HB

70

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February 17, 1987

MEMORANDUM

TO: House Judiciary Committee

FROM: Representative John Sund

RE: HB70 "An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

.....

According to Chairperson Tom Conley, the State Medical Board is failing to carry out its statutory assigned functions and thus failing in part to detect and weed out incompetent and impaired practice. Due to inadequate funding the Board cannot carry out investigations, perform day to day administrative functions, meet with statutory required regularity, cooperate effectively with national regulatory groups, etc.

The Board further lacks sufficiently strong statutory powers vis a vis access to information from hospitals and authority over its non membership to carry out supervision effectively (in terms of assuring competence and the detection of impairment and illegal or unethical practice).

HB70 addresses these issues and makes a few minor housekeeping changes as requested by the State Medical Board.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
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M E M O R A N D U M February 17, 1987

SUBJECT: Sectional analysis of HB 70, relating to the State Medical Board

TO: Representative John Sund

FROM: Edward H. Hein
Legislative Counsel

Section 1 requires that the amount of fees collected by the state for medical licenses, permits, and applications during the previous calendar year shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board.

Sec. 2 requires that applicants for medical license examinations submit their applications to the State Medical Board 120 days before the examination date, rather than 40 days before the examination date.

Sec. 3 eliminates oral examinations for licenses to practice medicine or osteopathy.

Sec. 4 rewrites the statute relating to inactive medical licenses. Current law requires that a licensee must reside outside the state in order to obtain an inactive license. As rewritten, a licensee's residence would be irrelevant. The only criterion would be whether the licensee practices in the state. If the licensee does practice in the state, no matter how infrequently, the licensee must hold an active license.

Sec. 5 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a). These acts are: (1) securing a license through deceit, fraud, or intentional misrepresenta-

tion; (2) engaging in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities; (3) advertising professional services in a false or misleading manner; (4) having been convicted of a felony or other crime substantially related to the licensee's qualifications, functions, or duties, or a crime involving unlawful procurement, sale, prescription, or dispensing of drugs; (5) having procured, sold, prescribed or dispensed drugs in violation of law; (6) intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards, even if the patient was not injured; (7) failing to comply with the provisions of AS 08.64, or a regulation or order of the board; (8) demonstrating professional incompetence, gross negligence, or repeated negligent conduct, or addiction to drugs, or unfitness because of physical or mental disability; (9) engaging in unprofessional, lewd, or immoral conduct while serving a patient; (10) performing an abortion (A) without a license; or (B) outside of a hospital or other facility approved by the Department of Health and Social Services or a federal hospital; or (C) on an unmarried minor without consent of the minor's parent or guardian; or (D) on a woman who has not been in the state for at least 30 days before the abortion; (11) violating any ethical code regulation adopted by the board; (12) denying care or treatment to a patient or person seeking treatment solely because the patient or person fails or refuses to agree to arbitrate under AS 09.55.535(a); or (13) having had a medical license or certificate suspended or revoked in anotner state, U.S. territory, or Canadian province, unless the suspension or revocation was for failure to pay fees.

Sec. 6 adds to current law a requirement that a hospital that places a consultation requirement on, revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.

Sec. 7 clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a

practitioner is a danger to the health or welfare of the public or the practitioner's patients". This section also specifically authorizes the board to suspend the licensee's license before appointing the committee or before receiving the committee's report.

Sec. 8 adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Sec. 9 adds two new statutes. AS 08.64.337 gives the medical board subpoena power and the power to administer oaths for purposes of an investigation of a licensee. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board expense, and may include tests requested by the examining physician.

Sec. 10 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings.

Sec. 11 repeals provisions relating to license examinations to reflect the board's current examining practices.

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Department of Commerce & Economic Development / POSITION PAPER

HB 70: "An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

Section 1: proposes amending AS 08.01.065 by requiring the department to allocate an amount equal to the fees collected during the previous year to be used on behalf of the State Medical Board by the Division of Occupational Licensing.

Currently, all licensing fees collected are deposited directly into the general fund. By law, medical licenses are renewed on a quadrennial basis, therefore, generating large sums of revenue every fourth year. While the average annual revenue generated through licensing fees exceeds the board's budget in a given fiscal year, licensing fees generated each fiscal year other than the renewal year account only for 20% of the average revenues. The department would not support this proposal since an allocation to the State Medical Board based on the amount equal to the fees collected in the previous year would need to be supplemented by general funds or licensing fees generated by other licensed occupations.

Instead, the department would recommend amending AS 08.01.065 by adding the new subsection to read:

> "(e) The Division of Occupational Licensing shall allocate funding for licensed occupations under AS 08.01 based to the extent possible upon the average amount of fees collected for applications, licenses and permits in the previous two fiscal years."

In addition, Section 5 of AS 08.01.100 should be amended to read:

> "(a) [EXCEPT AS OTHERWISE PROVIDED IN THIS TITLE] licenses must [SHALL] be renewed biennially on the dates set by the department with the approval of the respective board."

These two statutory changes would enable the division to renew all licenses every two years and budget for all occupations based on the amount of fees collected by the division. Fees could be more easily adjusted to ensure operating costs of the licensing boards were covered in accordance with AS 08.01.065(c).

*Section 2: proposes amending AS 08.64.210(b) by changing the number of days which an application must be submitted prior to the examination date from 40 to 120.

The examination administered to medical applicants is a national exam for which filing dates are set on a national level. Because the filing date can be changed by the national federation of state licensing board, the department recommends that the filing date be established in regulations instead of statutes. This will allow the board to amend the application filing deadline according to national requirements. The department offers the following change:

"(b) The application for examination shall be submitted to the board in accordance with the application date established by regulation [AT LEAST 40 DAYS BEFORE THE EXAMINATION DATE]."

Section 3: proposes amending AS 08.64.220(a) to eliminate the oral examination requirement. The department supports this proposal since oral examinations are more subjective in nature and more difficult to defend when examination results are appealed.

Section 4: clarifies that any licensee who practices medicine in the State of Alaska must possess an active license. The department supports this proposed clarification.

*Section 5: grants the board the authority to impose a civil fine of not more than $10,000.

*Section 6: adds reporting requirements for physicians and hospitals when a hospital places a consultation requirement on, revokes, suspends or conditions the privileges of a licensee.

*Section 7: authorizes the board to summarily suspend a license if the board has reason to believe that the licensee poses a danger to the health or welfare of the public or the licensee's patients.

*Section 8: grants immunity from civil liability for a physician, hospital or hospital committee who complies with reporting requirements of the State Medical Board.

*Section 9: grants the board subpoena powers to secure books, papers and records of a person who the board believes has information relevant to an investigation. The section also grants the board authority to order a licensee to submit to a medical or psychiatric examination at the expense of the board.

The department supports Sections 5, 6, 7, 8 and 9 since these proposals would increase the medical board's power to enforce their licensing statutes.

In summary, the department supports all sections of HB 70 except Section 1 which we would support if amended as proposed by the department.

J. Anthony Smith, Commissioner
Department of Commerce & Economic Development

Date: 2/13/87

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transferred, nor shall the public credit be used, except for a public purpose.

Dedicated Funds

SECTION 7. The proceeds of any state tax or license shall not be dedicated to any special purpose, except as provided in section 15 of this article or when required by the federal government for state participation in federal programs. This provision shall not prohibit the continuance of any dedication for special purposes existing upon the date of ratification of this section by the people of Alaska.

(The amendment to this section was approved by the voters of the state November 2, 1976 and became effective February 21, 1977. This amendment inserted "as provided in section 15 of this article or" in the first sentence.)

State Debt

SECTION 8. No state debt shall be contracted unless authorized by law for capital improvements or unless authorized by law for housing loans for veterans, and ratified by a majority of the qualified voters of the State who vote on the question. The State may, as provided by law and without ratification, contract debt for the purpose of repelling invasion, suppressing insurrection, defending the State in war, meeting natural disasters, or redeeming indebtedness outstanding at the time this constitution becomes effective. [Amendment approved November 2, 1982]

Effect of amendments. - The amendment approved November 2, 1982, inserted "or unless authorized by law for housing loans for veterans" in the first sentence.

Local Debts

SECTION 9. No debt shall be contracted by any political subdivision of the State, unless authorized for capital improvements by its governing body and ratified by a majority vote of those qualified to vote and voting on the question.

Interim Borrowing

SECTION 10. The State and its political subdivisions may borrow money to meet appropriations for any fiscal year in anticipation of the collection of the revenues for that year, but all debt so contracted shall be paid before the end of the next fiscal year.

Exceptions

SECTION 11. The restrictions on contracting debt do not apply to debt incurred through the issuance of revenue bonds by a public enterprise or public corporation of the State or a political subdivision, when the only security is the revenues of the enterprise or corporation. The restrictions do not apply to indebtedness to be paid from special assessments on the benefited property, nor do they apply to refunding indebtedness of the State or its political subdivisions.

Budget

SECTION 12. The governor shall submit to the legislature, at a time fixed by law, a budget for the next fiscal year setting forth all proposed expenditures and anticipated income of all departments, offices, and agencies of the State. The governor, at the same time, shall submit a general appropriation bill to authorize the proposed expenditures, and a bill or bills covering recommendations in the budget for new or additional revenues.

Expenditures

SECTION 13. No money shall be withdrawn from the treasury except in accordance with appropriations made by law. No obligation for the payment of money shall be incurred except as authorized by law. Unobligated appropriations outstanding at the end of the period of time specified by law shall be void.

Legislative Post-Audit

SECTION 14. The legislature shall appoint an auditor to serve at its pleasure. He shall be a certified public accountant. The auditor shall conduct post-audits as prescribed by law and shall report to the legislature and to the governor.

Alaska Permanent Fund

SECTION 15. At least twenty-five per cent of all mineral lease rentals, royalties, royalty sale proceeds, federal mineral revenue sharing payments and bonuses received by the State shall be placed in a permanent fund, the principal of which shall be used only for those income-producing investments specifically designated by law as eligible for permanent fund investments. All

MEMO

TO: Representative John Sund
FROM: T.L. Conley, Chairperson, State Medical Board
DATE: December 03, 1986
SUBJ: Revisions to AS 08.64

The Problem:

1) The State Medical Board is failing to carry out its statutory assigned functions and thus failing in part to detect and weed out incompetent and impaired practice due to inadequate funding to carry out investigations, perform day to day administrative functions, meet with statutory required regularity, cooperate effectively with national regulatory groups, etc.

2) The State Medical Board further lacks sufficiently strong statutory powers vis a vis access to information from hospitals and authority over its own membership to carry out supervision effectively (in terms of assuring competence and the detection of impairment and illegal or unethical practice).

3) The need for minor housekeeping changes.

Proposed Remedy:

1) Revisions #1, 2, 3, 7, 9, and 10 to AS 08.64 address this deficiency and set the State Medical Board up as a state instr. mentality capable of setting and collecting fees at whatever level is necessary to accomplish the statutory task. This will permit the board to hire the necessary investigative and administrative personnel to carry out its functions, hold regular meetings, investigate infractions, etc. By requiring the board to contract for these services through the Division of Occupational Licensing, efficiency and economy is maintained. It is stressed that the entire economic burden for this will be carried by the regulated group and not become a burden on the general population.

2) Revisions 11, 12, 13, and 14 expand the powers of the board to require cooperation from hospitals and hospital committees, block loopholes in the existing statute and provide the board with expanded investigative tools by affording it the right to command appearance and order examinations. Note that to ease compliance in the case of hospitals, immunity from civil liability is offered.

3) Revisions 4, 5, 6, and 8 are of a housekeeping nature.

Note: This is presented as an outline only. Doubtless careful scrutiny of the whole chapter would yield other sections in need of revision to comply with these general guidelines. Additionally the impact on other statutory cognates would require evaluation. I would mention one of concern, namely the need to consider imposition of a penalty on hospitals failing to comply with 08.64.336.

1. Revise 08.64.010 to read: Creation and membership of State Medical Board. There is created an executive instrumentality of the state known as the Alaska State Medical Licensing Board, referred to in this chapter as the State Medical Board. The State Medical Board shall have a common seal shall, after scrutiny of qualifications, issue licenses to physicians, osteopaths and podiatrists, and permits to paramedics and physician assistants; shall investigate infractions of rules and statues, particularly as they relate to malpractice by any members, new applicants or those already licensed or permitted of the regulated groups and on findings of deficiencies take corrective action up to and including refusal of licenses or permits to applicants or revocation of previously issued licenses or permits. Further the State Medical Board shall review existing regulations and shall propose and adopt such new regulations as shall be necessary from time to time to ensure that quality medical care be readily and efficiently available to the population. The State Medical Board shall also advise the Legislature on necessary change of statutes to ensure these ends.

As an instrumentality of the state, the State medical Board shall be empowered to set and collect fees, disburse funds, enter into contracts, hire administrative and investigative personnel and hold, encumber and dispose of real and personal property. As an executive instrumentality, under legislative oversight, it shall enter into a contract with the Division of Occupational Licensure, Department of Commerce and Economic Development for administrative support, the collection and disbursement of fees, personnel management of board employees, the preparation of budgets and annual reports, and other day to day matters supportive of board function.

The State Medical Board shall consist of five physicians licensed in the state and residing in as many separate geographical areas of the state as possible, and two persons with no direct financial interest in the health care industry. These members shall be appointed the governor with legislative confirmation.

Comment: This is the pivotal revision from which most of the rest follows. It is an idea derived from AS 08.08 the Alaska Integrated Bar Act and arises from the observation that the State Bar is effective in imposing discipline among its members as it has access to the necessary funds and is invested with sufficient authority to carry out its tasks albeit indirectly through the authority of the Supreme Court.

There are some differences of course. In the case of the State Bar the administrative machinery resides with the Bar Association while the power to impose sanctions vests (officially) with the Supreme Court. It is clear of course that the Court generally just adds an imprimatur to that which is decided by the State Bar. In the case of the State Medical Board the administrative machinery would officially reside with the board but would effectively (by contract) be run by the Division of Occupation Licensing, while the authority to impose discipline would both officially and in actuality remain with the board as it does now.

As things now stand the State Medical Board is languishing in ineffectiveness with inadequate funds to carry out its statutory functions. It is clear, in consultation with the State Medical Association, that the will exists with the state's physicians to make the medical board an effective instrument and to pay in fees whatever it takes to accomplish this end.

The stumbling block is Chapter IX, Section 7 of the State Constitution which prohibits the dedication of public funds to specific purposes. It would appear the State Bar has found an effective way around the difficulty by its designation as an instrumentality of the state. Acknowledging the lead of the State Bar in this area, the State Medical Board in the proposed revision of AS 08.64.010 seeks to follow suit.

The State Medical Board would of course have no objection to deriving its budget from the general fund if such could be relied on for sustenance. It is however clear that such is not possible. Several years ago in return for a verbal guarantee to provide adequate funds for board function the board gave its support to a significant increase in licensing fees only to have the agreement abrogated by both the legislature and the governor.

Recognizing its former naivetee in relying on verbal agreements and understanding that access to monies from the general fund will vary from year to year depending on political and financial forces beyond its (or perhaps anyones) control the board seeks by this change to ensure its continuing effectiveness while not burdening the taxpayer with the cost of its maintenance.

2. Revise 08.64.101 Duties.
3) Submit an annual report of its proceedings to the governor. [including a statement of money received and disbursed] - add 6) Submit an annual budget to the governor detailing administrative, travel, per diem, investigative, contractual and legal expenses and advising what fee levels assessed against licensed and permitted members regulated by the State Medical Board will be required to cover expenses and achieve a balanced budget.

Comment. An obvious corollary of AS 08.64.010.

3. Revise 08.64.110 Per diem and expenses. The members of the board are entitled to per diem and expenses [authorized by law] at prevailing state rates. These expenses shall be drawn from the State Medical Board's annual operating budget.

Comment: Necessitated by changes above as per diem and expenses will be drawn from the budget not from general funds.

4. Revise 08.64.210(b) The application for examination shall be submitted to the board at least [40] 120 days before the examination date.

Comment: 40 days is insufficient lead time for ordering exams. Currently an application deadline of 120 days prior to exam is set by regulation [12AAC 40.015(b)] so, at present, statute and regulation are in conflict.

5. Revise 08.64.220 Contents of examination and grading (a) the board shall make the examination written and [oral]... - delete oral.

Comment: We do not require oral examination at present as it can easily be considered arbitrary and capricious and has been so considered in case law. It is not a necessary protection and its requirement could open the state to unnecessary civil litigation and liability.

6. Delete 08.64.260(b), (c) and (d) 08.64.260(a) should remain unchanged.

Comment: The exam now offered is the FLEX [Federation of State Medical Boards Licensure Exam], a standardized national exam, that as of 1985 is a two part rather than a three part exam. Details of the comparison and application of the two exams are tedious. After prolonged consideration the State Medical Board promulgated regulations 12AAC 40.020(a-h) to cover the subject. 08.64.260(b)(c) and (d) are in conflict with these as they refer to the old examination. They are applied in connection with the prior regulations under 12AAC 40.020 when considering examinees who took the FLEX prior to May 18, 1985. The three part FLEX is no longer available from the Federation of State Medical Boards.

7. Revise AS 08.64.311 to read: "Licenses and permits will be renewed annually; renewal dates may be staggered depending on the time of first issuance.

Comment: Annual renewal will be required at least in the initial stages of the new program till the board can determine actual costs. It may later be possible to extend the licenses and permits to two or three years as the board gains more experience with actual costs. Staggering renewal dates will distribute the work load and has precedent in the Division of Motor Vehicles, etc.

8. Revise 08.64.313: Inactive license. A licensee [residing outside Alaska] may renew a license issued under this chapter as inactive. If the licensee practices [intermittently] no matter how infrequently in Alaska, the licensee may not hold an inactive license.

Comment: Present statute seems to discriminate against state residents. The presumption of the present statute is understood but it would seem the rest of the state codes work on the presumption of good faith unless the facts prove otherwise so this statute should work in like fashion.

9. Revise 08.64.315 Fees. Fees will be imposed on a year to year basis in such manner as to raise sufficient revenue to permit a balanced budget. The fees will be distributed on a capitation basis with the exception that the board shall be given authority to reduce or forgive the fees of no more than 3% of its regulated membership on the basis of demonstrated financial hardship.

Comment: The new program to function on a zero-based budgetary basis will obviously have to adjust fees to cover expenses. The power to forgive or reduce fees in a limited number of cases will permit the board to deal with legitimate cases of hardship - the physician or other health care providers medically incapacitated for a substantial portion of the year, provider working for limited salary at a mission station, etc. It adds a grace note of humane concern to the process.

10. Revise 08.64.320 Disposition of fees. Fees collected shall be deposited with the State Medical Board.

Comment: An obvious correllary of the foregoing. Other acceptable language would be "...deposited with the Division of Occupational Licensing, State of Alaska, for the sole use of the State Medical Board." But the proposed language is cleaner.

11. Revise 08.64.331(a) - delete present (7) and replace with new (7), to wit: 08.64.331(a)(7) impose a fine not to exceed $10,000; or (new 8) impose one or more of the sanctions set out in (1)-(7) of this subsection.

Comment: Though likely to be used by the board infrequently it is a useful tool to have available especially in dealing with sociopaths. In such cases arranging for the malefactor to in effect pay for board expenses incurred in pursuing the matter seems both just and sensible. Collecting such fines in selected cases also reduces the burden on the vast majority of licensees and permittees who would continue to practice competently and within the law even if the board were not to exist.

12. Revise 08.64.336(b) to read: A hospital that places a consultation requirement upon, revokes, suspends, restricts, conditions, or refuses to grant hospital privileges to a person licensed to practice medicine or surgery or osteopathy in this state (because that person poses a danger to the public) shall report to the board the name and address of the person and the reason for restricting, revoking, suspending, conditioning or refusing to grant hospital privileges or for placing upon the practitioner a consultation requirement. This shall occur in all cases except those instances where the sole and only cause for taking adversive action was failure of the practitioner to complete hospital records in a timely manner or failure to attend staff or committee meetings. It shall also occur whether the action taken was agreed to voluntarily by the practitioner or not.

Revise 08.64.336(c) to read: Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and upon (a finding of reasonable cause) a finding that reasonable cause exists to believe the practitioner may constitute a danger to the health and welfare of his/her own patients or the public, may appoint a committee of three qualified physicians to examine the licensee and report their findings to the board.

Add 08.64.336(e) to read: Nothing in this section shall preclude the board from invoking the provisions of 08.64.331(c) if deemed necessary.

Add 08.64.336(f) to read: Immunity. A physician, hospital or hospital committee (who) which, in good faith, makes a report to the State Medical Board under this section or (who) which participates in board investigations or judicial proceedings related to the submission of reports under this section, is immune from any civil or criminal liability which might otherwise be incurred or imposed.

