been ordered for a patient, the nurse must cross check the medication order with the medi that is being administered in order to ensure that they are one and the same. Ms. Yadro outlined this standard of care as follow

> Q: (by Ms. Lytle) Does the fact that another nurse, who's not a Respondent in this case, hung the IV solution change your opinion at all?
> A: No. Nurses' responsibilities and accountability does not end or begin with when you come on your shift

and what is presented to you. A nurse – if another nurse hung an IV, I would consider it my responsibility, the nurse's responsibility to validate that that is indeed what is hanging. It's, you just simply have to validate that information. You can't go on assumptions. And in this case, validating what was hanging would have taken less than a minute. It wasn't some big drawn-out procedure, and especially if I was coming on, I was coming on to a shift and somebody had left something for me, I certainly would have to collect my own information and make my own assessments. I definitely would not leave it open for debate or question. I would have to find my own assessments. That's what I do as a nurse when I come on. No matter what somebody else tells me, it is my responsibility and duty to form my own assessments and gather my own information.

Q: So just to be clear, what is the minimum that a nurse needs to do in the real world in order to meet the minimum standard of care to ensure that what is in that IV solution is what is supposed to be in that solution?

A: I would expect that a nurse would, when they're doing their assessments, would go into a room and know for certain what is going into their patient, what is coming out of their patient, what's going on with their patient. It's part of the overall assessment that nurses are required to do when they come on to their shift. You need to collect your own database. And I would at the minimum expect that a nurse would know and be able to verify that the IV that was ordered is the IV that's hanging.

Q: And to know that information, what is the minimum that a nurse actually has to do?

A: They have to look at the bag. They have to check the M.D. order, and they have to look physically at the bag.

(Tr. at 35-37).

When Ms. Klemmer made her assessment of Baby C.L. she was able to see only a portion of the IV label. The particular letters she saw were "DEX." Based on her experience in Mercy Medical Center's nursery and the IV solutions typically used on infants, she believed that the solution she saw was 10% Dextrose. Similarly, Ms. Klemmer, when conducting her assessment of Baby C.L., reported that when she looked at the bag of IV solution, she saw that it was "kind of folded in" and that it had the lettering "10% DEXTR" on it. Based on her experience at Mercy Medical Center, she too believed she was looking at a bag of 10% Dextrose. Nurse Kujawa also noted having a similar experience with her initial assessment of Baby C.L. According to her report, the physician order was for 10% Dextrose. When she looked at the bag of solution to confirm that information, she saw "10% DEX" and was therefore satisfied that what was flowing from it was 10% Dextrose. It was not until she went to check on Baby C.L. approximately four hours later that she discovered that the IV solution was not 10% Dextrose, but was instead 10% Dextran with 5% Dextrose.

In contrast to Ms. Yadro's testimony, Jill Harr, a professor of nursing at Bellin College of Nursing at Green Bay, concluded that there had not been a violation of the standard of care in this case. She testified, in pertinent part, as follows:

Q: (by Mr. Sager) Now, you know that in hindsight there was a medication error in this case and it was 10 percent dextran that was administered?

A: Yes.

Q: And you understand how this occurred and listened carefully to the way these nurses made their assessments. Is your opinion still, even though there was a medication error, that they complied with these standards of nursing practice and minimum competency that I just asked you about?

A: I believe they did.

Q: Why?

A: I believe that they felt satisfied that they -- that indeed the right solution was hanging. As we now know in retrospect it wasn't, but they were satisfied in their own minds at the time that they looked it and that that was correct.

Q: They did make an assessment, in other words?

A: Yes.

Q: The assessment turned out to be incorrect?

A: (Indicating).

Q: You have to answer yes or no.

A: Yes.

Q: Based on your assessment of this, was that a reasonable assessment to make based on their assumptions

and how you know this unit operation and the type of IV solution and the potential for mixups; was that all reasonable?

A: I believe it was.

****

Q: (by Ms. Lytle) So you said that you think that they complied with the minimum standard of care because in their minds they were sure that they had the correct medication, is that right?

A: Yes.

Q: So the standard then hinges on what's in their minds?

A: I think it always does. The nurse has to be convinced as to what they're seeing, what they're doing, what assessments they're making. That doesn't mean that they're not sometimes in error, but if they're convinced of it, that's the best that you can ever hope for.

Q: But what's in their mind is going to depend on what gets put in their minds, right?

A: Yes.

Q: So if they are looking at only part of the entire spectrum of information that's available, willfully looking at part of the entire spectrum of information that's available, is it still your opinion that they've met the minimum standard of care?

A: I don't believe they were willfully only looking at part of it. I think they felt that they were seeing -- they were seeing what they expected to see.

Q: Well, they chose not to smooth out that bag and look at the entire name, right?