Add 08.64.336 (g) to read: Evidence not privileged. Neither the physician - patient privilege nor the exclusion of a hospital staff, governing body or hospital committee from compliance with Administrative Procedures Act Public Meetings Section [44.62.310(d)(4&5)] shall be grounds for excusing the failure to submit a required report under this section or for excluding evidence presented to the board or in a judicial proceeding arising wholly or partly out of the submission of such a report.

Comment: We are finding that hospital administrators, staffs, and committees and individual practitioners, fearful that a reported physician will initiate civil suit, have tended to adopt a very narrow interpretation of what they are required to report. They argue that either the action taken isn't restriction or refusal to grant privileges (but rather a conditioning, consultation requirement, suspension or revocation) or that the practitioner involved could be said (usually by liberal interpretation) not to be endangering his/her patients or the public.

To obviate the problem we propose requiring all actions be reported except for minor actions involving delinquent medical records or failure to attend meetings (these actions tend to be automatic and a minor tool used by hospital staffs to prod members into carrying out day to day functions). It creates more work for us but give greater assurance that we will hear of problems. In general physicians and hospital staffs suspect incipient problems before they come to public notice so we need an effective way of tapping into the resource. To do so we need to remove discretion from hospital staffs and thus insulate them from torts. The additional protection offered by 08.64.336 (f & g) should further insulate those who report and hopefully make them more willing to come forward - the idea is drawn from the Child Protection Statute AS 47.17.

Given sovereign immunity (which should clearly apply in this situation), the state does not take on the liability shed by the individual physician or hospital staff. AS 08.64.336(e) is added to block a potential loophole...if egregious misconduct is involved , we don't wish to be esstopped by a requirement to filter the matter through an appointed committee, etc., with resultant delays, if the matter may result in serious harm or death.

13. Add a new section 08.64.337 Power of the Board to Command Appearance. The board shall have the authority to require a licensee or permittee under its jurisdiction to appear before the board to answer questions about his/her licensure status, prohibited acts, allegations or impairment or incompetence or other matters at the board's discretion. The requirement to appear shall be in writing with assured service. The reason for the appearance shall be stated in writing and shall be a part of the permanent record. Where possible, the decision to require appearance will be voted on by the whole board; between board meetings, it shall be the responsibility of the chairperson, in consultation with the Assistant Attorney General assigned to this function and with the concurrence in writing of two other board members, to determine that sufficient cause exists to command appearance of a licensee or permittee.

Failure of a licensee or permittee to appear before the board when commanded to do so shall constitute grounds to impose disciplinary sanctions under 08.64.326(a)(8) and 08.64.331.

Comment: We may use this once in five to ten years, but it should obviously be available if someone decides to thumb his or her nose to the board. Curiously, we have no authority to require anyone to appear at present or so the Attorney General's office informs the board. Obviously, we aren't barbarians and we will, of course, ask first, then try to persuade and only as a final recourse command.

14. Add a new section 08.64.338 Power of the Board to Command an Examination. The board shall have the authority to require a licensee or permittee under its jurisdiction to submit to a medical and/or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board to make such an examination at board expense and submit his/her findings to the board. Submission of biological specimens advised by the appointed examiner shall be considered an intregal part of the required examination.

The requirement to submit to an examination shall be in writing with assured service. The decision to require such an examination shall be by vote of the whole board in official session and shall be taken after consultation with the Assistant Attorney General assigned to the function to determine that sufficient cause exists to command an examination.

Failure of a licensee or permittee to submit to an examination, in whole or in part, when commanded to do so shall constitute grounds to impose disciplinary sanctions under 08.64.320(a)(8) and 08.64.331.

Comment: From time to time in various ways the board becomes aware of practitioners who are medically or psychiatrically impaired or suffering from substance abuse problems [or the board has strong reason to believe such is the case on medical grounds]. Unless these practitioners are reported to the board under 08.64.336 or come to public attention by harming someone we are apparently (under present rules as interpreted by the AG's office) prevented from effectively investigating the matter much less trying to intervene. The board, at its last meeting, heard of three such cases and was effectively prevented from taking any action. The power to order an examination, though less than an assurance that we will be successful in these situations, may go a long way to either solving individual problems or inducing "voluntary cooperation."

ALASKA STATE MEDICAL BOARD

Department of Commerce & Economic Development
Division of Occupation Licensing
Pouch D
Juneau, Alaska 99811

November 3, 1986

Dear Alaska Physician:

Greetings from a group you probably never wanted to hear from again after you got your license. We are still here and we need your attention, your input, and unfortunately some of your hard earned money.

The Medical Board, your watchdog on medical practice, is in rather serious trouble. As with other state functions we have been seriously impacted by the recent state funding problems. Unlike other state programs we have been in serious decline for a number of years proceeding these cuts and thus with the recent additional funding cuts find ourselves rendered close to becoming functionless. The problem is both one of actual funding and the method by which the state allocates funds.

At present licensing fees [the $600/4 years you pay for a license] go into the general fund. From these and other funds the state allocates a budget to the Division of Occupational Licensing which hires the pool of administrative personnel and investigators that run all 28 licensing boards authorized by state law [these range from the State Boards of Nursing, Medicine, Pharmacy and Dentistry to the Board of Barbers and Hairdressers]. No board is allocated a specific budget and it is clear that on balance certain boards which generate significant income (such as Medicine) carry boards which do not.

The situation is a complicated one but the upshot of the whole arrangement for the State Medical Board is that we have been reduced to three meetings a year, have the use of a half-time to three quarter time investigator and share a licensing secretary with several other boards. Investigations are languishing, licensing in delayed, litigations involving demonstrated malpractice are on hold, etc. Recently the investigator, stationed in Anchorage, was unable to travel to the Kenai Peninsula to investigate a very serious charge of impairment due to lack of funds. The list goes on.

In meetings recently with the Alaska State Medical Association it was decided to try to confront the problem directly. It was pointed out that in addition to the moral imperative to ensure adequate licensing supervision that the present failure to do so was adversely impacting the malpractice crisis. Those opposing tort reform consistently point to a failure to adequately supervise medicine and rein in poor and impaired practice as a cause of the present problem. Sadly one has to concede that in Alaska they have a strong case, not because the will is not there, nor because the means are not in place in theory, but because the function is not being funded.

With a new administration and a new legislature coming in now seems an ideal time to solve the problem. The State Medical Board with the support and concurrence of the Alaska State Medical Association is proposing that the State Medical Board be accorded a dedicated budget derived from licensing fee receipts. This budget would need to be adequate to provide a full time investigator, a full time licensing secretary and a full time executive director to supervise day to day functioning of the board. Included also would be adequate support services, funds for travel for the investigator, adequate funding for the board to meet quarterly as required by law (something not presently occurring), etc.

We feel this can only be sold to the government if it is budgeted on a zero-based basis, i.e. that the whole program be carried on generated fees. It will cost about $400,000 per annum which for an adequate licensing function is not in anyway excessive but due to lack of economy of scale in a small state (in terms of population) will necessarily cost the state's physicians significantly more than would be the case in a larger jurisdiction. For the first year we would propose using the "fund balance" remaining from the last $600/4 year renewal [the amount is $600 X 934 (active licenses) plus $200 X 305 (inactive licenses) minus 50% for being two years into the four year cycle. The total is approximately $300,000.] Needless to say we would be out of funds before the end of the first year and thus your license, scheduled to expire 31 December 1988 would have to be renewed at the end of the first year of the new program (i.e. on 31 December 1987). Subsequently licensing would be annual and would be based on actual costs distributed on a capitation basis. It won't be cheap; our best estimates (given added income from locum tenans licenses, physicians assistants, etc.) suggest that it will run $250-$300/year.

We feel we need to take the high ground on this and inform the state that we will do an adequate job, at no cost to the rest of the state, from our own resources. The quid pro quo will be that we will be accorded a dedicated budget that can't be siphoned off by other activities. Additionally with assurance of financial independence we can deal with special cases of need such as licensing of physicians in mission stations in the interior at nominal fee levels.

The State Medical Board is cognizant of the fact that there may be some difficulty with the proposal given Section 7, Article IX of the Alaska State Constitution which prohibits the dedication of public funds to specific purposes. One might argue that given the financial problems the state is facing modification of this provision seems in order. It is likely to be more palatable to the public than raising taxes for all.

Moreover precedent exists de facto if not de jure for such an approach in the case of the State Bar Association which funds itself completely from fees assessed on the state's lawyers. The organization is a curious one as it seems to be extra-legal in ways that would never be permitted to any other group of professionals supervised by the state. The State Bar Association administers the required "licensing" exam, investigates infractions and rules on disciplinary matters, but since it doesn't act directly on such matters but rather through the judiciary it escapes legislative control and public scrutiny. The State Bar Association also acts as the voice of the states' lawyers in professional matters in contrast to the situation in medicine and other professional areas where the professional organization and the licensing board are completely separate, the former private and the latter public and under state control. The situation almost begs that we reask Juvenal's question "Sed quis custodiet ipsos custodes?"

One recognizes the argument for this curious system is the separation of powers argument. Despite it's extra-legal existence however the State Bar is recognized as having a statutory existence in quite a number of places in the state's codes and even in the constitution in Article IV. One could thus advance the precedent argument that if the State Bar, a legally recognized organization, can raise dedicated funds other legally constituted boards should have similar consideration.

It is noted that the Bar Assoiciation is considered an "instrumentality of the state" under AS 08.08.010 [as apposed to the State Medical Board's designation as a state agency]. As such it is empowered under AS 08.08.080 (c)(2) to "establish, collect, deposit, invest, and disburse membership and admission fees, penalties and other funds...." This is all statuatory language and thus under legislative perview. Perhaps then the answer is to redefine the State Medical Board as an instrumentality of the state [an executive instrumentality subject to legislative control rather than in the case of the State Bar Association a judicial instrumentality] by statute and accord it similar powers. It is clear that the Bar Association has substantial authority to impose discipline; given that ethical and competent conduct is at least as important in medicine as it is in law the State Medical Board should be accorded similar authority.

Practitioners should alsc be aware of board plans to institute a monitored treatment program in conjunction with the Alaska State Medical Association. This would be directed at physicians impaired by drug and alcohol use. Good studies show that up to 90% of at least alcohol impaired physicians can achieve control over their disease and return to active practice with proper help. The program envisioned would be biphasic with ASMA running the treatment phase and accepting both voluntary referrals and mandatory referrals of physicians under board supervision. The mandatory referrals would be offered to impaired physicians in lieu of prolonged, disputations and expensive licensing actions with the full panoply of hearings, lawyers, court appearances, etc.

During supervision the license would of course be conditioned - usually in terms of temporary suspension from practice during initial inpatient therapy followed by licensing conditions during several years of monitored outpatient therapy (the physician would be able to practice during the period if compliant with the treatment program). Both voluntary and involuntary programs would be monitored treatment programs as this has been clearly demonstrated to be the only effective route.

The board attended a seminar this summer presented by John Ulwelling, Executive Secretary of the Oregon State Board of Medical Examiners which has an effective and dynamic program in operation. Ours would be similarly based allowing for local differences. It is clear we have the necessary authority to cover such a program. However as things now stand, even though it will in the long run save the state money, it would appear we do not have the staff or funds to ensure effectiveness. This despite the fact that the state's role in this is the easier and less expensive aspect of the program. Moreover experience has shown that the very existence of such a program drives people into it voluntarily (and thus anonymously) before they come to the board's attention (which of course we think is just great).

Your input into all this is urgently requested. We will be presenting it to the Governor and Legislature in the near future and requesting necessary legislation to cement it in place. You may contact me with your input or contact any of the state board members (names and address below.) Please let us know what you think.

Sincerely,

T. L. Conley

Thomas L. Conley, M.D.
Chairperson
Alaska State Medical Board

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CITIZENS COALITION FOR TORT REFORM

PRIORITY

Representative John Sund
Judiciary Committee, Alaska State House
PO Box V
Juneau, Alaska 99811

Feb 2, 1987

Representative Sund,

On behalf of the Coalition for Tort Reform I would like to advise you of our very strong support of HB70, An Act relating to the State Medical Board; and amending Rule 510(d) of the Alaska Rules of Evidence. We respectfully request your assistance in moving this important legislation through the system as rapidly as possible. We believe this will do much in establishing important consumer trust in the medical profession.

We have reviewed this legislation very carefully and find that it directly addresses many of the concerns of the Coalition. As you know we are a broadly based coalition of statewide associations and consumer groups concerned with the continuing liability insurance crisis. Last year we focused on reform of the state tort laws. Our agenda is far broader. We are very supportive of efforts, such as HB70 because it addresses related components of this serious socio-political problem.

We look forward to listening in on your committee hearings this week and hope you will allow the Coalition an opportunity to testify on insurance reform as well as other issues this year.

I believe you have met our new Executive Director, Ric Davidge. We wish to emphasize our desire to work closely with you during this legislature.

Best wishes,

Al Tamagni
Chairman of the Board

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An Overview of State Medical Discipline

Richard P. Kusserow; Elisabeth A. Handley, MPA; Mark R. Yessian, PhD

The Office of Inspector General's responsibility for financially penalizing and excluding health care professionals from Medicare and Medicaid participation led to an interest in examining the state medical boards' licensure and discipline processes. This article discusses the results of the subsequent study and focuses only on medical discipline issues. We found that the rate of disciplinary actions taken by boards has been increasing. However, revocations and suspensions, the most serious category of actions, have remained relatively constant. Additionally, consumers and law enforcement agencies are the most active sources of possible violations. Individual health care professionals, hospitals, peer review organizations, and medical societies provide strikingly few reports. To rectify these problems, we encourage states to increase physician license renewal fees to fund expansion and improvement of boards' enforcement activities and to consider ways to limit the legal liability of those making good-faith referrals.

(*JAMA* 1987;257:820-824)

IN THE two decades following the advent of the Medicare program, we have observed state medical boards undergoing great change. Their responsibilities have expanded tremendously from the licensure and discipline of physicians to include a growing number of other health care professionals such as nurses, podiatrists, physician assistants, physical therapists, and emergency medical technicians. Additionally, consumer awareness has grown with a concomitant rise in consumer reporting to state boards. These factors have resulted in an increasing work load.

Boards are increasingly strained to handle the growing disciplinary work load before them. It is not uncommon for them to have backlogs of hundreds of cases pending assignment while investigators are weighted down with active caseloads of 60 to 70 or more cases. Board officials offered a number of factors that have contributed to this. Not only must they regulate more professions, they must also deal with a rising number of cases due to an increase in consumer complaints, more active law enforcement involving physicians, and mandated reporting of malpractice cases in some states.

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LITTLE RISE IN BOARD RESOURCES

In response to their expanded responsibilities and work loads, nearly all states have been raising their fees in recent years. In most states, medical board revenues derive entirely from fees imposed on physicians. Two thirds of this fee income comes from renewal fees paid by licensed physicians. The remainder is from fees charged to those seeking licensure on the basis of a license held in another state or endorsement of a certificate received from the National Board of Medical Examiners. Boards are typically part of the state budget process and subject to the same budgetary and personnel controls as other state agencies.

Renewal fees, usually good for two to three years, have increased from an average annual level of about $31 in 1979 to $51 in 1985. (These data were obtained from annual reviews done by the American Medical Association and from a state-by-state survey conducted by the Office of Inspector General.) However, they have barely kept pace with inflation. Moreover, many state boards are not necessarily allowed to spend all the money they collect from fees. Instead, this money goes into the state's general revenue funds.

Severe budgetary constraints are precluding boards from enhancing the number or quality of investigators and from taking better advantage of computer technology that could improve their productivity. Laborious and costly procedures geared to quieter times, long since past, contribute to the time and complexity of internal review and due process hearings.

Combined, these factors leave boards in an extremely vulnerable position, with investigatory and administrative resources well below the level necessary to handle the job before them effectively. Thus, although medical licensure and discipline is about a $50 million a year enterprise, many board officials feel as though they can make only limited progress in improving their licensing and disciplining performance. (This estimate is based on a 50-state survey done by the Office of Inspector General.)

INSPECTOR GENERAL'S ROLE

In the last few years, the involvement of the Office of Inspector General of the US Department of Health and Human Services (DHHS) in a number of activities made it increasingly aware of the limitations within which state medical boards were operating. The Inspector General is charged by law with the responsibility of policing the Medicare and Medicaid programs for fraud and abuse.

From the scandals involving fraudu-

ient medical credentials from two Caribbean medical schools, it became apparent that the credentials verification capabilities of most states might be seriously flawed. Because of the Office of Inspector General's role in prosecuting criminal cases and imposing exclusions on hundreds of health care providers, it was also clear that communication between those in a position to witness unprofessional practice and those with the authority to do something about it was inadequate. In many cases, information about practitioners with recurrent cases of misbehavior or malpractice never reached medical boards.

The Office of Inspector General became aware of loopholes through which poor health care providers could slip. Many physicians under investigation would voluntarily surrender their licenses in one state and then would continue practicing medicine by moving to another state where they also had a license. Under current law, the Office of Inspector General found that it had no authority to exclude these physicians from Medicare and Medicaid participation except in the state in which the license had been initially revoked or suspended.

Given these developments, our responsibility for financially penalizing and excluding from Medicare and Medicaid participation health care professionals who have committed fraud or abused our programs and beneficiaries, the Inspector General's Office conducted a program inspection. Its purpose was to help DHHS and other interested parties gain a broadly based and up-to-date overview of state medical licensure and discipline and to recommend possible solutions to alleviate problems we discovered. The study specifically examined pressures being exerted on licensure and discipline processes, the changes taking place, and the effects being achieved.

The study took place between July 1985 and March 1986 and involved visits to 14 states, where we met with medical board officials and many others, including representatives of medical societies, hospitals, and peer review organizations (PROs). We also had telephone discussions with medical board directors in another ten states, and met with representatives of the American Medical Association, the Federation of State Medical Boards (FSMB), the American Association of Medical Colleges, the Educational Commission for Foreign Medical Graduates, and other major national organizations concerned with medical licensure and discipline. Altogether, the states we visited or had telephone discussions with account for 72% of the physicians licensed in the United States.[1]

While our study addressed medical licensure and discipline, this brief article focuses only on the latter. It provides an overview of the study's major findings concerning medical discipline and then offers a few concluding observations and recommendations.

OTHER FORCES INFLUENCING BOARDS

Boards have had to contend with increased work loads and responsibilities without a concomitant real increase in resources. There are several other significant factors that have played a role in states' abilities to license and discipline physicians.

Foreign Medical Graduates

First among these is the factor of foreign medical graduates (FMGs), about half of whom are Americans. There have always been foreign medical schools for American students to attend and foreign medical students who were interested in doing their residency training in the United States. Largely because of the discovery of "phony doctor" networks and the establishment of proprietary foreign medical schools geared to US citizens in the Caribbean basin, state boards became increasingly interested in the adequacy of education received by FMGs. As one state board executive director said, "The quality of the education being received by FMGs is a much bigger issue than the phony credential one. It is an issue that is less within our control. And one that is not confined to the Caribbean schools."

While they noted that there are a number of excellent foreign schools, board officials stressed that many of the schools, especially the newer ones, are far inferior to US and Canadian medical schools, which undergo accreditation. They expressed particular concern about inadequate clinical training and minimal admission requirements.[2]

Meanwhile, the number of FMGs receiving initial state licenses was rising, from 3131 in 1981 to 4753 in 1983. This represented an increase from 16.6% to 23.1% of all those receiving initial licenses. Although this level was well below the peak year of 1973, when 7419 FMGs (44.5%) were granted initial licenses, the resumption of growth contributed to the uneasiness being felt by many state board officials. (Licensing data were obtained from the American Medical Association.)

While many have been questioning the adequacy of education received by FMGs, the federal government has continued to subsidize some FMGs' education by granting US Department of Education and Veterans Administration loans to students attending questionable foreign schools. In addition, Medicare funding for residency training of FMGs (as well as graduates of US medical schools) continues.

Because of these concerns, boards began devoting significant resources to addressing the adequacy of education received by FMGs. In fact, a few states (such as California, New York, and New Jersey) have visited foreign schools to assess their quality. By 1983 and 1984, in the states accounting for the great majority of practicing physicians in the United States, the licensing of FMGs had become the premier policy issue facing the state medical boards. Discipline, which typically accounts for two to three times greater expenditures than licensing, remained an area of concern, but was overshadowed by the FMG problem.

Changed Public Perception and Malpractice

In recent years, public perception about the adequacy of board disciplinary actions has shifted. Newspaper exposés have berated boards for not better protecting the public. Headlines scream, "Doctor Sued 14 Times, But No State Hearing," (*Chicago Tribune*, May 10, 1982, p1) and "Doctors Practice While Wheels Turn" (*Detroit Free Press*, April 1, 1984, p 11a). (The *Detroit Free Press*' examination was a particularly extensive one. It led to a seven-part report published between April 1 and 8, 1984.) This has placed a lot of pressure on boards to examine their practices.

The editor of the *New England Journal of Medicine*, Arnold S. Relman, MD, expressed this view in a March 1985 editorial: "All the evidence suggests that most if not all the States have been too lax—not too strict—in their enforcement of medical professional standards."[3]

The public is also frustrated with the length of time that due process takes, and blames boards for "dragging their feet" on cases. As one high-level official noted, "The public perceives that bad doctors shouldn't be practicing medicine, but we must give these doctors due process. Not everyone understands this."

Physicians' status in society has also been eroding, partially as a result of the liability crisis as it relates to malpractice claims. Many Americans' view of physicians has shifted from reverence to questioning. Indeed, a large number of patients who feel they have been wronged by physicians have been willing to litigate in increasing numbers,

with higher dollar awards made by courts and the skyrocketing cost of liability insurance. All of this has put renewed pressure on state medical boards to "weed out" bad doctors.

Organizational Changes

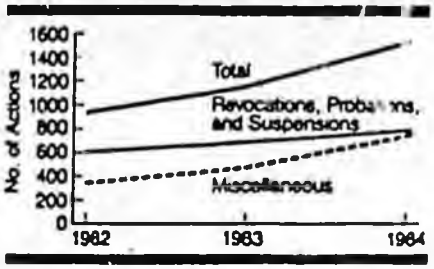
Boards have experienced other significant changes in recent years in addition to rising work loads greater than the resources to deal with them. Both the organizational structure and size of boards have changed. While in 1969, only 16 boards were housed under the aegis of a central agency, currently 31 of them are. This has both advantages and disadvantages. While under the aegis of a central agency, a board has greater protection against lawsuits that have a chilling effect, but may have a harder time competing for scarce resources than if it stands alone.

Boards have broadened their base, with nearly all boards now having at least one or two nonphysician members, whereas one half had none in 1965. The size of boards has also increased, with board members finding it necessary to devote considerably more time to the role than did their predecessors, at greater personal sacrifice to their own practices. Paid an average per diem of only about $50, these members are typically appointed by the governor for terms of three to six years. In the more populated states, board members often spend at least 30 days per year on board business.

STATE BOARDS' RESPONSE

State boards have reacted to burgeoning work loads and pressures. Recently, states have strengthened the investigatory powers of boards (for instance, the granting of subpoena powers); expanded their disciplinary authorities (most notably, the authorization to immediately suspend physicians posing a "clear and present danger" to the public); widened their access to disciplinary actions taken in other places (through mandatory reporting laws); and broadened the grounds on which they can take disciplinary action. The latter development, following an earlier wave of such activity in the 1970s, has led to more detailed specifications of unprofessional conduct, covering such matters as sexual abuse, incompetence, and violations of controlled substance laws. Since 1982, at least 20 states have amended their laws to clarify the grounds on which physicians can be disciplined.

States' responses to overworked investigators and board members have focused mainly on ways of easing the burden on board members. Among the changes instituted are allowing boards to draw on the work of hearing officers, to delegate the conduct of hearings to individual members, and to hire medical or legal consultants to help guide the use of investigatory resources. In Colorado, a change that splits board members' time between inquiry and hearing panels appears to be especially promising.



Trends in selected categories of state disciplinary actions from 1982 through 1984. Source: Federation of State Medical Boards.

Incidence of Disciplinary Actions

Over the past few years, the number of disciplinary actions taken against physicians has been increasing. National tabulations made by the FSMB reveal an increase of 62% in actions (excluding simple administrative actions), from 953 in 1982 to 1540 in 1984, (Figure). (The numbers used for 1982 and 1983 are unofficial FSMB figures.)

However, a closer look at the Figure indicates that the most serious actions, such as revocations, suspensions, and probations, have not grown nearly as much as the other actions, increasing only slightly from 600 in 1982 to 788 in 1984. This has occurred despite the fact that approximately 15 000 to 20 000 new physicians enter practice each year. The miscellaneous or tier-2 category accounts for the bulk of the increase and includes reprimands, censures, and stipulated agreements. Indeed, it is likely that the increase in this category is even greater than the FSMB's summary suggests, because many stipulated (or plea bargain) agreements are made on a confidential basis, with the information not reported to the FSMB.

Some observers have dismissed these second-tier actions, which are often handled in informal proceedings, as being relatively inconsequential. In actuality, however, they are often quite significant and may involve a voluntary surrender of license for a period of time or a restriction of prescription privileges. Moreover, these actions represent a practical response by boards faced with insufficient investigatory resources and the memory of the many costly cases that have lingered during the hearing and judicial process for years while the physician involved has continued to practice. Unfortunately, it has also masked many serious cases and has permitted many physicians to continue practicing who would otherwise have lost their licenses.

Types of Violations

The inappropriate writing of prescriptions is by far the most common violation on which disciplinary actions are based, accounting for about one half of all actions taken by state boards. These are serious matters involving not only excessive or unnecessary prescribing of drugs to patients, but also unlawful distribution to drug addicts. They are also the easiest kinds of cases for investigators to develop, especially in states with triplicate prescription laws.

The second major type of violation is the self-abuse of drugs and/or alcohol. In most states, this category is expanding, both in absolute and proportionate terms. Together with overprescribing, it accounts for three fourths or more of all disciplinary actions.

Throughout the nation, programs designed to help impaired physicians have been expanding and receiving increased attention. Typically these programs are run by medical societies or other private organizations. While the exact approaches vary, they generally involve group sessions, signed agreements stipulating the terms of participation, and periodic monitoring to ensure that participating physicians are adhering to the agreements. Some programs, such as the one in Oregon, stress inpatient care, while others focus on outpatient treatment.

While these programs have been generally well received, they have met with some criticism and skepticism. Some interested parties are concerned about physicians being treated too sympathetically for behavior that can be harmful to their patients. The result in some states has been a tightening of monitoring practices and a closer examination of the responsibilities these programs have to report violations to the boards. Since a substantial number of physicians have enrolled in these programs voluntarily (without any board involvement), the issue of reporting violations to the boards has become an especially sensitive one because physicians signed up with the understanding that their participation would be confidential.

The remaining types of violations underlying disciplinary actions cover a wide range. Among the most prominent are cases involving conviction for a felony or fraud. Much less prominent are cases involving incompetency or sexual abuse, which are among the most difficult kinds of cases to develop.

The minimal response in the area of physician incompetency is placing boards in an increasingly untenable position as the incidence of malpractice cases and public concern about the implications of these cases increase. As noted before, it is increasingly believed that boards can and should do something about this situation.

Why, then, the minimal response to date? At least three factors seem to be involved: (1) the complexity, length, and cost of cases concerning alleged incompetence, even where a malpractice judgment has been rendered; (2) the substantial burden of proof that tends to call for "clear and convincing" evidence rather than the "preponderance of evidence"; and (3) the considerable variations among physicians themselves about what constitutes acceptable practice in many facets of medicine. One board's executive director summed up his frustrations in this area by noting:

> We just can't seem to do anything with malpractice. In fact, we've never had a disciplinary action based on malpractice. It's such tender legal ground, even though we have a statute. So when there is a malpractice case, we tend to look for another basis for disciplinary action.

Yet, in the course of addressing rising malpractice costs, some states are taking initiatives that could prove to be consequential. Particularly noteworthy are two amendments Wisconsin made in 1985 to its medical practice act. One allows for a court finding of physician negligence in patient care to serve as conclusive evidence that a physician is guilty of negligence of treatment. This frees the board from the need to hold a probable cause hearing in such cases. Another more significant amendment provides the board with a lesser burden of proof in disciplinary proceedings, one that calls for a "preponderance of evidence" rather than "clear and convincing evidence."

Also of note are laws in California and Oregon that authorize boards to compel a physician to take a clinical competency examination if there is reasonable cause to believe that his or her skill level is inadequate. The California effort allows a physician two chances to pass an oral examination conducted by a panel of two physicians. The Oregon effort, under way for a number of years, may involve oral or written examinations, but generally employs the latter because they offer a firmer legal basis for subsequently denying a license or imposing discipline.

Source of Disciplinary Actions

Earlier we mentioned that during the past few years, the number of consumer complaints received by boards has been rising, often quite substantially. The greater visibility of boards and the establishment of toll-free complaint lines in some states have contributed to this development.

These consumer complaints, together with information provided by government agencies (mainly law enforcement agencies), account for most of the disciplinary actions eventually taken by boards. Strikingly few such actions first come to a board's attention as a result of referrals from those who would most naturally make referrals and who are the most qualified to make referrals—medical societies, PROs, health care institutions, and individual health care professionals. The reason for this seems mostly to stem from a lack of an affirmative legal duty to report individuals and from the fear of being sued for reporting someone.

The Secretary of Health and Human Services, Otis R. Bowen, MD, released our report when he addressed New York University's graduating medical class on June 5, 1986. He noted the lack of referrals made by health care professionals and urged students, "Speak up when you see poor medicine being practiced. Not to do so is to render a grave disservice to patients and the profession alike."

Board officials, when commenting on this situation, often pointed to the PROs as an especially unproductive source of information. The following comment from the executive director of the board in a heavily populated state would probably be endorsed by many of his colleagues across the country: "We get very little from the PROs. They take care of their own problems in-house until they get out of hand. We should be getting a lot more information from them."

Aware that much important information is not being passed on to boards, many states have initiated, expanded, or tightened reporting laws. The majority of states currently have reporting laws. Since 1982, at least 17 states have taken action to require reporting. (Annual reviews by the FSMB serve as a basis for this and other information concerning changes in state licensure and discipline laws.) Most of these laws focus on hospitals. They usually require hospitals to inform boards of any changes in a physician's staff privileges or (in some states) of any resignations from the staff. A growing number require the reporting of malpractice judgments or settlements, often if they exceed a certain amount (eg, $10 000 in Georgia, $25 000 in New Jersey, $30 000 in California). A few states have laws that direct individual practitioners to report poor performance.

Nevertheless, reporting laws have not had the expected impact. When asking why, one often hears reference to the "brotherhood of silence," an inherent resistance to reporting one's peers. Another reason often cited is a fear of legal liability, even in states that have granted criminal and civil immunity to those who report information in good faith.

Information Sharing

States now provide the FSMB (and thereby other states) with regular reports on disciplinary actions they have taken. This represents considerable progress compared with the situation two to three years ago.

However, the extent of the actions reported varies from state to state. Many boards do not report licensure denials. More notably, many do not report tier-2 disciplinary actions if they did not involve a formal hearing or were imposed with the understanding that they would be confidential. The rationale for holding back on these cases is that confidentiality or lack of publicity were key to the agreements that enabled discipline to be imposed without a formal hearing. Yet, the failure to report such cases means that other states are prevented from obtaining information that could prove to be important to them if a disciplined physician relocates to their jurisdiction and practices on an unsuspecting public.

Furthermore, from state to state and even within states, there are considerable inconsistencies in the type of disciplinary actions taken in relation to the charges and even in the meaning of the different types of actions. The FSMB has promoted some consistency by establishing a standardized coding system for the different types of violations that boards use in reporting their actions to the FSMB. Unfortunately, many states fail to use it or use it irregularly, leaving it to the FSMB to choose what appears to be the most appropriate code. To foster greater consistency within the state, California developed a manual of disciplinary guidelines and model disciplinary orders a number of years ago, and regularly revises it to keep pace with developments. The FSMB has also devised and distributed *A Model for the Preparation of a Guidebook on Medical Discipline.*

While the FSMB's data base serves as the primary vehicle for the states to keep abreast of disciplinary actions taken in other states, follow-up communication among the states themselves is the means for obtaining more detailed

information concerning the specifics of a case. In this context, substantial and effective information sharing is being achieved through the mailing of final board orders on a case through informal networking among board investigators and administrators. Where problems in gaining access to information have occurred, they have concerned cases still pending formal board action or tier-2 cases in which the action was agreed to be confidential.

Finally, within the states, boards typically inform medical societies and Medicaid state agencies of all formal disciplinary actions. They are less likely to do so with respect to other entities such as PROs, insurance companies, and hospitals. Most do not actively inform the general public or the medical community of their actions. However, a few boards, such as Florida's, regularly identify disciplined physicians in newsletters published by the board, medical society, or other parties, believing that publicizing the information has preventive value.

CONCLUSION AND RECOMMENDATIONS

We have shown how boards have been confronted with increased work loads, inadequate financial support, and many conflicting pressures. Yet, their ability to act as necessary is predicated on their resource level. Accordingly, we believe physician license renewal fees should be set at a level sufficient to support expansion and improvement of the enforcement activities of the boards. (A recent report by the Public Citizen Health Research Group called for an increase in annual physician renewal fees to at least $500, "with all of the money going to identification and discipline of doctors who are incompetent or otherwise practicing bad medicine."[1]) These fees should be dedicated to board activities and not be diverted to general revenue funds. At the end of 1985, the average annual renewal fee rose to $51, a level that barely kept pace with inflation in the 1980s.

Of the issues previously addressed, the boards' inability to help abate the flood of malpractice cases is the most troublesome. In recent years, the small increases in funding made available to boards have often been made with the expectation that boards would help stem the tidal wave of cases. Some of the recent initiatives have been noted; however, without doubt, the public's expectations have been rising much faster than boards have been able to respond.

Medical malpractice that is not rectified is a twofold problem for American society. Clearly, the safety and well-being of patients seeking medical care is threatened when incompetent physicians remain in practice—however large or small their numbers. (We believe that the current level of litigation overrepresents the number of physicians who perform negligently. Not all physicians who are sued for malpractice are guilty of negligence or misconduct, in our opinion. However, it is important to eliminate poor practitioners through disciplinary action, whenever possible.) Additionally, all patients pay higher prices due to the escalating cost of premiums and awards and the defensive medicine practiced to minimize the likelihood of successful malpractice suits. Many observers also believe that incompetent physicians also unnecessarily add billions of dollars annually to the nation's health expenditures.

In a speech read before the American Medical Association on Feb 21, 1986, Otis R. Bowen, MD, the first physician to be the Secretary of Health and Human Services, made it clear that the development of an effective system of medical discipline is crucial to a resolution of the nation's malpractice problem:

> We cannot expect Americans to endorse any solution to the malpractice issue unless we address the central question of the physician's responsibility. If we ignore the "bad apple" in our profession, then we contribute to the malpractice problem. We then do not deserve any legislative relief.

For boards to play an important part in addressing this problem, it is clear that there must be substantial changes in the legal ground rules governing their handling of malpractice cases. The fear of being sued has had a chilling effect on reporting of incompetence. Perhaps states should consider ways to limit the liability of those making good-faith referrals at the same time that they create affirmative legal duties to report professional misconduct or incompetency. No less clear than the chilling effect of potential litigation is the fact that the resources available to boards must be increased. At present, most boards lack sufficient resources to devote serious attention to such cases without jeopardizing their other disciplinary and licensing responsibilities. We are hopeful that an increase in renewal fees, which boards are allowed to keep, could help eliminate this problem.

We in the federal government can provide some help in improving medical discipline efforts without undermining the central state role in this arena. One form of assistance we can provide is to assure more affirmative action within our own domain. That is, we can help ensure that PROs and Medicare carriers provide more extensive and timely reporting to state medical boards of cases involving physician misconduct or incompetence. In fact, based on our report, Secretary Bowen has directed that regulations and instructions intended to foster this objective be developed.

Another potentially significant form of federal assistance is represented by the Medicare and Medicaid Patient and Program Protection Act (HR 1868), passed by the US House of Representatives in 1985 in response to concerns about physicians being sanctioned in one state and then moving their practice to another state. Parallel legislation (S 1323) is now being considered in the US Senate and is widely supported. (The Medicare and Medicaid Patient and Program Protection Act failed to be enacted by the 99th US Congress, but we expect it to be reintroduced in this upcoming session.)

Passage of this legislation would close many existing loopholes, facilitate more efficient sanctioning by DHHS, and promote more extensive and effective sharing of disciplinary action among the states and DHHS. It would provide a much-needed vehicle for fostering (1) further and more timely reporting of disciplinary actions to a central clearinghouse, (2) more extensive nationwide distribution of information on such actions, and (3) more consistent definitions of the type of violations committed by physicians. This last issue is important when one considers that currently there is total reciprocity among states for licensing, but not for disciplinary decisions.

The federal government's reliance on state medical boards to provide the front line of protection for millions of Medicare and Medicaid patients creates an important stake in the improvement by the individual state regarding state medical discipline. A spirit of partnership involving federal and state government and the medical profession is vital if we are to accelerate and sustain progress in this direction.

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State Medical Discipline: Defects and Hindrances

In 1913, a year after the founding of the Federation of State Medical Boards of the United States, N. P. Colwell, MD, secretary of the American Medical Association's Council on Medical Education and an original fellow of the federation, writing in the first issue of the federation's quarterly, stressed the need of the state medical boards for improved medical practice acts, adequate funding and staffing, increased legal authority, and effective communication among themselves regarding unfit practitioners. The state boards, he said, "have striven valiantly against almost insurmountable obstacles to do their full duty. . . . The important thing is for [them] to recognize the defects . . . take stock of the hindrances, and altogether, through the Federation of State Medical Boards . . . press the campaign for betterment."[1]

See also p 820.

For 75 years, the federation has pressed the campaign for betterment in medical licensure and discipline. In its publications and educational programs, in every professional and public forum open to it, in legislative halls and the media, the federation has hammered at the defects and hindrances defined by Dr Colwell. Through its activities and services, it has sought to facilitate the effective and rational regulation of medical practice. However, while the concerted efforts of the federation and the state boards, combined with the concern of the public and the media, have gone a long way over the years to stimulate dramatic gains in the effectiveness of state medical discipline, serious problems persist.

In this issue of THE JOURNAL, Kusserow et al[2] present an overview of the current status of medical discipline in the states based on an examination of state medical licensing and disciplinary processes conducted by the Office of the Inspector General of the US Department of Health and Human Services. Bearing responsibility for regulation of the Medicare/Medicaid systems, the authors see more effective state medical discipline as essential to their own efforts. They also believe it would assist in reducing the incidence of malpractice litigation, though they are aware of its limited potential in that regard.[3] Their conclusions demonstrate a recognition of the many obstacles the state boards and the federation have struggled against for years. The authors point out the ever-increasing work load carried by the state medical boards, the pressures on the boards, the problems presented to many of them by inadequate statutes, funding, and staffing, and the too-frequent failure of the medical community to report to the boards physicians whose professional performance is open to reasonable question. Having elaborated these problems, the authors call for higher license reregistration fees, dedicated board funds, and liability protection for those reporting questionable physicians to the boards in good faith.

From a federal perspective, the authors recommend that peer-review organizations and Medicare carriers be required to report relevant information regarding physician performance to the boards. They also urge the adoption of federal legislation that would close loopholes in Medicare/Medicaid enforcement provisions, allow the sharing of information

between the US Department of Health and Human Services and the states, foster improvement in the centralized reporting and distribution of disciplinary action information, and stimulate more consistent definitions of violations.

In their recommendations related to the needs of the state boards, the authors echo and reinforce views long advocated by the federation and the boards themselves. The federation's development and active promotion of *A Guide to the Essentials of a Modern Medical Practice Act*,[4] which in its current edition has influenced the medical practice acts of over 20 states in two years, and its resolutions on board status and powers[5] have contributed significantly to a recognition of the need for state action in support of the boards. The federation's recent publication of *A Model for the Preparation of a Guidebook on Medical Discipline*[6] and its annual public releases of state board disciplinary action summaries have called attention to the importance of consistency in disciplinary processes and definitions.

The federation's most important effort, however, has been the development of the Physician Disciplinary Data Bank (DDB), the nation's preeminent system for collecting and distributing information on formal disciplinary actions taken by state boards and others against physicians.[7] The DDB can be traced to 1915, when 19 board actions were reported in the first issue of the *Federation Bulletin* (*Monthly Bulletin* 1915;1:4-5). Though disciplinary data were submitted to the federation only sporadically by state boards for many years, thousands of actions were reported in the *Bulletin* before 1971, when the *Monthly Disciplinary Action Report* was introduced. From such beginnings grew the computerized and highly sophisticated DDB of today, which has made it almost impossible for a physician formally disciplined by one jurisdiction to go undetected by another in which he may hold or seek a license.

The federation has also actively supported federal legislation to assist state boards in their disciplinary efforts. It testified vigorously in favor of those sections of the Health Care Quality Improvement Act of 1986, recently signed by the President, that protect good-faith peer-review activities, mandate the reporting of malpractice, hospital privileging, and state disciplinary data, and call for a central data repository (Title IV, Public Law 99-660). Far from perfect, this legislation, thoughtfully implemented, can advance current trends, provide significant assistance to the state boards, and enhance the efforts of the federation.