A: I don't believe they felt at the time that there was a need to, because they felt that what they were seeing was indeed what it was.

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Q: (by Ms. Lytle) So you're saying in an ideal world they would have looked at the entire name on the IV bag, but in the real world they somehow have -- don't have the obligation to?

A: I'm not saying they don't have an obligation to. I think that if you had a number of nurses and said look at this IV bag, you'll see some of them will and some of them won't and that they will all feel like they are satisfied with what they are seeing.

Q: So as long as the nurse is satisfied, she's met the standard?

A: If she feels satisfied, then she has, yes.

(Tr. at 236-37, 257-59, and 260).

Ms. Herr maintains that because each of these nurses was satisfied in her own mind that what they looked at on the label was correct, they, in turn, had met the requirement of having done a complete assessment. Ms. Herr's opinion is not persuasive. While the evidence demonstrates that each of these three nurses conducted an assessment, they were nevertheless incomplete. They were incomplete because, with the exception of Ms. Kujawa's final one, they merely glanced at a folded bag of IV solution, without unfolding it in order to read the entire label. As a result, they each reached a conclusion based on partial and incomplete information. The fact that they were individually satisfied in their own minds that what they saw was indeed what had been ordered is not a reasonable standard of care. Otherwise, whatever one believes in his or her mind to be correct will then become the standard of care within the nursing profession. Based upon that logic, complete verification would never be necessary or required. Instead, only partial confirmation of critical information would be needed as long as nurses believed that whatever they were seeing on a label was consistent with what they believed had been ordered. An objective standard would cease to exist. In its place would be an ever-changing standard based upon individual perceptions. Because Ms. Herr's standard of care is based on a fluid concept rather than upon an objective measure to which all nurses can adhere, her testimony on this issue is simply not credible, nor is it persuasive.

Because each of these nurses failed to take a full and complete look at the label on the IV solution and then verify that information with what was contained in the medication order for Baby C.L., their assessments were incomplete and thus fell below the minimal standards of professional conduct. In their defense, Mesdames Klemmer, Kurtti, and Kujawa argue that at the time of this incident the labeling for the two solutions, that is, the 10% Dextrose versus the 10% Dextran, 5% Dextrose, was virtually identical. While that may well have been the case, it is an unconvincing argument. Indeed, it suggests that even more caution should have been exercised in reading labels if there was even a remote possibility that another type of solution could have been substituted for the one ordered.

These nurses also argue that they had not previously encountered the 10% Dextran, 5% Dextrose solution in the

nursery, and, as such, had no expectation that anything other than the 10% Dextrose would be ordered for an infant. They also argue that the policy for obtaining this solution is now different and that the labels for these two solutions no longer look alike. Although that is undoubtedly true, it misses the point. The fact remains that when conducting an assessment of a patient, regardless of what hospital unit a patient is on, nurses are obligated to look at labels in their entirety and to verify that what they see on the label is what was ordered by the treating physician.

Registered nurses are able to practice in multiple settings. They are not restricted to one area of health care and may practice wherever they choose. Consequently, they are free to work in a variety of settings and often do, floating between different units in a hospital, for instance, or moonlighting as an itinerant nurse. It is therefore imperative for them to exercise vigilance in checking medication orders against the actual medication being administered in every setting in which they work. Failure to do so violates the standard of care within the nursing profession and wrongly encourages complacency in settings in which it cannot be tolerated.

The question therefore remains as to what the appropriate form of discipline is for Lynn M. Klemmer, Carol J. Kujawa, and Brenda K. Kurtti. It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. *State v. MacIntyre*, 41 Wis. 2d 481, 485 (1969).

To assist in that determination, it is useful to consider the response that each nurse provided to the question of whether, in hindsight, she would do anything differently in assessing this infant. Ms. Klemmer responded in the following manner:

Q: (by Mr. Sager) Let me ask you a direct real quick question. You know the allegations against you that you failed to make an assessment of this patient and that you failed to appreciate the error in the IV medication. As you look back, would you have done anything different in your assessment of this infant on the afternoon of December 24, 1996?
A: I would do nothing different now.

****

Q: (by Mr. Sager) Now, I assume that this has had an effect on you. Would you change your practice today if you had that same kind of foldover D-E-X-T-R happen to you again?
A: I wouldn't change it. I assumed that that was the correct solution and the most common solution we'd be running in the newborn nursery.

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Q: (By Ms. Lytle) So I need to know the answer. Now, as you practice, if you come on a shift, there's an IV bag hanging, it's folded in, you see the first few letters, it looks like a bag that you're familiar with, do you unfold it or not?
A: If I'm comfortable with the bag that is hanging, I would not change my practice.
Q: So that's your regular way of practicing, that's how you would approach things in the normal course of business?
A: In this instance, with this IV, and IVs, if it's the solution that is -- if I feel comfortable with that solution hanging, I would continue on doing my assessments.
Q: And without unfolding the bag?
A: Yes, if I felt that that solution, that I saw there, that I was comfortable with what that solution was.