As fundamental as the recommendations made by Kusserow et al are, it should be noted that other specific steps are called for. Mandatory reporting to boards exists in one form or another in all but three of the licensing jurisdictions responding to a federation survey.[8,9] Though mandatory reporting should be broadened to include more sources of information in a number of jurisdictions, it is a clear-cut trend. However, enforcement of mandatory reporting has been less than adequate and should be improved. Obviously, liability protection should be offered those reporting to boards in good faith. Forty-two licensing jurisdictions report having some such form of protection now.[8,9] It should be provided in all jurisdictions for all good-faith reporting, not simply that required by law. Board members, board staffs, and others serving the boards should be provided legal immunity and indemnification for good-faith actions taken as a result of their board responsibilities. Efforts must also be made at the federal level to provide effective protection from federal suits to board members performing their duties in good faith under state law as well as to those engaged in good-faith peer-review activities.

These points made, it must be emphasized that Kusserow et al deserve congratulations for their fresh documentation and restatement of the challenges facing the state boards. The federation is encouraged that responsible federal officials have listened so attentively to the boards and have gained an appreciation of the difficulties with which the boards deal on a daily basis. In the long run, this clearer understanding must contribute to improving the environment in which the boards function.

The success of efforts to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of the state boards. These can only come from state legislatures willing to act responsibly. The appeal of Dr Colwell in 1913, the work of the federation and the boards over 75 years, the concerns of the public and the media, and the recommendations of the authors all come back to the same critical point. Those who sit in the legislatures of the various states must recognize that the effective regulation of medical practice is in their hands. The work of the state medical boards will always be a direct reflection of the will and purpose of the state legislatures.

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ACTION KIT

JANUARY 1987

ANTITRUST IMMUNITY FOR HOSPITALS AND PHYSICIAN PEER REVIEWERS

HOSPITAL LAW CHAPTER: AIDS

P.L. 99-660 Sec. 401 et seq.

cc: Towell HAA Exec Committee

FEB 3 1987

The Health Care Quality Improvement Act of 1986

A major new federal law known as the Health Care Quality Improvement Act of 1986 can radically change — for the better — the credentialling and quality management programs of every hospital in this country.

The Act, which was signed into law on November 14, 1986, provides significant legal protection to both the hospital and physicians involved in the peer review process. It also requires health care entities and insurance companies to report practitioners who have been subject to professional disciplinary action or malpractice verdicts and settlements to a national clearinghouse.

All things considered, the Act is unquestionably the most important piece of legislation to date affecting hospital-medical staff quality management operations. Hospitals and their medical staffs must therefore take immediate steps to reap the full benefits of this law and to position themselves to fulfill the responsibilities that it imposes.

IMMUNITY PROVISIONS

There are two different immunities provided by the Act. One is for individuals who provide information to entities, including hospitals, conducting professional review activities. The other is for individuals and entities who take professional review actions against physicians.

The immunity for those providing information to professional review bodies is very broad. A "professional review body" is defined as a health care entity or the governing body or any committee (including medical staff committee) of a health care entity which conducts professional review activity. "Health care entities" include hospitals, other entities that provide health care services (including HMOs or group medical practices), and professional societies.

"Professional review activity" means an activity of a health care entity with respect to an individual physician that either: (a) determines whether the physician may have medical staff appointment or clinical privileges, (b) determines the scope or conditions of such privileges or appointment, or (c) changes or modifies such privileges or appointment.

The Act provides that any person who provides information to a professional review body regarding the competence or professional conduct of a physician shall be immune from liability in damages under any federal or state law unless the information provided is false and the person providing it knew that it was false.

Professional review bodies and other persons who assist them in professional review activities are also protected from damage suits so long as the professional review action was taken:

(1) in the reasonable belief that the action was in the furtherance of quality health care;

(2) after a reasonable effort to obtain the facts of the matter;

(3) after adequate notice and hearing procedures are afforded to the physician involved; and

(4) in the reasonable belief that the action was warranted by the facts known.

continued page 2

Due Process Hearings — New Care Needed

To gain the full benefit of the immunity provisions of the Health Care Quality Improvement Act, hospitals will have to make sure that their medical staff hearing and appeals procedures meet the standards set forth in the Act.

In order to protect his antitrust claim and its potential for large damages, the attorney for the physician will *always* contend that the hearing and appeals procedures did not meet the requirements of the Act. Hospitals must be meticulous in seeing that they do. Counsel should be involved in hearing and appeals matters at the very beginning and throughout.

The standards require notice to the physician of the proposed action and a hearing prior to the action becoming final. The initial notice to the physician must state: (1) that a professional review action has been proposed to be taken against the physician; (2) the reasons for the proposed action; (3) that the physician has the right to request the hearing on the proposed action; (4) any time limit which shall not be less than thirty days within which to request a hearing; and (5) a summary of the physician's rights in the hearing.

If the physician requests the hearing, then he must be given notice of the time, place and date of the hear-

continued page 4

Liable For Radiation Therapy Service

From time to time we have discussed cases in which it seems the hospital was held liable just because the harmful occurrence took place within the hospital's walls. That seems unfair, but it is the fact that under certain circumstances courts will impose liability on the hospital, even though no hospital employee acted in a way to cause harm to the patient.

One of the legal theories that supports this liability is the doctrine of "ostensible" or "apparent" authority. A recent appellate decision in Illinois highlights in dramatic fashion the application of the theory.

In Sztorc v. Northwest Hospital, 496 N.E.2d 1200 (Ill. App. Ct. 1986), the patient had undergone 31 radiation treatments after a right radical mastectomy in 1975 at the defendant hospital. Between 1975 and 1978 following the radiation treatments, she noticed a gradual loss of function in her right arm.

In July and August of 1979 plaintiff underwent surgery on her right brachial plexus at the Oschner Clinic in New Orleans. The performing surgeon told her that it would take at least a year to tell whether the desired nerve regeneration would occur and recommended a course of physical therapy for the plaintiff, which she continued at the defendant hospital upon her return home. She remained under the care of her family physician. In 1981, she returned to New Orleans and was informed that her right brachial plexus had been permanently damaged as a result of the overexposure to radiation in 1975.

She filed suit against the hospital, her family physician and the surgeon who performed the mastectomy. The defendant hospital moved for summary judgment claiming that there was no relationship between the staff of the X-ray department and the hospital and, consequently, no liability should be imposed on the hospital.

The following facts with respect to the X-ray department were undisputed: The department was comprised of a group of associated physicians operating under the name of "IG Radiology" and was owned, operated and staffed by Dr. Irving Greenberg. One of the physicians in the group was in charge of administering radiation therapy to plaintiff. Those physicians had staff privileges at the defendant hospital; however, none of them were employed by the defendant hospital.

All of the radiation therapy equipment, including that used in treating plaintiff, was owned by Dr. Greenberg, who was solely responsible for its maintenance, repair and calibration. The defendant hospital did not receive any revenues from radiation treatment provided by Dr. Greenberg's group to plaintiff or to any other patient in 1975. In that year, Dr. Greenberg received payment for outpatient radiation services directly from his patients. A technician employed by Dr. Greenberg advised patients of the fee and issued receipts bearing Dr. Greenberg's name.

The record also showed that the X-ray department was located on the main floor of the defendant h[illegible] In order to reach it, plaintiff and other outpatients had to enter through the hospital's main entrance, proceed through its lobby, turn right down a main corridor and pass through a set of swinging doors labeled "X-ray Department." These doors also bore the names of Dr. Greenberg and his associates and the designation "Department of Radiation Therapy."

The same X-ray department served both inpatients and outpatients, and appointments for radiation therapy for both types of patients were ultimately scheduled by the same technician who was employed by Dr. Greenberg. There was no dress code or other manner by which patients or the general public could differentiate employees of Dr. Greenberg's group from other employees in the hospital.

The trial court granted the defendant hospital's motion for summary judgment. The plaintiff appealed that decision.

The Illinois appellate court ruled that even where there is not an actual agency relationship, hospitals may be held liable for the acts of independent physicians practicing on the premises. The court then noted that several other states have adopted the "apparent agency" doctrine to preclude the entry of summary judgment under circumstances where a person, like the plaintiff, goes to a hospital, which holds itself out as a full service institution offering a range and variety of services such as radiation treatment, under the assumption that such services are, in fact, being provided by the hospital. These decisions, said the court, "have been based upon the presumption that when a person goes to a full service

continued page 4

Improvement Act of 1986 cont'

The Act goes on to set forth specific conditions which, if met, will be deemed to provide "adequate notice and hearing" to the physician who is the subject of the professional review action. [See Due Process Hearings –]

The Act also provides additional protection by allowing defendants in suits challenging professional review actions to recover attorneys' fees and costs of defense in the event that they substantially prevail in the action.

It should be noted that the immunity provided for professional review activities is not absolute. The immunity does not apply to actions brought under the federal civil rights laws, injunction or declaratory judgment actions, actions by governmental agencies such as the Federal Trade Commission (FTC), or criminal proceedings. The immunity also does not apply to actions brought by non-physician practitioners, such as podiatrists or chiropractors.

Even where the immunity would otherwise apply, the immunity can be lost if the action was based on certain improper motives. For example, professional review actions not based on the competence or professional behavior of the physician, such as actions based on the physician's affiliation (or lack thereof) with any professional association, his fees, advertising, or business solicitation methods, his affiliation with HMOs, or the fact that he is paid a salary are not protected by the Act. Nor are any actions taken by professional societies under investigation by the FTC for anti-competitive practices.

The immunities provided under the Act are effective for suits brought un-

der federal law based on professional review actions taken subsequent to November 14, 1986 — the date the legislation was signed into law. They will also apply to actions brought under state law in most cases after October 14, 1989. However, the immunity can be applicable to state court suits before 1989 if the state "opts in" to the new law. The state can also "opt out" by rejecting immunity provisions, but if it takes no action before 1989, the immunity provisions automatically apply to state law suits as well.

REPORTING REQUIREMENTS

In addition to providing immunity for professional review actions, the Act also requires reporting of certain actions to the Secretary of Health and Human Services (HHS), and to state boards of medical examiners. Specifically, health care facilities are required to report to the medical licensing boards in their state, any professional review action that adversely affects the clinical privileges of the physician for longer than 30 days, or the surrender of clinical privileges by a physician while an investigation related to possible incompetence or improper professional conduct is underway. Similar reports are permitted, but not required, in the case of actions taken with respect to non-physician practitioners. The state licensing boards are, in turn, required to report this information to the Secretary of Health and Human Services.

The failure of a health care facility to report an action that would otherwise be required to be reported, must also be reported by the state board to HHS. If the health care facility fails to report when required, it will lose the immunity protection provided in the other portions of the Act.

The required information must be reported at least monthly. The reporting requirements will go into effect by November 14, 1987.

Insurance companies, as well as health care facilities, are also required to report any payments made, pursuant to insurance policies or otherwise, in settlement or in satisfaction of judgments in medical malpractice actions. These reports must include not only the amount of the payment, but also the name of the practitioner involved, the name of any hospital with which the practitioner is associated, and a description of the acts or omissions, and injuries or illnesses, upon which the original malpractice claim was based.

Any person making a required report is immune from any liability in any civil action unless the information reported was false and they had knowledge of the falsity of the information. The information reported is also to be maintained in a confidential manner and can only be disclosed in cases relating to professional review activity.

Not only can hospitals receive information from the national data bank containing the reported information that will be established by HHS, they will be required to do so whenever a physician or other licensed health care practitioner applies to be on the medical staff or otherwise requests clinical privileges. Information must also be requested by the hospital once every two years for physicians and other practitioners already on the medical staff or who already exercise clinical privileges at the hospital. The intent is to make this request an integral part of the reappointment process.

If the hospital subsequently relies on information provided to it by HHS, it will not be held liable for so relying on it unless it has actual knowledge that the information was false. Moreover, if the hospital fails to obtain information as required, it will be presumed to have knowledge of this information in the event it is sued for malpractice. ■

How To Take Advantage Of The Act

Since the Quality Improvement Act so fundamentally changes the rules with respect to credentialling and quality assurance, hospitals should take action now to be ready to take advantage of the immunities in the Act, as well as to be protected from potential liability. This Act protects against the time, expense and trauma involved in a long, drawn-out antitrust suit. It is worth changing all bylaws and procedures as necessary. Do it now, for the protections of the Act are available now. Among the steps that should be put into place as soon as possible are:

- The credentialling provisions of the hospital's medical staff bylaws should be reviewed in detail and revised as necessary to assure compliance with the Act. In particular, the hearing and appeal provisions in the bylaws should be amended to conform with the due process provisions in the Act. [See Due Process Hearings —]
- The process by which applicants for staff appointment and reappointment are evaluated should be scrutinized to make sure that it will not forfeit the immunity provided by the Act. In particular, the composition of committees engaged in peer review and credentialling should be reviewed carefully to ensure that the committees are not structured to include practitioners who are likely to be alleged to be in direct economic competition with the subjects of professional review activity.

This means that medical staff committees making recommendations to the hospital board on credentialling matters should not be composed of "representatives" of particular departments. Rather the individuals on these committees should be chosen for their ability to make thorough, reasoned recommendations concerning applicants for appointment and clinical privileges. Also, there should be clear conflict of interest provisions that require a physician involved in the credentialling process not to take part in any action dealing with an individual with whom he might be in direct economic competition.

- Provisions in medical staff bylaws that require the approval of the entire staff prior to sending a credentialling recommendation to the board should be repealed immediately. The definition of professional review body only includes *committees* of the medical staff — not the medical staff as a whole. The immunity provided by the Act will not extend to any process where the entire medical staff makes a recommendation on appointment to the board.
- Credentialling forms, such as appointment and reappointment application forms, should be thoroughly scrutinized to ensure that they elicit all of the information that will be needed for the credentials committee and board to make a reasonable determination in credentialling cases. The

CONTINUED ON PAGE 4

Due Process Hearings — (cont.)

ing at least 30 days in advance of the hearing. He must also be provided with a list of witnesses expected to testify on behalf of the professional review body.

The hearing can be held before a panel of individuals who are not in direct economic competition with the physician, a mutually acceptable arbitrator, or a hearing officer appointed by the hospital who is not in direct economic competition with the physician. This last option is one not often used by hospitals up to now, but it has a number of advantages from the standpoint of providing a more thorough review of the facts of the situation, as well as protecting physicians on the medical staff who would otherwise have been on the hearing panel from allegations that they were engaged in a conspiracy against the physician in question.

If the physician fails to appear at the hearing, his right to the hearing can be forfeited. Also, a physician can waive his due process rights, but any such waiver must be in writing. A specific waiver as part of a contract between the physician and hospital would also suffice.

At the hearing the physician has the right to be represented by an attorney or other person of his choice, to have a record made of the hearing proceedings, to call, examine and cross-examine witnesses, to present evidence deemed to be relevant by the hearing officer regardless of its admissibility in a court of law, and to submit a written statement at the close of the hearing.

Copies of the hearing record can be obtained by the physician upon paying a reasonable fee. After the hearing is over, the physician must also have the right to receive the written recommendation of the panel which must include a statement of the basis for its recommendations and to receive the ultimate written decision of the health care entity.

The Act permits summary suspension of clinical privileges during the course of an investigation (which cannot be longer than 14 days in length) or the immediate suspension or restriction of privileges "where the failure to take such action may result in imminent danger to the health of any individual." In the latter case, the suspension has to be followed up by a subsequent notice and hearing or other adequate procedures.

Hospitals should take steps now to make sure that their credentialling and hearing and appeal procedures meet these requirements. It may be advantageous from a procedural and legal standpoint for these procedures to be placed not in the medical staff bylaws, as has traditionally been the case, but in a separate hearing and appeals policy adopted by the board of the hospital. These procedures would be employed in all cases where negative recommendations are made concerning staff appointment and clinical privileges.

While the Act does not state that these procedures are the exclusive means of providing due process, they are deemed as adequate due process by the Act. They will therefore form the standard for medical staff due process actions in the years to come. Hospitals would do well to conform their own procedures to them as soon as possible. ■

Therapy Service (cont.)

hospital for care and treatment, he or she does so in reliance on the reputation of the institution and the skill and expertise of its personnel."

The appellate court therefore reversed the judgment of the trial court and remanded the case for trial.

This case demonstrates dramatically that the hospital is at risk for all behavior which occurs on its premises no matter who the actor is. It is an illustration of how critical it is for hospitals to have in place effective evaluation programs so that all health care services are monitored and maintained at high levels of quality. Even in the case of an exclusive contractual arrangement for the provision of services there is a need for all practitioners to maintain the highest standards of care when they perform in the institution.

From a more practical standpoint the case highlights the importance of "telling it like it is." It would have been most helpful if the entrance to the X-ray department had clearly indicated the fact that the X-ray group was not a direct hospital operation.

The case does not inform us whether the hospital was indemnified by the physician group. One would hope so. In any event, these kinds of cases are no longer "rare birds." It would be in everyone's interest to review these kinds of relationships to assess potential liability. ■

Advantage Of The Act (cont.)

information requested by the forms should be as thorough and complete as possible and staff bylaws should not permit any action to be taken until the application is complete and until all outstanding questions with respect to the application have been resolved. Taking action either affirmatively or negatively without having all of the facts necessary to support the action (especially information that will be available from HHS) is now extremely dangerous from a legal perspective.

• The credentialling and quality management provisions of any hospital affiliated HMO or PPO should be subjected to the same type of scrutiny. HMOs (certainly) and PPOs (probably) are considered health care entities which can avail themselves of the immunities provided in this Act.

The Health Care Quality Improvement Act of 1986 should prove to be a positive force in promoting quality health care. However, it will only prove to be so if hospitals and physicians make it work. The failure on the part of hospitals and their medical staffs to quickly respond to the requirements of this Act will result in legal disaster for them. ■

ACTION-Kit for hospital law is written by members of the firm of Horty, Springer & Mattern, P.C.

JOHN HORTY, editor

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(7)

HOUSE COMMITTEE REPORT

Date referred: 2/20/87

FURTHER REFERRALS: Finance

DATE: 3-9-87

The Judiciary Committee has considered HB 70

"An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

RECOMMENDS:

[✓] replace with CSHB 70(Judiciary) [✓] the same title
[ ] a new title

[ ] attached amendment(s)

[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[✓] same as previous fiscal note published 2/20/87
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

Chairman's signature

STATE OF ALASKA
THE LEGISLATURE

POUCH V · STATE CAPITOL
JUNEAU, ALASKA 99811
907·465·3800

LEGISLATIVE AFFAIRS AGENCY

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May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H. JUD.	3-9-87	1:30p.m.
H. JUD	3-5-87	1:30p.m.
H. JUD	2-24-87	1:30p.m.

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 24, 1987

SUBJECT: Amendments to CSHB 70 (L&C)

TO: Representative John Sund

FROM: Edward H. Hein EH
Legislative Counsel

Enclosed are the amendments requested by your aide, Howard Wayne. These reflect the changes suggested by Dr. Conley of the State Medical Board. You will note some differences, however, between his suggestions and these amendments. The amendment to AS 08.01.065(e) remains (e), not (d). I have inserted additional language to avoid a dedicated fund problem and any implication that this provision overrides any specific appropriation by the legislature. The provision allowing the board to set fees appears in the amendment to AS 08.64.315, plus a cross-reference in AS 08.01.065(a).

The suggested deletions of AS 08.64.260(b), (c), and (d) already appear in Sec. 12 of the CS. Dr. Conley's suggested amendment to AS 08.64.338 is unnecessary because the board already has authority to revoke a license for failure to comply with a board order. See AS 08.64.326(a)(7) and 08.64.331(a)(1). The suggested amendment to AS 08.64.336(b) includes the phrase "licensed to practice medicine or surgery or osteopathy." This is ambiguous in light of the phrase "licensed to practice medicine and surgery or osteopathy" that appears in current law in AS 08.64.332 and 08.64.336(a) and (b). I have used the "and . . . or" construction in the amendment to be consistent, but this needs to be clarified with Dr. Conley.

Finally, Dr. Conley suggested providing a penalty for hospitals that fail to report under AS 08.64.336(b). One approach would be to amend AS 18.20.050 by inserting a cross-reference to AS 08.64.336(b). That would allow the Department of Health and Social Services to suspend or revoke a hospital's license for substantial failure to comply with reporting requirements.

EHH:mkr
m9/047

Enclosures

5-0291Ba
Hein

A M E N D M E N T

Offered in the HOUSE By Sund

TO: CSHB 70(L&C)

Page 1, after line 9:

Insert a new bill section to read:

"* Section 1. AS 08.01.065(a) is amended to read:

(a) Except as provided in AS 08.64.315, the [THE] department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter and for real estate brokers and salesmen under AS 08.88."

Renumber the following bill section accordingly.

Page 1, line 12:

Delete "An"

Insert "To the extent that appropriations are available for the purpose, and notwithstanding the requirement of AS 37.07.080(e) that approval of the Office of the Governor is required, an"

Page 1, after line 16:

Insert a new bill section to read:

"* Sec. 3. AS 08.64.101 is amended to read:

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

(2) develop written guidelines to insure that licensing requirements are not unreasonably burdensome and the issuance of licenses is not unreasonably withheld or delayed;

(3) submit an annual report of its proceedings to the governor, including a statement of money received and disbursed;

(4) after a hearing, impose disciplinary sanctions on persons who violate this chapter, or the regulations or orders of the board;

(5) adopt regulations insuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee;

(6) hire an executive director and necessary staff;

(7) contract with private professional organizations to establish an impaired medical professionals program to treat persons licensed under this chapter who abuse addictive substances."

Renumber following bill sections accordingly.

Page 2, after line 2:

Insert a new bill section to read:

"* Sec. 8. AS 08.64.315 is amended to read:

Sec. 08.64.315. FEES. The board [DEPARTMENT] shall set fees [UNDER AS 08.01.065] for each of the following:

(1) application;

(2) license by examination;

(3) license by endorsement or waiver of examination;

(4) temporary permit;

(5) locum tenens permit;

(6) license renewal, active;

(7) license renewal, inactive;

(8) license by reexamination."

Renumber following bill section accordingly.

Page 2, after line 22:

Insert a new bill section to read:

"* Sec. 10. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank actions taken by the board under AS 08.64.331 and license suspensions or surrenders under AS 08.64.332 or 08.64.334."

Renumber following bill sections accordingly.

Page 2, line 27:

Delete "this"

Insert "<u>the</u> [THIS]"

Page 3, line 2, after "privileges.":

Insert "<u>A hospital shall also report to the board the name and address</u>

of a person licensed to practice medicine and surgery or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital."

CS For HB 70 (Judiciary)

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office.

Section 1 requires that to the extent possible and despite AS 37.07.080(e), which prohibits transfers between appropriations without legislative authority and transfers between line items without the governor's approval, one half of the amount of fees collected by the state for medical licenses, permits, and applications during the previous two calendar years shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board. The two-year average is specified because the department renews all licenses at the same time. This will prevent a yearly imbalance of appropriations, i.e., a large appropriation one year followed by a small appropriation the next. ~~The appropriations will be made~~

Section 2 adds to the Board's duties the hiring of an executive secretary and necessary staff and the ability to contract out an impaired medical professional program for licensees with substance abuse problems.

Section 3 requires that all applicants be checked through the Federation of State Medical Boards disciplinary data bank for any previous problems.

Section 4 repeals the 40-day requirement for exam applications and requires that the application deadline will be established by regulation.

Section 5 eliminates oral examinations for licenses to practice medicine or osteopathy.

Section 6 requires that all license applicants be personally interviewed by at least one medical board member. Present statute seems to leave this open to choice.

Section 7 requires that licenses be renewed at least every two years instead of the present four years. The department shall establish the renewal date. This permits the department to continue its policy of renewing all licenses at the same time.

Section 8 rewrites the statute relating to inactive medical licenses. Current law requires that a licensee must reside outside the state in order to obtain an inactive license. As rewritten, a licensee's residence would be irrelevant. The only criterion would be whether the licensee practices

in the state. If the licensee does practice in the state, no matter how infrequently, the licensee must hold an active license.

Section 9 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a).

Section 10 is a housekeeping measure to remove the term "surgery" from statute. Surgeons do not hold separate licenses from other physicians.

Section 11: Requires the Board to report to the Federation of State Medical Boards data bank any license refusals, restrictions, suspensions, surrenders, etc. as described in AS 08.64.240, 08.64.331, 08.64.332 and 08.64.334.

Section 12 adds to current law a requirement that a hospital that revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.
The hospital must also report the name and address of a physician if that physician resigned while under an investigation that could have lead to a restriction, suspension, condition, etc.
This section also clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a practitioner is a danger to the health or welfare of the public or the practitioner's patients." This section also specifically authorizes the board to suspend the licensee's license before appointing the committee or before receiving the committee's report.
Finally, this section adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Section 13 adds a new statute. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board

expense, and may include tests requested by the examining physician.

Section 14 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that unless the identity of a patient would be revealed, a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings. The amendment includes, however, that the court may decide it necessary to reveal the identity of a patient in order to serve justice.

Section 15 repeals provisions relating to license examinations to reflect the board's current examining practices.

CHANGES MADE TO CS HB 70 (L&C) IN JUDICIARY CS

1. Gave the Board the power to set licensing fees instead of the Department. (Sections 1 and 9)

2. Made appropriations to the Board subject to availability and despite AS 37.07.080(e), which prohibits transfers between appropriations without legislative authority and transfers between line itmes without the governor's approval. (Section 2)

3. Allowed payments made annually to the Board to be calculated on a biennial basis. This is to conform with the renewal policy of the division in which all licenses are renewed at the same time. (Section 2)

4. Added to the Board's duties the power to hire an executive secretary and necessary staff and to contract out an impaired medical professional program for licensees with substance abuse problems. (Section 3)

5. Required the Board to check all applicants through the Federation of State Medical Boards disciplinary data bank. (Section 4)

6. Made the department responsible for setting the license renewal date. (Section 7)

7. Took "surgery" out of the bill as a housekeeping measure. (Sections 11 and 13)

8. Required the board to report all disciplinary action to the Federation of State Medical Board data bank. (Section 12)

change 9. Defined "consultation requirement" to mean "requirement of peer review of the patient orders." (Section 13)

10. Added that a hospital must report the name and address of a physician to the Board if that physician resigned while under an investigation that could have led to a result that requires reporting under AS 08.64.336. (Section 13)

11. Deleted subpoena power - Sec 13

12 added privacy of records Sec 14 interview

5-0291L

Original sponsors: Sund, Koponen,
Taylor and Zawacki

Stein
3/10/87

del. to Sund

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.065 is amended by adding a new subsection to read:

(e) To the extent that appropriations are available for the purpose, and notwithstanding the requirement of AS 37.07.080(e) that approval of the office of management and budget is required, an amount equal to one-half of the amount of fees collected during the previous two calendar years for applications, licenses, and permits issued under AS 08.64 shall be allocated each fiscal year by the department, without the approval of the office of management and budget, for services provided to or on behalf of the State Medical Board by the division of occupational licensing.

* Sec. 2. AS 08.64.101 is amended to read:

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

(2) develop written guidelines to insure that licensing requirements are not unreasonably burdensome and the issuance of licenses is not unreasonably withheld or delayed;

(3) submit an annual report of its proceedings to the governor, including a statement of money received and disbursed;

(4) after a hearing, impose disciplinary sanctions on

persons who violate this chapter, or the regulations or orders of the board;

(5) adopt regulations insuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee;

(6) hire an executive secretary and necessary staff;

(7) contract with private professional organizations to establish an impaired medical professionals program to treat persons licensed under this chapter who abuse addictive substances.

* Sec. 3. AS 08.64.200 is amended by adding a new subsection to read:

(b) The board shall determine whether each physician applicant has any disciplinary or other actions recorded in the nationwide disciplinary data bank of the Federation of State Medical Boards.

* Sec. 4. AS 08.64.210(b) is repealed and reenacted to read:

(b) The deadline for submitting an exam application to the board shall be established by regulation.

* Sec. 5. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 6. AS 08.64.255 is amended to read:

Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licensure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in person by at least one member of the board before a license will be issued. The interview must [SHALL] be recorded. If [, AND, IF] the application is denied on the basis of the interview, the denial must [SHALL] be stated in writing, with the reasons for it, and the record must [SHALL] be preserved.

* Sec. 7. AS 08.64.311 is repealed and reenacted to read:

Sec. 08.64.311. LICENSE RENEWAL. The department shall establish

license renewal dates. Licenses shall be renewed biennially, unless the commissioner, by regulation, provides for more frequent renewals.

* Sec. 8. AS 08.64.313 is repealed and reenacted to read:

Sec. 08.64.313. INACTIVE LICENSE. A licensee who does not practice in the state may hold an inactive license. A person who practices in the state, however infrequently, shall hold an active license.

* Sec. 9. AS 08.64.331(a) is amended to read:

(a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may

(1) permanently revoke a license to practice;

(2) suspend a license for a determinate period of time;

(3) censure a licensee;

(4) issue a letter of reprimand;

(5) place a licensee on probationary status and require the licensee to

(A) report regularly to the board on matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of a licensee; [OR]

(7) <u>impose a civil fine of not more than $10,000; or</u>

<u>(8)</u> impose one or more of the sanctions set out in <u>(1) - (7)</u> [(1) - (6)] of this subsection.

* Sec. 10. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR

INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the board determines that the person has been restored to reason.

* Sec. 11. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license refusals under AS 08.64.240, actions taken by the board under AS 08.64.331, and license suspensions or surrenders under AS 08.64.332 or 08.64.334.

* Sec. 12. AS 08.64.336 is repealed and reenacted to read:

Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (a) A physician who professionally treats a person licensed to practice medicine or osteopathy in this state for alcoholism or drug addiction, or for mental, emotional, or personality disorders, shall report it to the board if the physician providing treatment feels that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice. The report shall state the name and address of the person and the condition found.

(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or imposes a consultation requirement on, a person licensed to practice medicine or osteopathy

in the state shall report to the board the name and address of the person and the reasons for the action. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a consultation requirement. A report is required under this subsection regardless of whether the person voluntarily agrees to the action taken by the hospital. A report is not required if the sole reason for the action is the person's failure to complete hospital records in a timely manner or to attend staff or committee meetings. In this subsection "consultation requirement" means a restriction placed on a person's existing hospital privileges requiring consultation with a designated physician or group of physicians in order to continue to exercise the hospital privileges.

(c) Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and, upon a finding that there is reasonable cause to believe that the person who is the subject of the report is a danger to the health or welfare of the public or to the person's patients, the board may appoint a committee of three qualified physicians to examine the person and report its findings to the board. Notwithstanding the provisions of this subsection, the board may summarily suspend a license under AS 08.64.331(c) before appointing an examining committee or before the committee makes or reports its findings.

(d) If the board finds that a person licensed to practice medicine or osteopathy is unable to continue in practice with reasonable

safety to the person's patients or to the public, the board shall initiate action to suspend, revoke, limit, or condition the person's license to the extent necessary for the protection of the person's patients and the public.

(e) A physician, hospital, or hospital committee that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil or criminal liability for the submission or participation.

(f) A physician or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 13. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes of an investigation under this chapter, the board may order a person to whom it has issued a license or permit to submit to a medical or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board. An examination shall be at the board's expense. An examination may include the required submission of biological specimens requested by the examining physician or practitioner.

* Sec. 14. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

(d) EXCEPTIONS. There is no privilege under this rule:

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) Crime or Fraud. If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

(3) Breach of Duty Arising Out of Physician-Patient Relationship. As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

(4) Proceedings for Hospitalization. For communications relevant to an issue in proceedings to hospitalize the patient for physical, mental or emotional illness, if the physician or psychotherapist, in the course of diagnosis or treatment, has determined that the patient is in need of hospitalization.

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336, other than information that would

establish the identity of a patient, unless the court finds that it is necessary to admit the identifying information in order to serve the interests of justice.

(6) Examination by Order of Judge. As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition.

(7) Criminal Proceeding. For physician-patient communications in a criminal proceeding. This exception does not apply to the psychotherapist-patient privilege.

* Sec. 15. AS 08.64.260(b), (c), and (d) are repealed.

Adopted CS 3/9 +3 Amds

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5-0291L
Hein
3/6/87

Original sponsors: Sund, Koponen,
Taylor and Zawacki

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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(e) To the extent that appropriations are available for the purpose, and notwithstanding the requirement of AS 37.07.080(e) that approval of the office of management and budget is required, an amount equal to one-half of the amount of fees collected during the previous two calendar years for applications, licenses, and permits issued under AS 08.64 shall be allocated each fiscal year by the department, without the approval of the office of management and budget, for services provided to or on behalf of the State Medical Board by the division of occupational licensing.

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Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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(3) submit an annual report of its proceedings to the governor, including a statement of money received and disbursed;

(4) after a hearing, impose disciplinary sanctions on

persons who violate this chapter, or the regulations or orders of the board;

(5) adopt regulations insuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee;

(6) hire an executive secretary and necessary staff;

(7) contract with private professional organizations to establish an impaired medical professionals program to treat persons licensed under this chapter who abuse addictive substances.

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(b) The board shall determine whether each physician applicant has any disciplinary or other actions recorded in the nationwide disciplinary data bank of the Federation of State Medical Boards.

* Sec. 4. AS 08.64.210(b) is repealed and reenacted to read:

(b) The deadline for submitting an exam application to the board shall be established by regulation.

* Sec. 5. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 6. AS 08.64.311 is repealed and reenacted to read:

Sec. 08.64.311. LICENSE RENEWAL. The department shall establish license renewal dates. Licenses shall be renewed biennially, unless the commissioner, by regulation, provides for more frequent renewals.

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Sec. 08.64.313. INACTIVE LICENSE. A licensee who does not practice in the state may hold an inactive license. A person who practices in the state, however infrequently, shall hold an active license.

* Sec. 8. AS 08.64.331(a) is amended to read:

(a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may

(1) permanently revoke a license to practice;

(2) suspend a license for a determinate period of time;

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(4) issue a letter of reprimand;

(5) place a licensee on probationary status and require the licensee to

(A) report regularly to the board on matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of a licensee; [OR]

(7) impose a civil fine of not more than $10,000; or

(8) impose one or more of the sanctions set out in (1) - (7) [(1) - (6)] of this subsection.

* Sec. 9. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the

board determines that the person has been restored to reason.

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Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license refusals under AS 08.64.240, actions taken by the board under AS 08.64.331, and license suspensions or surrenders under AS 08.64.332 or 08.64.334.

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(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or requires peer review of the patient orders of, a person licensed to practice medicine or osteopathy in the state shall report to the board the name and address of the person and the reasons for the action. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a

requirement of peer review of the person's patient orders. A report is required under this subsection regardless of whether the person voluntarily agrees to the action taken by the hospital. A report is not required if the sole reason for the action is the person's failure to complete hospital records in a timely manner or to attend staff or committee meetings.

(c) Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and, upon a finding that there is reasonable cause to believe that the person who is the subject of the report is a danger to the health or welfare of the public or to the person's patients, the board may appoint a committee of three qualified physicians to examine the person and report its findings to the board. Notwithstanding the provisions of this subsection, the board may summarily suspend a license under AS 08.64.331(c) before appointing an examining committee or before the committee makes or reports its findings.

(d) If the board finds that a person licensed to practice medicine or osteopathy is unable to continue in practice with reasonable safety to the person's patients or to the public, the board shall initiate action to suspend, revoke, limit, or condition the person's license to the extent necessary for the protection of the person's patients and the public.

(e) A physician, hospital, or hospital committee that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil or criminal liability for the submission or participation.

(f) A physician or hospital may n t refuse to submit a report under this section or withhold from the board or its investigators

evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 12. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes of an investigation under this chapter, the board may order a person to whom it has issued a license or permit to submit to a medical or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board. An examination shall be at the board's expense. An examination may include the required submission of biological specimens requested by the examining physician or practitioner.

* Sec. 13. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

(d) EXCEPTIONS. There is no privilege under this rule:

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) Crime or Fraud. If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone

to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

(3) Breach of Duty Arising Out of Physician-Patient Relationship. As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

(4) Proceedings for Hospitalization. For communications relevant to an issue in proceedings to hospitalize the patient for physical, mental or emotional illness, if the physician or psychotherapist, in the course of diagnosis or treatment, has determined that the patient is in need of hospitalization.

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336.

(6) Examination by Order of Judge. As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition.

(7) Criminal Proceeding. For physician-patient

communications in a criminal proceeding. This exception does not apply to the psychotherapist-patient privilege.

* Sec. 14. AS 08.64.260(b), (c), and (d) are repealed.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM March 7, 1987

SUBJECT: AS 08.64.336(e) in CSHB 70 (Jud)

TO: Representative John Sund
Chairman, House Judiciary Committee

FROM: Edward H. Hein EHH
Legislative Counsel

Under AS 08.64.336(e), which appears at page 5, lines 23 - 27 of CSHB 70 (Judiciary), a physician, hospital, or hospital committee that submits a report required under AS 08.64.336(a) or (b), or that participates in an investigation or judicial proceeding related to the report, could not be held liable civilly or criminally for submitting the report or for participating in the investigation or judicial proceeding. The only exception is if the submission of the report or the participation in the investigation or proceeding was done in bad faith, i.e., falsely.

This provision makes it clear that a physician or hospital that complies with its statutory duty to report certain information to the board cannot be sued for doing so. This provision is intended to encourage reporting by people who might be reluctant to do so for fear of being sued, even though they are required by law to do so.

AS 08.64.336(e) is very similar to AS 18.23.010(a). That provision makes any person immune from civil liability for furnishing any information to the State Medical Board or other "review organization", unless the person knew or should have known that the information was false.

EHH:csh
c7/083

5-0291La
Hein

Adopted

AMENDMENT #1

Offered in the HOUSE

By Sund/Cotton

TO: CSHB 70(Jud)

Page 4, lines 20 - 21:

Delete "requires peer review of the patient orders of"

Insert "imposes a consultation requirement on"

Page 5, line 1:

Delete "requirement of peer review of the person's patient orders"

Insert "consultation requirement"

Page 5, line 6, after "meetings.":

Insert "In this subsection "consultation requirement" means a restriction placed on a person's existing hospital privileges requiring consultation with a designated physician or group of physicians in order to continue to exercise the hospital privileges."

Adopted #2

A M E N D M E N T

Offered in the House By Gruenberg

To: C S. for HB 70 (Judiciary)

Page 7, line ~~15~~, following "AS 08.64.336" delete: "." and insert: "other than information that would establish the identity of a patient unless the court finds that it is necessary to admit such identifying information in order to serve the interests of justice."

A M E N D M E N T

3/9/87

Offered in the HOUSE Judiciary Committee By ~~AAG Peter Ferchlich~~ Ed Ford

TO: CSHB 70(L&C)

Page 1, line 21 ← page 2, line 9

Delete new AS 08.64.101(6) and (7) and substitute the following:

* Sec. 2. AS 08.64.101 is amended by adding a new subsection to read:

(b) The department may, after consultation with the board,

(1) hire an executive secretary; and

(2) contract with private professional organizations to establish an impaired medical professionals program to treat persons licensed under this chapter who abuse addictive substances.

Page 2, line 11:

Delete "board" and insert "department."

#3 Cotten Adopted

Page 2, line 20:

Insert new Sec. 6 to read:

* Sec. 6. AS 08.64.255 is amended to read:

Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licensure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in person by at least one member of the board before a license will be issued. The interview must [SHALL] be recorded. If[, AND, IF] the application is denied on the basis of the interview, the denial must [SHALL] be stated in writing, with the reasons for it, and the record must [SHALL] be preserved.

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 5, 1987

SUBJECT: Amendment to HB 70, State Medical Board bill

TO: Representative John Sund
Chairman, House Judiciary Committee

FROM: Edward H. Hein EHH
Legislative Counsel

Enclosed is the CS draft requested for you by Shari Kochman. At her request I am explaining why I have retained the amendment to AS 08.01.065 that I recommended in amendments dated 2/24/87 and that appears in Sec. 2 of the CS.

The clause "To the extent that appropriations are available for the purpose," has been inserted to avoid the argument that this section unconstitutionally attempts to restrict the legislature's power to appropriate.

The second clause, "and notwithstanding the requirement of AS 37.07.080(e) that approval of the office of management and budget is required," is needed to clarify that the requirement of this section applies regardless of whether OMB approves. Without this language, this section conflicts with AS 37.07.080(e).

If, after reviewing this memo, you still wish to delete these two clauses, please let me know and I will change it.

EHH:csh
c7/078

Enclosure

5-0291L
Hein
3/5/87

Original sponsors: Sund, Koponen,
Taylor and Zawacki

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.065(a) is amended to read:

(a) Except as provided in AS 08.64.315, the [THE] department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter and for real estate brokers and salesmen under AS 08.88.

* Sec. 2. AS 08.01.065 is amended by adding a new subsection to read:

(e) To the extent that appropriations are available for the purpose, and notwithstanding the requirement of AS 37.07.080(e) that approval of the office of management and budget is required, an amount equal to one-half of the amount of fees collected during the previous two calendar years for applications, licenses, and permits issued under AS 08.64 shall be allocated each fiscal year by the department, without the approval of the office of management and budget, for services provided to or on behalf of the State Medical Board by the division of occupational licensing.