(Tr. at 127, 151-52, and 156-57).

In response to a similar line of questioning, Ms. Kurtti testified as follows:

Q: (by Ms. Lytle) As you practice today, if you come upon an IV bag for a patient of yours that is folded in on itself and you can see a few letters and it looks very much like bags that you were familiar with, do you unfold the bag and take a look and read the label on the bag?
A: Not necessarily, no.
Q: Under what circumstances would you unfold the bag?
A: If I couldn't see anything on it, I possibly would. But if I -- and we use so few IVs, even on our moms,

that, I mean, we use one main one, and that would probably be about the only time that I would actually take it apart, if I couldn't see any writing on it at all.

Q: What's the main solution that you use with moms?

A: Lactated ringers.

Q: So if you saw L-A-C on the bag and it looked pretty much like the lactated ringers, would you unfold and take a look at it?

A: Probably not, no.

(Tr. at 194-95)

Ms. Kujawa, when asked this same question, replied in the following way:

Q: (by Mr. Sager) Have you any comment on how this has affected you and what you do in the future with regard to assessing situations like this? Have you changed your practice; what do you do now?

A: If -- in hindsight, because of the fact that the -- if a bag would be folded, I would open it up. If a bag is totally visible to me and I can read everything on the bag and know that it's D10 or whatever.

Q: You heard Nurse Kurtti say that if, for example, there was a bag up there and all she could see was L-A-C and R-I-N-G, what would you do if you could only see that type of medication information and the physician's order was for lactated ringers?

A: Prior to this incident, I would have assumed that was lactated ringers.

Q: Would you do the same today?

A: If the bag was folded, as I said, I would.

Q: You would take it apart?

A: I would open it up.

****

Q: (by Ms. Lytle) But your testimony is that now as -- well, I understand you're retired, but as you practiced most recently, if you came on a shift and an IV was hanging and you saw just a couple of letters and it looked like an IV that you were familiar with, you would still unfold it and read the entire solution name?

A: Yes, because as Mr. Sager said, once burned, twice cautious.

(Tr. at 219-20)

With the exception of Ms. Kujawa's response, these answers are startling. They demonstrate that Ms. Klemmer and Ms. Kurtti believe that this was merely a minor infraction for which they were not responsible. It further demonstrates that this same type of error would occur repeatedly because they intend to do nothing differently when faced with a similar set of circumstances in the future. Their attitude is not only perplexing, but also dangerous especially given the insignificant amount of energy and effort it would take to unfold an intravenous bag of solution and to read its label fully. Throughout their shifts, each of these nurses made hourly checks on Baby C.L. During each of those checks they could easily have reached up to the pole on which the bag of IV solution was hanging and touched it. Each could have done so within a matter of seconds to verify that the medication being administered was correct.

But rather than concede that they need to alter their practice, Ms. Klemmer and Ms. Kurtti steadfastly cling to the proposition that they can rely upon their own assumptions about what medication is being administered instead of actually making certain that it is correct. Their position is untenable. Making assumptions about what type of medication is being administered to a patient is undeniably dangerous. As this case illustrates, mistakes can and do happen. In order to avoid them and potential fatalities, nurses must adhere to the required standard of care. Unfortunately, the standard was not followed here.

Corrective measures are therefore appropriate for Ms. Klemmer and Ms. Kurtti. Those include remedial education as it relates to administering medications, especially intravenous ones, and a reprimand. Additionally, Ms. Klemmer and Ms. Kurtti are prohibited from acting as nursing supervisors or as charge nurses for a one year period. These disciplinary measures are necessary in order to rehabilitate the practices of Ms. Klemmer and Ms. Kurtti. They are also being imposed in an effort to deter other nurses from acting in a similar manner as well as to safeguard the public.

Because Ms. Kujawa acknowledged her responsibility with respect to Baby C.L.'s medication error and indicated that her practices have since changed, and also in light of her retirement from the practice of nursing, additional disciplinary

measures, apart from a reprimand, are not warranted.

In addition to the aforementioned discipline, the imposition of costs against these three nurses is recommended. Section 440.22(2), Stats., provides in relevant part as follows:

> In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against a respondent is a discretionary decision on the part of the Board of Nursing, and that the Board's discretion extends to the decision whether to assess the full costs or only a portion of the costs. The recommendation that the full costs of the proceeding be assessed is based primarily on fairness to other members of the profession.

The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding. Accordingly, the assessable costs of this proceeding should be imposed on Ms. Klemmer, Ms. Kurtti, and Ms. Kujawa.

Dated this 13th day of October, 2004, at Madison, Wisconsin.

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Jacquelynn B. Rothstein
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