* Sec. 3. AS 08.64.101 is amended to read:

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

(2) develop written guidelines to insure that licensing requirements are not unreasonably burdensome and the issuance of licenses is not unreasonably withheld or delayed;

(3) submit an annual report of its proceedings to the governor, including a statement of money received and disbursed;

(4) after a hearing, impose disciplinary sanctions on persons who violate this chapter, or the regulations or orders of the board;

(5) adopt regulations insuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee;

(6) hire an executive secretary and necessary staff;

(7) contract with private professional organizations to establish an impaired medical professionals program to treat persons licensed under this chapter who abuse addictive substances.

* Sec. 4. AS 08.64.200 is amended by adding a new subsection to read:

(b) The board shall determine whether each physician applicant has any disciplinary or other actions recorded in the nationwide disciplinary data bank of the Federation of State Medical Boards.

* Sec. 5. AS 08.64.210(b) is repealed and reenacted to read:

(b) The deadline for submitting an exam application to the board shall be established by regulation.

* Sec. 6. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 7. AS 08.64.311 is repealed and reenacted to read:

Sec. 08.64.311. LICENSE RENEWAL. The department shall establish license renewal dates. Licenses shall be renewed biennially, unless the commissioner, by regulation, provides for more frequent renewals.

* Sec. 8. AS 08.64.313 is repealed and reenacted to read:

Sec. 08.64.313. INACTIVE LICENSE. A licensee who does not practice in the state may hold an inactive license. A person who practices in the state, however infrequently, shall hold an active license.

* Sec. 9. AS 08.64.315 is amended to read:

Sec. 08.64.315. FEES. The board [DEPARTMENT] shall set fees [UNDER AS 08.01.065] for each of the following:

(1) application;

(2) license by examination;

(3) license by endorsement or waiver of examination;

(4) temporary permit;

(5) locum tenens permit;

(6) license renewal, active;

(7) license renewal, inactive;

(8) license by reexamination.

* Sec. 10. AS 08.64.331(a) is amended to read:

(a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may

(1) permanently revoke a license to practice;

(2) suspend a license for a determinate period of time;

(3) censure a licensee;

(4) issue a letter of reprimand;

(5) place a licensee on probationary status and require the licensee to

(A) report regularly to the board on matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a

satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of a licensee; [OR]

(7) impose a civil fine of not more than $10,000; or

(8) impose one or more of the sanctions set out in (1) - (7) [(1) - (6)] of this subsection.

* Sec. 11. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the board determines that the person has been restored to reason.

* Sec. 12. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license refusals under AS 08.64.240, action taken by the board under AS 08.64.331, and license suspensions or surrenders under AS 08.64.332 or 08.64.334.

* Sec. 13. AS 08.64.336 is repealed and reenacted to read:

Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (a) A physician who professionally treats a person licensed to practice medicine or osteopathy in this state for alcoholism or drug addiction,

or for mental, emotional, or personality disorders, shall report it to the board if the physician providing treatment feels that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice. The report shall state the name and address of the person and the condition found.

(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or requires peer review of the patient orders of, a person licensed to practice medicine or osteopathy in the state shall report to the board the name and address of the person and the reasons for the action. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a requirement of peer review of the person's patient orders. A report is required under this subsection regardless of whether the person voluntarily agrees to the action taken by the hospital. A report is not required if the sole reason for the action is the person's failure to complete hospital records in a timely manner or to attend staff or committee meetings.

(c) Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and, upon a finding that there is reasonable cause to believe that the person who is the subject of the report is a danger to the health or welfare of the public or to the person's patients, the board may appoint a committee of three qualified physicians to examine the person and report its findings to

the board. Notwithstanding the provisions of this subsection, the board may summarily suspend a license under AS 08.64.331(c) before appointing an examining committee or before the committee makes or reports its findings.

(d) If the board finds that a person licensed to practice medicine or osteopathy is unable to continue in practice with reasonable safety to the person's patients or to the public, the board shall initiate action to suspend, revoke, limit, or condition the person's license to the extent necessary for the protection of the person's patients and the public.

(e) A physician, hospital, or hospital committee that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil or criminal liability for the submission or participation.

(f) A physician or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 14. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.337. SUBPOENA POWER. For the purposes of an investigation under this chapter, the board may issue a subpoena to, administer or cause to be administered an oath to, and examine or cause to have examined the parts of the books, papers, and records of a person to whom the board has issued a license or permit or to a person the

board reasonably believes has information relevant to the investigation. The superior court, on application of the board, shall enforce the attendance and testimony of witnesses and the production and examination of books, papers, and records.

Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes of an investigation under this chapter, the board may order a person to whom it has issued a license or permit to submit to a medical or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board. An examination shall be at the board's expense. An examination may include the required submission of biological specimens requested by the examining physician or practitioner.

* Sec. 15. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

(d) EXCEPTIONS. There is no privilege under this rule:

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) Crime or Fraud. If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

(3) Breach of Duty Arising Out of Physician-Patient

Relationship. As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

(4) Proceedings for Hospitalization. For communications relevant to an issue in proceedings to hospitalize the patient for physical, mental or emotional illness, if the physician or psychotherapist, in the course of diagnosis or treatment. has determined that the patient is in need of hospitalization.

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336.

(6) Examination by Order of Judge. As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition.

(7) Criminal Proceeding. For physician-patient communications in a criminal proceeding. This exception does not apply to the psychotherapist-patient privilege.

* Sec. 16. AS 08.64.260(b), (c), and (d) are repealed.

5 March 87

Dear John,

After discussing the teleconference with the Medical Board and subsequently the Alaska State Medical Association the following is suggested:

) Section 13

AS 08.64.336 (b) [Page 5 of Judiciary CS for HB 70] lines 4-10 ... to grant hospital privileges to, [or requires peer review of the patients orders of] or limits previously granted privileges of, a person ...

and lines 17-18 ... hospital privileges, [or in the imposition of a requirement of peer review of the person's patient orders.] or in the imposition of limitations on previously granted privileges.

AS 08.64.336 (f) [Page 6 of Judiciary CS for HB 70]. Add new sentence at line 23: The board shall hold such reports confidential and they shall be non-discoverable unless and until the board shall issue a final order of disciplinary action under AS 08.64.331(b)

Section 14

AS 08.64.338 [Page 7 of Judiciary CS for HB 70] Line 6:

"... under this chapter, and on a finding of reasonable cause, the board..."

[This is a request from ASMA for language that will help to reassure the board doesn't act in an arbitrary & capricious fashion and is fine with us - indeed we are enjoined in various other sections from so acting.].

Section 15

Rule 504(d)(5) of the Alaska Rules of Evidence. [Page 8 of Judiciary CS for HB 70] Line 15:

We would support insertion of language requiring the deletion of patients names from such reports if not materially necessary to the case.

During my absence from 5 March to 16 March George Rhymer M.D in Anchorage has agreed to serve as liason and will be available to testify if needed. His address is 3340 Providence Dr / Suite 552 / Anchorage 99508. Phone contact is

(day) 662-2211 + ask operator to page.
Alternate day number 561-3211. Home
number 694-9600.

Again thanks for all the help.
All think of you all while Jim skiing ...
but maybe not too often.

Peace
Tom

JEFF Partnow
FBI

Rm 11
St Bernard
Lodge
Taos Ski Valley

Questions to answer on HB70

Dr. Conley:

1. Amendment #1: Problem making Medical Board only board in Division exempt from the Department setting fees.

2. Amendment #4: Same problem as in #1.

3. Amendment #3: Problem with board having authority to hire staff and that position of executive director doesn't exist. Change to executive secretary, which Nursing Board hires, and approval is subject to the Division.

Sister Barbara:

1. Amendment #7: How to define investigation. It must be an investigation that resulted in a consultation requirement, revocation, suspension, condition, restriction or refusal of hospital privileges. But does that restriction come after or before investigating. If after, then how do we define investigation.

2. Need definition of consultation requirement. - need panel need peer approval of orders patient

Ed Hein:

1. Grant immunity to treating physicians for reporting a patient physician's drug, alcohol, etc. problem. Give immunity to members of hospital peer review group. Use Health Care Quality Improvement Act of 1986 as guideline. Just state in statute "in compliance with the Health Care Quality Improvement Act of 1986."

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

APR 15 1987

April 8, 1987

Representative John Sund
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John:

I got word yesterday that House Bill 70 passed the House by a unanimous vote. The news was very gratifying.

I would again like to thank you for all hard work and the many hours you and your staff have spent on this bill. I will continue to be available as the bill moves into the Senate and will contact Senator Hensley's office tomorrow to make myself available for whatever committee hearings, etc. are deemed necessary for it's passage.

Again many thanks. Your efforts are very much appreciated. A particularly thanks to Shari and Howard for all the work that they have put in on this plus doubtless other members of your staff who are working behind the scenes.

Sincerely,

Tom

Thomas L. Conley, M.D.
Chairman

TLC:ts

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

APR 18 1988

April 15, 1988

Honorable John Sund
PO Box V
Juneau, Alaska 99811

Dear Representative Sund:

The State Medical Board would like to urge your support of SB 501 which would place the board's Executive Secretary in the partially exempt service.

It was assumed at the time of the passage of HB 70 creating the executive secretary position last year that it was a partially exempt one and such was reflected in the fiscal note. Unfortunately the specific language wasn't in the bill proper.

The board went through a time consuming and moderately expensive process of screening, interviewing and choosing an incumbent for the position. The potential evident in the candidate we selected has proved out and by dint of involving herself in extensive training she is at the point of becoming a really effective board administrator. This is particularly important as we prepare to launch the impaired physician program. The development of the program has been primarily her responsibility and the board is looking forward to her direction of it as it is implemented.

Unfortunately, since the position is not listed as partially exempt, the best that could be done was to make the position a temporary classified one that will shortly have to be readvertised. Given lay-off preferences we might well loose a now trained and effective executive. In the short run that will set the board back almost a year.

More importantly in the long run, the precedent of having the board's executive not serve at the pleasure of the board has significant potential for vitiating the effectiveness of the position. Mutual trust and a community of interest between the board and its executive is a must and it therefore seems logical that the position should be a partially exempt one.

Your support of this effort would be greatly appreciated. The board and I will be happy to answer any questions you might have on the matter.

Sincerely,

Thomas L. Conley, MD
Chairman

TLC:ts

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 17, 1987

SUBJECT: Sectional analysis of HB 70, relating to the State Medical Board

TO: Representative John Sund

FROM: Edward H. Hein
Legislative Counsel

Section 1 requires that the amount of fees collected by the state for medical licenses, permits, and applications during the previous calendar year shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board.

Sec. 2 requires that applicants for medical license examinations submit their applications to the State Medical Board 120 days before the examination date, rather than 40 days before the examination date.

Sec. 3 eliminates oral examinations for licenses to practice medicine or osteopathy.

Sec. 4 rewrites the statute relating to inactive medical licenses. Current law requires that a licensee must reside outside the state in order to obtain an inactive license. As rewritten, a licensee's residence would be irrelevant. The only criterion would be whether the licensee practices in the state. If the licensee does practice in the state, no matter how infrequently, the licensee must hold an active license.

Sec. 5 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a). These acts are: (1) securing a license through deceit, fraud, or intentional misrepresenta-

tion; (2) engaging in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities; (3) advertising professional services in a false or misleading manner; (4) having been convicted of a felony or other crime substantially related to the licensee's qualifications, functions, or duties, or a crime involving unlawful procurement, sale, prescription, or dispensing of drugs; (5) having procured, sold, prescribed, or dispensed drugs in violation of law; (6) intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards, even if the patient was not injured; (7) failing to comply with the provisions of AS 08.64, or a regulation or order of the board; (8) demonstrating professional incompetence, gross negligence, or repeated negligent conduct, or addiction to drugs, or unfitness because of physical or mental disability; (9) engaging in unprofessional, lewd, or immoral conduct while serving a patient; (10) performing an abortion (A) without a license; or (B) outside of a hospital or other facility approved by the Department of Health and Social Services or a federal hospital; or (C) on an unmarried minor without consent of the minor's parent or guardian; or (D) on a woman who has not been in the state for at least 30 days before the abortion; (11) violating any ethical code regulation adopted by the board; (12) denying care or treatment to a patient or person seeking treatment solely because the patient or person fails or refuses to agree to arbitrate under AS 09.55.535(a); or (13) having had a medical license or certificate suspended or revoked in another state, U.S. territory, or Canadian province, unless the suspension or revocation was for failure to pay fees.

Sec. 8 adds to current law a requirement that a hospital that places a consultation requirement on, revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.

Sec. 9 clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a

practitioner is a danger to the health or welfare of the public or the practitioner's patients". This section also specifically authorizes the board to suspend the li ensee's license before appointing the committee or before receiving the committee's report.

Sec. 8 adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Sec. 9 adds two new statutes. AS 08.64.337 gives the medical board subpoena power and the power to administer oaths for purposes of an investigation of a licensee. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board expense, and may include tests requested by the examining physician.

Sec. 10 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings.

Sec. 11 repeals provisions relating to license examinations to reflect the board's current examining practices.

EHH:mkr
m9/018

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 98111

February 18, 1987

Representative John Sund
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John,

Please find enclosed the proposed amendments to HB70 we discussed. After much consideration I elected to delete the amendment calling for ordering of re-examination in cases of suspected "intellectual" incompetence due to considerations of the complexity of the matter and the need to hear from all respondents before proceeding.

As you know wide-ranging, general, written exams (generally either the FLEX exam or an even more comprehensive three part exam offered over a period of years to most all U.S. medical students / post graduate fellows referred to as the National Board of Medical Examiners Test) are required at the point of initial licensing in whatever jurisdiction that occurs. This is appropriate as one needs a good overview of the whole discipline before specializing in its sub-branches. It is however questionable how appropriate it would be to require such an exam of someone who has been in specialty practice for many years if his/her competence were to be questioned. One could for instance be well qualified in cardiology and be unable to appropriately manage complicated obstetrics or orthopedic-subjects on which a general exam demands knowledgeable responses.

Perhaps the answer is to let the board tailor its choice of an appropriate re-examination of an individual suspected of incompetence in a purely medical sense (as opposed to psychiatric, physical or substance abuse generated incompetence) to the individual case. Various specialty exams are available for this purpose but the logistics are complicated.

The Medical Board faces sunset this year and legislation re-authorizing it for (probably) four years is due to be introduced at a latter date. Most likely, pending further thought and input from a number of sources, it would be best to hold on this area for now and if deemed a solid proposal submit such as a rider on that legislation.

I'm very impressed with and appreciative of the speed with which HB70 is moving and would do nothing to hinder it; thus I think this area is one to hold off on for now till mature judgment can be brought to bear.

As you know the board has given considerable thought to the impaired physician question. In addition to wishing to set up a monitored treatment program for licensees under board supervision (i.e. those who come to board attention) it is desired by having the program in place to encourage individuals to voluntarily enter such programs before coming to board notice. Such creates somewhat of a problem in that part of the purpose of the program for voluntary referrals would be vitiated if the individuals were reported to the board.

Thomas L. Conley, M.D. *Chairman* 3612 Tongass Avenue, Ketchikan, Alaska 99901

The FSMB publication "A Guide to the Essentials of a Modern Medical Practice Act" suggests that those conducting such a board approved program should be exempt from the mandatory reporting requirements relating to impaired physicians (voluntarily) participating satisfactorily in the program.

I bring the subject up to query if we need such language or whether we can depend on the present 08.64.336(a) which requires a physician who professionally treats another physician for alcoholism or drug addiction to report to the board if "the physician providing treatment feels that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice." I actually think I'm bringing up the question to answer it if the subject arises. The language would seem to give us the necessary authority to write regulatory provisions for treatment programs to ensure reporting of the individual who voluntarily enters a monitored treatment program and then relapses. Thus this also seems an area to hold on to permit the bill to go forward.

Sincerely,

Yours

Thomas L. Conley, M.D.

TLC/mm

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

January 22, 1987

Representative John Sund
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John,

Please find enclosed the proposed changes to the Medical Board Bill I spoke to Howard about today (they were messaged up to him in rough form via Legislative Affairs this morning). Subsequent to contacting Howard, I discovered that though Ed Hein in his memo concerning the draft copy stated that he had included deletion of 08.64.260 (b) (c) &(d) it did not appear in the draft so I have included it with the proposed changes.

The addition of language to the new subsection 08.01.065 (d) [Ibelieve it must be (d) rather than (e) since the present 08.01.065 has only subsections (a) through (c)] stating that fees shall be set by the board is designed to prevent future problems. At present our relations with the department and division are excellent so that there should be no difficulties in getting fees set in such manner as to support adequate functioning, including hiring of an Executive Director, etc. However the players change over time and the board could find itself facing hostility to its functioning in the future as it has on occassion in the past. One way this hostility could be played out would be for the division to set fees below the level necessary for the board to function adequately. I recognize this sounds somewhat paronoid but our experience supports the contention that the problem can exist. Thus rather than leaving things to the mercy of personalities it seems better to set it in law relying on the wisdom of the admittedly somewhat artificial concept that the "rule of Law" is perferable to "rule of individuals".

Of course the argument can cut both ways and I won't argue that in past power struggles between the board and the division that the board has had a monopoly on virtue. However it is clear that physicians around the state are indeed willing to pay higher fees to support an effective licensing activity and it would thus be a shame to see the effort thwarted at some future point by internicine squabbling.It's a touchy business I realize, for it does indeed increase the power of a subsidiary activity of the Division of Occupational Licensing. To be able to accept that with grace and equanimity requires a mature and self-confident division administrator and I don't think we can rely on always having such a person in the position. Fortunately at this critical junction we do.

The proposed additions to AS08.64.101 are designed to formalize in law two critical means by which the board hopes to carry out its function. While it might be argued that the duty and authority to do these things is implicit in the legislation it seems on balance better to state them explicity. That we need a day to day administrator to carry out board policy and supervise enforcement is abundantly obvious to the board members and is in no way an extravagant move. Moreover as the funds to achieve such will come from those regulated it will not be a drain on the state's budget at a time of economic decline.

T.L. Conley, Chairman * 3612 Tongass Avenue, Ketchikan, AK 99901 * (907) 225-5146
5144

The authority to set up an impaired professional's program by contractual arrangement has been discussed before, AS08.64.101 (7) formalizes this. Funding will be via charges to the licensee requiring the services except for the administrative aspects which will derive from fees.

Deletion of AS08.64.260 (b) (c) and (d) is justified by changes in the FLEX exam, a standardized national exam, that as of 1985 is a two part rather than a three part exam.. Details of the comparison and application of the two exams are tedious. After prolonged consideration the State Medical Board promulgated regulations 12AAC40.020 (a-h) to cover the subject. AS08.64.260 (b) (c) and (d) are in conflict with these as they refer to the old examination. They are applied in connection with prior regulations under 12AAC40.020 when considering examinees who took the FLEX prior to May 18, 1985. The three part FLEX is no longer available from the Federation of State Medical Boards. In future it would probably be best to leave close details such as interpretation of tests that change from time to time in regulation rather than statute for obvious reasons.

When I spoke with Howard today, he mentioned you had some hesitancies about AS08.64.336 (e) & (f) the provision covering immunity for those reporting to the board in good faith. Our experience suggests this is a critical element in the revisions and the lack of such assurances is the principal cause of our failure to hear about infractions and incidents and patterns of malpractice. Just before talking to Howard I got a call asking for advice about how to handle just such a situation wherein the medical staff of one of the state's hospitals wishes to deny renewal of privleges to two physicians on the grounds of incompetence and a pattern suggesting malpractice. They were told that the hospital, whose governing board has the final say in such matters (something of which many people are unaware), would not accept their recommendation because the hospital would then be obliged to report such and feared civil suit for so doing. During the last year I have gotten five calls of similar nature concerning variants of the same problem.

Enclosed I have also sent you a copy of a Federation of State Medical Boards publication entitled Essentials of a Modern Medical Practice Act. I would particularly direct your attention to Section XII, Compulsory Reporting and Investigation. It may be a little broader than one may care to enact (for instance one could interpret it to imply that an offending physician is required to report himself which is likely impractical and may offend concepts of self incrimination) but is gives food for thought. It does advise that penalties should be established for demonstrated failure to report which may be an excellent idea. It may also be a good idea to require reporting in the circumstance that a physician resigns from a hospital staff while under investigation regarding privleges, etc.

Finally we are somewhat in confusion as to how to manage and fund the transition period from our present way of conducting business to that which we would hope to have on line next year if the legislation passes. At present physicians licenses are issued for four years and are next due to expire on 12/31/88. Thus the bulk of fee income comes to the state in December every fourth year with only a trickle from new licenses and temporary licenses between those times.

Thus being funded at the fee income level of 1987 will not permit us to do even the present inadequate job in 1988. In our original proposal we called for annual renewal so we could adjust fees in such manner as necessary to meet expenses.

What might work would be to change the expiration date of licenses now in force to 12/31/87, collect the renewals in Nov/Dec '87 and thus have the funds to function in 1988. Thereafter we would advise renewal be annual or at the most every two years. To do this we probably need authority in law.

Again thanks for all your help and support in the effort and good luck this session. I suspect we are either going to get it together as a state this year and emerge with much greater maturity or we are going to be in a world of hurt. I'm particularly pleased by the idea of getting a statement of minimum funding by joint resolution sometime in March. It should let local governments and school districts budget more rationally and force the issue of what we are going to be willing to pay for locally.

Sincierly,

Thomas L. Conley, M.D.

TLC/mm

P.S. Dave Johnson here and George Brenneman of our board from Anchorage feel the first sentence of AS08.01.065 (d) should start "An amount at least equal to ...". The argument is that it forstalls quibblers who want to cause difficulties due to minor mismatches of funds and permits a fall back position if the economy goes completely gunny-sack and the board has to be run at some minimal level during times of financial disaster.

Amend AS0864.336 (b) to add a new line at line 28, to wit:

27 ...refusing to grant hospital privileges. Additionally a person licensed to practice medicine or surgery or osteopathy in this state who resigns his/her hospital staff privileges while under investigation by a hospital or committee thereof shall be reported to the board. A report is required...

Amend 08.64.338 to add new language at line 16, to wit:

15 ...examining physician or practitioner. If a licensee fail to submit to an examination when properly directed to do so by the board the board may enter a final order of license revocation upon proper notice, hearing, and proof of refusal.

(In other words, failure to submit to an exam under such circumstances is cause for license revocation)

Add new section:

AS 08.64.335 Actions reported. All actions taken under AS 08.64.331, AS 08.64.332 and AS 08.64.334 above and denials of licensure under AS08.64.240 shall be expeditiously reported to the Federation of State Medical Boards for inclusion in the nationwide Disciplinary Data Bank.

(We have to this point interpreted our mandate as permitting this as such knowledge is in the public domain after the board acts. However sending the material to other agencies unsolicited could be interpreted as actively "publishing" such information. It could perhaps be argued as grounds for a claim against the state. Paranoid of me no doubt. The more important reason for adding the section is actually simple statement of intent.)

Finally as we discussed, there should be some sanction placed on failure to report as required under AS 08.64.336. Clearly we have authority in this regard vis-a-vis physicians via licensing action. We have no jurisdiction over hospitals so writing a sanction into AS08.64 for hospitals that fail to report seems neither proper nor practical. What this should consist of (misdemeanor, civil fine, etc.) and where in the state code it should be placed I would leave to your good offices and that of legislative affairs. I do think it is an important matter as hospitals may decide it more expeditious to risk noncompliance with a law without sanctions than the entanglements of reporting.

The previous recommendations for amendments to AS 08.01 are hereby also appended for completeness. Notice our additional line on AS 08.01.065 (d). Note also the division requests we substitute the designation executive secretary for executive director.

AS 08.01.065 (c) should be renumbered AS 08. 01. 065 (d) and should be rephrased to read:

d) An amount equal to the amount of fees collected for applications, licenses, and permits under AS08.64 during the previous calender year shall be allocated each year by the department for services provided to or on behalf of the State Medical Board by the Division of Occupational Licensing. These feels shall be set by the State Medical Board consistent with its statutory obligations.

AS 08.64.101 is Amended by adding two new subsections to read:

6) In consultation with and under the existing rules of the Division of Occupational Licensing to hire an Executive Secretary for the board and provide such administrative, secretarial, and investigative staff as shall prove necessary to ensure effective functioning of the activity. Financial support for the necessary positions shall derive from fees set by the board under AS 08.01.65 (d).

7) The board shall have the authority to enter into contractual arrangements with existing private professional organizations to set up an effective Impaired Professionals program to deal with physicians and members of other regulated groups displaying problems with abuse of addictive substances.

Delete AS 08.64.260 (b), (c), and (d). AS 08.64.260 (a) should remain unchanged.

AS08.01.065 (e) should be renumbered AS08.01.065 (d) and should be rephrased to read:

(d) An amount equal to the amount of fees collected for applications, licenses, and permits under AS08.64 during the previous calender year shall be allocated each year by the department for services provided to or on behalf of the State Medical Board by the Division of Occupational Licensing. These fees shall be set by the State Medical Board consistent with its statutory obligations.

AS08.64.101 is Amended by adding two new subsections to read:

6) In consultation with and under the existing rules of the Division of Occupational Licensing to hire an Executive Director for the board and provide such administrative, secretarial, and investigative staff as shall prove necessary to ensure effective functioning of the activity. Financial support for the necessary positions shall derive from fees set by the board under AS08.01.65 (d).

7) The board shall have the authority to enter into contractual arrangements with existing private professional organizations to set up an effective Impaired Professionals program to deal with physicians and members of other regulated groups displaying problems with abuse of addictive substances.

Delete As08.64.260 (b), (c) and (d) .

AS08.64.260 (a) should remain unchanged.

Rep. Koponen

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

P.O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2534

February 18, 1987

To: Members of House Labor &
Commerce & House Judiciary

From: T.L. Conley, Chairperson
Alaska State Medical Board

Representative Niilo Koponen of House Labor & Commerce requested a copy of the enclosed "Guide to the Essentials of a Modern Medical Practice Act" by the Federation of State Medical Boards as he considered HB 70 introduced by Representative John Sund. We felt the overview it provides would be helpful to the other legislators as they consider the legislation.

cc Kathy Marshall

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SEC. 323. EFFECTIVE DATE.

(a) GENERAL RULE.—Subtitle 1 of title XXI of the Public Health Service Act shall take effect on the date of the enactment of this Act and Subtitle 2 of such title and this title shall take effect on the effective date of a tax enacted after the date of the enactment of this Act to provide funds for compensation paid under such subtitle 2.

(b) INSUFFICIENCY OF FUNDS.—If at any time there are insufficient funds to pay all of the claims payable under subtitle 2 of title XXI of the Public Health Service Act for 180 days, such subtitle shall cease to be in effect until sufficient funds to pay all of the claims under such subtitle become available.

TITLE IV—ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SEC. 401. SHORT TITLE.

This title may be cited as the "Health Care Quality Improvement Act of 1986".

SEC. 402. FINDINGS.

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than these that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

PART A—PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

SEC. 411. PROFESSIONAL REVIEW.

(a) IN GENERAL.—

(1) LIMITATION ON DAMAGES FOR PROFESSIONAL REVIEW ACTIONS.—If a professional review action (as defined in section 431(9)) of a professional review body meets all the standards specified in section 412(a), except as provided in subsection (b)—

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act, 15 U.S.C. 15C, where such an action is otherwise authorized.

(2) PROTECTION FOR THOSE PROVIDING INFORMATION TO PROFESSIONAL REVIEW BODIES.—Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) EXCEPTION.—If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 423(a), the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 423(a), the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) TREATMENT UNDER STATE LAWS.—

(1) PROFESSIONAL REVIEW ACTIONS TAKEN ON OR AFTER OCTOBER 14, 1989.—Except as provided in paragraph (2), subsection (a) shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) EXCEPTIONS.—

(A) STATE EARLY OPT-IN.—Subsection (a) shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) STATE OPT-OUT.—Subsection (a) shall not apply to State laws in a State for actions commenced on or after October 14, 1989, if the State by legislation elects such treatment.

(C) EFFECTIVE DATE OF ELECTION.—An election under State law is not effective, for purposes of subparagraphs (A) and (B), for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

SEC. 412. STANDARDS FOR PROFESSIONAL REVIEW ACTIONS.

(a) IN GENERAL.—For purposes of the protection set forth in section 411(a), a professional review action must be taken—

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(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) unless the presumption is rebutted by a preponderance of the evidence.

(b) ADEQUATE NOTICE AND HEARING.—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) NOTICE OF PROPOSED ACTION.—The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) NOTICE OF HEARING.—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) CONDUCT OF HEARING AND NOTICE.—If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right—

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).

(c) ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES.—For purposes of section 411(a), nothing in this section shall be construed as—

(1) requiring the procedures referred to in subsection (a)(3)—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

SEC. 413. PAYMENT OF REASONABLE ATTORNEYS' FEES AND COSTS IN DEFENSE OF SUIT.

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 412(a) and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

SEC. 414. GUIDELINES OF THE SECRETARY.

The Secretary may establish, after notice and opportunity for comment, such voluntary guidelines as may assist the professional review bodies in meeting the standards described in section 412(a).

SEC. 415. CONSTRUCTION.

(a) IN GENERAL.—Except as specifically provided in this part, nothing in this part shall be construed as changing the liabilities or immunities under law.

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(b) SCOPE OF CLINICAL PRIVILEGES.—Nothing in this part shall be construed as requiring health care entities to provide clinical privileges to any or all classes or types of physicians or other licensed health care practitioners.

(c) TREATMENT OF NURSES AND OTHER PRACTITIONERS.—Nothing in this part shall be construed as affecting, or modifying any provision of Federal or State law, with respect to activities of professional review bodies regarding nurses, other licensed health care practitioners, or other health professionals who are not physicians.

(d) TREATMENT OF PATIENT MALPRACTICE CLAIMS.—Nothing in this title shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any defenses or immunities available to any physician, health care practitioner, or health care entity.

SEC. 416. EFFECTIVE DATE.

This part shall apply to professional review actions commenced on or after the date of the enactment of this Act.

PART B—REPORTING OF INFORMATION

SEC. 421. REQUIRING REPORTS ON MEDICAL MALPRACTICE PAYMENTS.

(a) IN GENERAL.—Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances thereof.

(b) INFORMATION TO BE REPORTED.—The information to be reported under subsection (a) includes—

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) SANCTIONS FOR FAILURE TO REPORT.—Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected under that section.

(d) REPORT ON TREATMENT OF SMALL PAYMENTS.—The Secretary shall study and report to Congress, not later than two years after the date of the enactment of this Act, on whether information respecting small payments should continue to be required to be reported under subsection (a) and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

SEC. 422. REPORTING OF SANCTIONS TAKEN BY BOARDS OF MEDICAL EXAMINERS.

(a) IN GENERAL.—

(1) ACTIONS SUBJECT TO REPORTING.—Each Board of Medical Examiners—

(A) which revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct, or

(B) to which a physician's license is surrendered,

shall report, in accordance with section 424, the information described in paragraph (2).

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) is—

(A) the name of the physician involved,

(B) a description of the acts or omissions or other reasons (if known) for the revocation, suspension, or surrender of license, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) FAILURE TO REPORT.—If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (a), the Secretary shall designate another qualified entity for the reporting of information under section 423.

SEC. 423. REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HEALTH CARE ENTITIES.

(a) REPORTING BY HEALTH CARE ENTITIES.—

(1) ON PHYSICIANS.—Each health care entity which—

(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

(B) accepts the surrender of clinical privileges of a physician—

(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or

(ii) in return for not conducting such an investigation or proceeding; or

(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,

shall report to the Board of Medical Examiners, in accordance with section 424(a), the information described in paragraph (3).

(2) PERMISSIVE REPORTING ON OTHER LICENSED HEALTH CARE PRACTITIONERS.—A health care entity may report to the Board of Medical Examiners, in accordance with section 424(a), the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the practitioner were a physician.

(3) INFORMATION TO BE REPORTED.—The information to be reported under this subsection is—

(A) the name of the physician or practitioner involved,

(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) REPORTING BY BOARD OF MEDICAL EXAMINERS.—Each Board of Medical Examiners shall report, in accordance with section 424, the information reported to it under subsection (a) and known instances of a health care entity's failure to report information under subsection (a)(1).

(c) SANCTIONS.—

(1) HEALTH CARE ENTITIES.—A health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 411(a)(1) if the Secretary publishes the name of the entity under section 411(b).

(2) BOARD OF MEDICAL EXAMINERS.—If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b), the Secretary shall designate another qualified entity for the reporting of information under subsection (b).

(d) REFERENCES TO BOARD OF MEDICAL EXAMINERS.—Any reference in this part to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 422(a) or subsection (b), a reference to such other qualified entity as the Secretary designates.

SEC. 424. FORM OF REPORTING.

(a) TIMING AND FORM.—The information required to be reported under sections 421, 422(a), and 423 shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date (not later than one year after the date of the enactment of this Act) specified by the Secretary.

(b) TO WHOM REPORTED.—The information required to be reported under sections 421, 422(a), and 423(b) shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this part.

(c) REPORTING TO STATE LICENSING BOARDS.—

(1) MALPRACTICE PAYMENTS.—Information required to be reported under section 421 shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) REPORTING TO OTHER LICENSING BOARDS.—Information required to be reported under section 423(b) shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b).

SEC. 425. DUTY OF HOSPITALS TO OBTAIN INFORMATION.

(a) IN GENERAL.—It is the duty of each hospital to request from the Secretary (or the agency designated under section 424(b)), on and after the date information is first required to be reported under section 424(a))—

(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this part concerning the physician or practitioner, and

(2) once every 2 years information reported under this part concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

(b) FAILURE TO OBTAIN INFORMATION.—With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) is presumed to have knowledge of any information reported under this part to the Secretary with respect to the physician or practitioner.

(c) RELIANCE ON INFORMATION PROVIDED.—Each hospital may rely upon information provided to the hospital under this title and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

SEC. 426. DISCLOSURE AND CORRECTION OF INFORMATION.

With respect to the information reported to the Secretary (or the agency designated under section 424(b)) under this part respecting a physician or other licensed health care practitioner, the Secretary shall, by regulation, provide for—

(1) disclosure of the information, upon request, to the physician or practitioner, and

(2) procedures in the case of disputed accuracy of the information.

SEC. 427. MISCELLANEOUS PROVISIONS.

(a) PROVIDING LICENSING BOARDS AND OTHER HEALTH CARE ENTITIES WITH ACCESS TO INFORMATION.—The Secretary (or the agency designated under section 424(b)) shall, upon request, provide information reported under this part with respect to a physician or other licensed health care practitioner to State licensing boards, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.

(b) CONFIDENTIALITY OF INFORMATION.—

(1) IN GENERAL.—Information reported under this part is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, with respect to medical malpractice actions, or in accordance with regulations of the Secretary promulgated pursuant to subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(2) PENALTY FOR VIOLATIONS.—Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the

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(3) USE OF INFORMATION.—Subject to paragraph (1), information provided under section 425 and subsection (a) is intended to be used solely with respect to activities in the furtherance of the quality of health care.

(c) RELIEF FROM LIABILITY FOR REPORTING.—No person or entity shall be held liable in any civil action with respect to any report made under this part without knowledge of the falsity of the information contained in the report.

(d) INTERPRETATION OF INFORMATION.—In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

PART C—DEFINITIONS AND REPORTS

SEC. 431. DEFINITIONS.

In this title.

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

(4)(A) The term "health care entity" means—

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act.

(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician—

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

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(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

SEC. 432. REPORTS AND MEMORANDA OF UNDERSTANDING.

(a) ANNUAL REPORTS TO CONGRESS.—The Secretary shall report to Congress, annually during the three years after the date of the enactment of this Act, on the implementation of this title.

(b) MEMORANDA OF UNDERSTANDING.—The Secretary of Health and Human Services shall seek to enter into memoranda of understanding with the Secretary of Defense and the Administrator of Veterans' Affairs to apply the provisions of part B of this title to hospitals and other facilities and health care providers under the jurisdiction of the Secretary or Administrator, respectively. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act, on any such memoranda and on the cooperation among such officials in establishing such memoranda.

(c) MEMORANDUM OF UNDERSTANDING WITH DRUG ENFORCEMENT ADMINISTRATION.—The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Administrator of Drug Enforcement relating to providing for the reporting by the Administrator to the Secretary of information respecting physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act, on any such memorandum and on the cooperation between the Secretary and the Administrator in establishing such a memorandum.

TITLE V—STATE COMPREHENSIVE MENTAL HEALTH SERVICES PLANS

SEC. 501. SHORT TITLE.

This title may be cited as the "State Comprehensive Mental Health Services Plan Act of 1986".

SEC. 502. STATE COMPREHENSIVE MENTAL HEALTH SERVICES PLAN.

Part B of title XIX of the Public Health Service Act is amended—

(1) by inserting before the heading for section 1911 the following:

"SUBPART 1—BLOCK GRANT"; and

(2) by adding at the end thereof the following:

Department of Commerce & Economic Development / POSITION PAPER

CSHB 70 (L&C): "An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

The department supports CSHB 70 with the exception of Sections 1 and 4.

Section 1: proposes amending AS 08.01.065 by requiring the department to allocate an amount equal to the fees collected during the previous year to be used on behalf of the State Medical Board by the Division of Occupational Licensing.

The way the proposed legislation is currently worded the State Medical Board would renew their licenses every two years and the division would allocate funding to the board based on the amount of revenue collected from fees for the previous year. The problem is that insufficient revenue is generated in the nonrenewal year to adequately fund the operations of the board. The department would, therefore, recommend revising Section 1 to read:

> (e) The Division of Occupational Licensing shall allocate funding for the State Medical Board based, to the extent possible, on the average amount of fees collected for applications, licenses and permits in the previous two fiscal years.

In addition, Section 4: proposes licenses be renewed every two years instead of every four years after the date of issue. Although the department supports the two year requirement, the renewal date should be established by the department as opposed to after the date of issue. If licenses were renewed two years after the date of issue, the department would be conducting a staggered and continuous renewal rather than prorating license renewals to a set date. This would require additional staff resources.

In summary, these two statutory provisions would enable the division to renew medical licenses every two years and establish a budget for the medical board based on the average revenue collected from fees for the previous two years. Fees could be more easily adjusted to ensure the operating costs of the medical board were covered in accordance with AS 08.01.065(c).

J. Anthony Smith, Commissioner
Department of Commerce and Economic Development

Date: _____

375SM

Tanana Valley Clinic

Family Medical Care

Since 1959

February 24, 1987

Representative John Sund
Chairman, House Judiciary Committee
Alaska State Legislature
Pouch V
Juneau Alaska 99811

Dear Representative Sund:

I have had the opportunity of reviewing your House Bill 70, and would like to share my thoughts on it with you.

I am very much in favor of working out some arrangement whereby the medical license fees paid by physicians in the State of Alaska be allocated to the account of the State Medical Board. I am aware of some of the difficulties - constitutional and otherwise - involved in this process, and appreciate your efforts toward their resolution. I know of no physician who is against this process, and I strongly feel that a better and more dependably funded State Medical Board will give you, the Legislature, and we, the people, the kind of service we expect from it.

The amendment to Section 8, Part (f), gives me some concern. I am worried that this section breeches the sanctity of the physician-patient relationship, and I question whether that is a good idea. Nothing prevents me, or any other physician, from advising and encouraging a patient to take a matter to appropriate authorities, be it the police, the District Attorney, or the State Medical Board. I could see myself being in the position of having to give a patient a Miranda-type warning, putting them on guard that the matter they were beginning to discuss had been mandated for report, and would become public knowledge. I think that could seriously hamper our further relationship.

I don't see the question of privacy of matters in the State Medical Board addressed in your bill. Has this been addressed previously? Its findings, conclusions and censures should certainly be within the public domain. Do you think it would be worthwhile having some of its debate and some of the fact-finding process shielded? This is obviously a touchy area, both from the public's right to know, and the participant's right to privacy.

1001 Noble Street • Fairbanks, Alaska 99701
(907) 452-1611

I appreciate your attention to this letter and your assistance with House Bill 70. Overall it looks like quite a good bill. I hope you would be willing to make some compromise about Section 8 (f).

Sincerely,

Charles Steiner, M.D.
Family Practice
Tanana Valley Medical-Surgical Group

CS:sr
cc: Ray Schalow, Executive Director
Alaska State Medical Association, Anchorage

cc: Rick Urion

FEDERATION BULLETIN

DECEMBER 1987

RICHARD C. LYONS, M.D.
Longtime Leader in Medical Education and Licensure in Pennsylvania

IN THIS ISSUE

FSMB • 75 YEARS OF SERVICE TO THE AMERICAN PEOPLE 1912 • 1987

1/22

Dear Shuri -

I received in the article of Alpha Zeta. Thanks for all the work Jenny Stricklland put in dealing on when the temporary position with Washington expires. I'll be in touch with you.

Sincerely,

Tom

Improvements in Medical Licensing in Alaska, "The Last Frontier"

THOMAS L. CONLEY, M.D.

Though vast in geographic area Alaska is quite small in population with fewer than 700,000 citizens and as of last count 1,036 licensed physicians. Like many "small" states Alaska has been slow to address the problems of professional licensure, with the state medical board accorded low priority and limited funds.

For a number of years the Alaska State Medical Board had recognized that basic changes in the system were needed. It found that the complexity of the cases it was handling was increasing with the increasing complexity of medicine, and that with a growing number of physicians in the labor pool a growing number of marginal practitioners were seeking to move to the periphery where they perceived regulation was sketchier and where "there are strange things done in the midnight sun/by the men who moil for gold."

In 1983 an effort was mounted to restructure board functioning and in return for doubling of licensing fees the legislature and governor's office agreed to provide an executive secretary and full time investigator. Only the fee increase survived the effort with the two positions falling to line item vetoes at the time the fiscal portions of the bill were considered and signed. Both the board and the state medical association got black eyes on that go-around with practitioners perceiving, correctly, that they had been willing to raise the fees necessary to support adequate functioning and had been left with increased fees and at the same time decreased functioning when the budget for the Division of Occupational Licensing (the parent organization) was slashed. The increased fees disappeared into the general fund as an excise tax.

Going into Fiscal Year 1987 the board was functioning with volunteer members, twenty-five to fifty per cent of the services of a single licensing examiner and about seventy-five per cent of the services of a single investigator whose funds wouldn't let him travel even limited distances to investigate serious complaints. Tongue in cheek, the board wondered in its Fiscal Year annual report whether a request for a grant from WHO or UNICEF might be in order.

At this juncture, the start of

Dr. Conley is chairman of the Alaska State Medical Board.

Fiscal Year 1987 in July 1986, with Division of Occupational Licensing support and some outside funding, the board organized in conjunction with the state medical association and the state's malpractice insurance carrier an impaired physicians seminar. This was put on by the executive director of the Oregon Board of Medical Examiners, John Ulwelling. Part of the discussion growing out of the experience was an increased awareness of the administrative and fiscal changes that would have to be effected to get such a program or any board program moving. The board resolved to give it another try and again approach the legislature for basic changes.

Through the fall of 1986 the board approached the Alaska State Medical Association for help and received a commitment to assist in getting legislation introduced. It also advised the state's physicians of its plans and canvassed them for support and input. At about the same time the Division of Occupational Licensing was fortunate to get a new director, Kathy Marshall, who perceived the appropriateness of the board's goals and was to prove effective in lining up division resources in helping to get legislation introduced, amended to meet various problems, and eventually passed.

Initially, the board's goals were limited and similar to those expressed in the failed 1983 legislation. However, after input from Dr. Bryant Galusha and Mr. Dale Breaden of the Federation of State Medical Boards (FSMB), the board decided to expand its horizons and try for legislation based on *A Guide to the Essentials of a Modern Medical Practice Act* prepared by the FSMB.

After the preliminary organizational effort and a fair amount of time lobbying candidates for the legislature and governor's office running in November 1986, the board was ready with suggested legislation late in December 1986. Representatives of the board and the Alaska State Medical Association met with Representative John Sund of Ketchikan and his staff around Christmas time and worked out a draft of legislation. After scrutiny and reworking by the legislative affairs agency this was pre-filed as HB 70 and was on the calendar at the start of the legislative session in January 1987.

Alaska's constitution, like that of a number of other states, prohibits dedicated funding with all revenues being deposited in the general fund. Short of a constitutional amendment which all involved thought politically impossible there was no way to directly tie board funding to specific fee revenue. Therefore, after much debate and amendment, the bill's language was crafted, to direct the Division of Occupational Licensing to make fees reflect services and services fees for all boards under its jurisdiction and issue licenses biennially rather than

quadriennually as in the past so that fees could be adjusted quickly to reflect expenses. This was felt to achieve the desired effect without offending constitutional prohibitions.

The bill also authorized an executive secretary and full-time investigator for the board, directed the board to implement an impaired physicians program, directed the board to report all disciplinary actions to the FSMB's Disciplinary Data Bank, and directed the division to collect a surcharge on a one time basis on all medical licenses to get the program running in the interim between bill passage and the next license expiration date of December 31, 1988. Other sections of the bill expanded the language on required reporting by hospitals and practitioners while at the same time making good faith reporting immune from civil or criminal penalty. To protect peer review functions of hospitals information reported to the board from these areas was held nondiscoverable and immune from subpoena unless and until a final board action was taken in the individual case. The Division of Health and Social Services was directed to take action against the licenses of hospitals that failed to cooperate in the matter of required reporting to the board (it was generally felt that hospitals wished to report but feared civil suit so that granting immunity and imposing sanctions for failure to report would put them in a protected position).

The bill took care of some housekeeping chores, corrected various conflicts between statute and regulations that had crept in over the years especially in regard to FLEX exams, and extended the life of the board under sunset provisions until 1991.

Though time consuming in terms of lobbying and provision of testimony, the bill proceeded through the House of Representatives quite smoothly under Representative Sund's supervision with most of the bugs worked out in the first two committees of reference. The board, the state medical association and the Division of Occupational Licensing all stayed on task wonderfully and maintained excellent communications in the process.

After unanimous passage by the House by mid-session there was some delay in the Senate when the bill was held up as a bargaining chip. The board was amazed — we had never been that important before. Finally on the penultimate day of the session the bill was moved out of the final committee of reference on the Senate side, moved to the floor and passed unanimously late in the evening. It had to travel briefly back to the House due to some minor board supported changes on the Senate floor and received unanimous House concurrence with about six hours to spare before adjournment. In

mid-June 1987 the governor signed the measure.

Using input from member boards around the country the board and division have since written a job description for the executive secretary's position and hope to have the job filled by October 1, 1987. It is anticipated that one of the major responsibilities of the new executive secretary will be implementation of an impaired physician's program.

It was an arduous but most rewarding effort and the board finds itself in a vastly different and improved position as it starts Fiscal Year 1988. Clearly none of it would have been possible without the efforts of the state medical association, concerned legislators, the Division of Occupational Licensing, The Federation of State Medical Boards and Alaska's physicians. The board feels they should all be proud of the outcome.

Alaska State Medical Board
Pouch D
Juneau, Alaska 99811
Dr. Conley
3612 Tongass Avenue
Ketchikan, Alaska 99901

Mail this form and your check or money order to:

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
STATE MEDICAL BOARD
POUCH D-LIC, JUNEAU, ALASKA 99811-0800

APPLICATION FOR RENEWAL OF MEDICAL LICENSE
(Renewal period covered: January 1, 1985-December 31, 1988

[Department use only]
Date: _____
Receipt: _____
Amount: _____
Initial: _____

Your license to practice medicine in the State of Alaska expires on December 31, 1984.

By law, it is illegal for you to practice or offer to practice medicine if your license has expired.

Name: License Number:

Social Security Number: Telephone Number:

Address: (Please make corrections if necessary)

City: State: Zip Code:

Date of Birth: (month / day / year) Height: (inches) Weight: Sex: Hair: Eyes:

General Information:

Specialty: _____

Other states and/or Canadian provinces which you are licensed: _____

Professional Problems:

During the last registration period, have you

	Yes	No		Yes	No
1. Had any mental illness?	☐	☐	4. Had any professional society revocations?	☐	☐
2. Had any felony convictions?	☐	☐	5. Had any final unfavorable liability judgments?	☐	☐
3. Had any hospital restrictions?	☐	☐	6. Have you had any license actions in another state or Canadian province?	☐	☐

If the answer is yes to any of the above, file a written explanation with your renewal application.

I certify under penalty of perjury that the above information furnished is true and correct.

Warning: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

_____
Signature

Date: _____

Required Fees

In accordance with AS 08.64.315 the renewal fees are as follows:

Active Renewal (four year period).....$600.00
Inactive Renewal (four-year period).....$200.00

In accordance with AS 08.01.100. a penalty fee shall be charged if a lic nse remains lapsed more than 60 days. [Penalty Fee $10.00]

Note: If you reside outside Alaska but practice intermittently in the State, you must hold an active Alaska license.

REMINDER - CO.ITINUING EDUCATION

In accordance with 12 AAC 40.200, proof of continuing education will be required at the next renewal.

If you are not familiar with the State Medical Board continuing education requirements, please request a copy of the regulations by writing to the address below:

Department of Commerce and Economic Development
State Medical Board
Pouch D
Juneau, Alaska 99811

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
P.O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2541

PROCEDURE FOR OBTAINING A LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF ALASKA. SEE ALSO ALASKA STATUTES, AS 08.01—03; AS 08.64; REGULATIONS, 12 AAC 40.

GENERAL INSTRUCTIONS:

A. DOCUMENTS: all copies of documents must be certified by a Notary Public to be true **copies of the orginial documents.** Copies no larger than 8½" by 11" are preferred. Your application, supporting credentials and documents will be returned if they are not complete and in proper form. The Medical Board will not review any file for licensure until all documents are on file in this division.

B. CITIZENSHIP: You must be a citizen of the United States or if a noncitizen, you must have **permanent resident status** in the United States. Proof of resident status in the form of an I-151 Immigration card must be shown at the time of your personal interview, if applicable.

C. FOREIGN MEDICAL GRADUATES: Refer to AS 08.64.225, .250, .210 and .200. You must (1) be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or (2) be licensed by **written examination:** (a) FLEX; (b) National Board; or (c) State Board in a state or territory of the United States or a Province of Canada. [Clarification: Foreign medical graduates not licensed in another jurisdiction must document ECFMG certification and pass the FLEX.] In addition, you must have completed a full year in an internship or residency program approved by the Council on Medical Education of the American Medical Association. Residency or internship must be served after graduation from medical school. Please follow the applicable licensing procedure below. Note that all copies of foreign language credentials must be certified by a Notary Public and must be accompanied by certified translations by a recognized translator. A certified true copy of your ECFMG Certificate must be submitted for permanent filing. Once your application is complete it will be reviewed by the Medical Board.

D. INTERVIEW: All applicants must be personally interviewed by at least one member of the Medical Board. A current list of board members is included. Interviews can be arranged by calling during normal working hours for appointments. If applicable, your Immigration I-151 card must be presented at this time. It is wise to arrange appointments well in advance to avoid conflicting schedules between yourself and the board member. If you have previously received a temporary permit or locum tenens permit, your interview for the permit may serve as your interview for permanent licensure at the discretion of the board member and if the interview has occurred within the last year.

E. LICENSURE BY EXAMINATION: The State Medical Board offers the Federation Licensing Examination (FLEX) twice yearly in June and December on dates established by the Federation of State Medical Boards. FLEX is a three-day, two-part examination. A booklet describing the examination is available upon request. **Applications for examination must be complete and on file 120 days in advance of the examination date and must include the following items:**

1. Completed application — including items 1 through 30.
2. Certified true* copy of your medical school diploma.
3. Certified true* copy of your certificate of internship or residency.
4. Verification of the status of your license in all states, territories or provinces in which you hold or have held licenses.

5. Fee: $250.00 — includes a nonrefundable $50.00 application fee and $200.00 examination fee.

6. ECFMG Certificate if applicable.

Once your application has been approved you will receive an admittance card which lists the date, time and location of the examination and your State Identification Number. This card must be surrendered to the monitor at the time of your examination. **The minimum passing grade for each part of the FLEX is a scale score of 75.** Upon successful completion of the exam and oral interview, and review of your application by the board, your permanent certificate will be awarded.

F. LICENSURE BY CREDENTIALS: The State Medical Board may waive their written examination and license you by endorsement if you either (1) hold an **active** license issued **after written examination** in a state or territory of the United States or a Province of Canada, which is equivalent to the FLEX exam, or (2) are a Diplomate of the National Board of Medical Examiners, or the National Board of Examiners for Osteopathic Physicians and Surgeons, or have passed the Federation Licensing Examination with a score of 75 in each component. The following items must be on file:

1. Completed application — including items 1 through 30.

   NOTE: Number 28 **must** be completed. In order for you to be eligible for waiver of our examination we must have evidence that you were examined in clinical and basic sciences. The verification of licensure form is not acceptable in lieu of Number 28. Actual grade report in each category examined must be submitted.

2. Certified true* copy of your medical school diploma.

3. Certified true* copy of your certificate of internship or residency.

4. Verification of the status of your license in all states, territories or provinces in which you hold or have held licenses.

5. A sworn statement listing all hospitals at which you have had privileges in the last five years and original letters, requested by you, but sent directly to the division from all hospitals where you have held privileges in the last five years.

6. Fee: $250.00 — includes a nonrefundable application fee and $200.00 credential fee.

7. Clearances from the Drug Enforcement Administration, the Federation of State Medical Boards and the AMA Physician Profile. These clearances and the AMA Physician Profile are requested by you and then forwarded directly to the division. They can take up to two months to process and as a result it will be to your advantage to request this information well in advance of the date you intend to start practicing. (NOTE: You are required to request the AMA Physician Profile even if you are not a member of the AMA.)

   The board will not review your application until all necessary information has been received, and your license will not be issued until the completed application has been considered at a meeting of the medical board.

   Once your application has been approved and you have been interviewed and recommended for licensure by a member of the board, your license certificate will be awarded.

* To obtain certified true copy, you must take the original documents and the photocopies to a notary public so he/she may compare the original to the photocopies. The notary must state that the photocopies are true and exact copies of the original document and attest to the fact by a written statement, signature and notary seal.

If you are unable to obtain certified true copies, you must submit transcripts from your medical school and a letter from the director verifying your residency or internship.

G. TEMPORARY PERMIT: Any member of the State Medical Board may issue a temporary permit. Temporary permits are issued as a courtesy to allow you to practice medicine pending a full board decision on your application. Board members interview all candidates for temporary licensure and require that a **complete notarized application** be on file with the following supporting documents before a temporary permit may be issued:

1. A certified true copy of your medical school diploma.

2. A certified true copy of your internship or residency certificate.

3. Verification of licensure, requested by you, but sent directly to the division office, from all the states where you hold or have held licenses.

4. A sworn statement listing all hospitals where you have had privileges in the last five years and original letters, requested by you, but sent directly to the division, from the last two hospitals where you have had privileges

5. Evidence of a successful completion of the FLEX examination, National Board, or a written exam leading to licensure in a state or territory of the United States of Province of Canada.

6. All application fees for permanent and temporary licensure.

7. I-151 cards if applicable; ECFMG certificate if applicable.

8. Clearance from the Federation of State Medical Boards. This clearance is requested by you and then forwarded directly to the division.

A member of the board will not grant a temporary permit until all the above documentation is on file with the division.

Your temporary permit is valid for eight months or until the board meets to consider your application for permanent licensure, whichever comes first.

H. LICENSE RENEWAL: Notification for license renewal is mailed out approximately 30 days before the license expiration date.

Failure to receive renewal notice is not considered an excuse for nonrenewal. A license which is not renewed by the due date lapses. In order to reinstate a license which remains lapsed for more than 60 days, a $20.00 penalty fee must be submitted along with the renewal fee. Fees are as follows: $600.00 - active renewal, $200.00 - inactive, out-of-state renewal. **You must reside and practice outside Alaska to be eligible for inactive renewal.** If you practice in-state intermittently you must renew on an active basis. Should you renew on an inactive basis and subsequently come to Alaska to practice, you must activate your license by payment of a $400.00 fee.

I. CONTINUING MEDICAL EDUCATION: Evidence of continuing medical education shall be required as applicable to current state requirements.

NOTE: It is illegal to practice with an inactive or lapsed license or permit. It is your responsibility to keep this office advised of your current address at all times to enable us to send renewal notices to you.

FOR INFORMATION ON PRACTICE OPPORTUNITIES, PLEASE CONTACT:

Alaska State Medical Association
4107 Laurel Street No. 1
Anchorage, Alaska 99504

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STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
P.O. BOX D-LIC
JUNEAU, ALASKA 99811-0800

STATE MEDICAL BOARD

I hereby apply for a license to practice as a ☐ Medical Doctor (M.D.) / ☐ Osteopath (D.O.) in the State of Alaska by: ☐ Examination ☐ Credentials

If applying by credentials, upon what state or provincial license or certificate do you base this application?

_____

Certificate No._____ Issue Date _____

Have you previously held a license, temporary permit or locum tenens permit in the State of Alaska?
☐ Yes ☐ No

This application must be completed in full. If any section does not apply, please write N/A in the space provided. Type or print information.

1. Name in Full _____ Social Security No. _____
2. Other names used, including maiden name _____

   _____
3. Legal Name Changes_____
4. Mailing Address _____ Zip Code _____
5. Residence Address _____ Zip Code _____
6. Place of Birth _____ Date of Birth _____
7. Are you a U.S. Citizen? Yes ☐ No ☐
   If yes, by birth ☐ /by naturalization ☐
   If no, what is your status? _____
8. MEDICAL EDUCATION

Name of School	Location	Month/Year
_____	_____	From _____ To _____
_____	_____	From _____ To _____
_____	_____	From _____ To _____
_____	_____	From _____ To _____
_____	_____	From _____ to _____

   Graduate from _____
   Exact date on diploma _____
9. List all states, territories, and foreign countries in which you hold c. have held medical licenses. Include current status of the license. _____

   _____

FOR OFFICE USE ONLY
Date: _____
Receipt No.:_____
Amount: _____
Initial: _____

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10. What is your specialty? _____
Board Certified? ☐ Yes ☐ No
Date of Certification _____

11. Where did you complete your internship? (Hospital name, location and period of service) _____

_____

12. Where did you complete your residency? (Hospital name, location and period of service) _____

_____

13. Have you ever served as a staff member in any hospital? ☐ Yes ☐ No
If so, give name and address of hospital and period of service. _____

_____

14. To what country, district or state medical societies have you belonged?

Name _____ Address _____
Name _____ Address _____
Name _____ Address _____

15. Have you ever taken the FLEX Examination? ☐ Yes ☐ No Date: _____

16. Have you ever served in the Armed Forces? ☐ Yes ☐ No
If so, date of commission _____ and date of discharge _____

If any of the following answers are yes, explain fully in a signed affidavit.

		YES	NO
17.	Have you ever been disciplined by any state board for any violation of the Medical Practice Act or unethical conduct?	☐	☐
18.	Have you ever been denied a certificate by, or the privilege of taking an examination before any state medical board?	☐	☐
19.	Have you ever had a license to practice medicine revoked, suspended, restricted or limited?	☐	☐
20.	Have you ever been convicted of a violation of a U.S. or state statute or Canadian law, excluding minor traffic violations?	☐	☐
21.	Are you now or have you ever been treated for emotional or mental illness, drug addiction or alcoholism?	☐	☐
22.	Have you ever applied for and been denied a Narcotic Tax Stamp?	☐	☐
23.	Have you ever surrendered your Narcotic Tax Stamp?	☐	☐
24.	Have you ever been convicted of a violation of any federal or state narcotic laws?	☐	☐
25.	Have you ever been disciplined by a hospital staff?	☐	☐
26.	Are you currently, or have you ever been under investigation by any state board or agency for alleged misconduct?	☐	☐
27.	Have you ever had hospital privileges revoked, conditioned, restricted, or had any disciplinary action regarding your privileges?	☐	☐

28. **ENDORSEMENT CERTIFICATION:** If completed by the National Board of Medical Examiners or the Federation of State Medical Boards — delete those portions which you are unable to certify.

I, _____ Secretary of _____
certify that _____ was granted License or Certificate No. _____
effective _____. I further certify that _____
after written examination before this Board obtained a general average of _____ percent (passing grade _____) in the following subjects: (Subjects must be stated in full.)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further certify that the applicant's License or Certificate is current and that there are not now nor have there ever been charges or complaints filed against the holder of said License or Certificate.

BOARD SEAL

_____
Signature

_____
Title

_____
Date

Return completed document to:

Department of Commerce and Economic Development
State Medical Board
P.O. Box D-LIC
Juneau, Alaska 99811-0800

29. Alaska Statute (AS 44.62.310) gives applicants the right to have their applications reviewed in private executive session or in public session.

Please check desired action:

☐ I want my application to be reviewed in closed executive session off the record.

☐ I want my application to be reviewed in open session on the record.

NOTE: If you have no preference or do not check either box, your application will be reviewed in executive session.

30. I HEREBY CERTIFY that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct and that the photograph which appears below is a true likeness of myself taken within the past 60 days. I understand that any false information or falsification of credentials may result in failure to obtain a license to practice medicine and surgery in the State of Alaska.

Photograph

_____
Signature of Applicant

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the state of _____ this _____ day of _____, 19_____.

_____
Notary Public

My Commission Expires: _____

NOTARY SEAL

NOTE: NOTARY PUBLIC SEAL MUST OVERLIE A PORTION OF THE PHOTOGRAPH.

NOTICE

The Alaska State Medical Board requires letters of standing from all hospitals where you hold or have held privileges in the past five years.

1. You must request each hospital to submit a letter regarding the status of your privileges to the addess below:

Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
P.O. Box D-Lic
Juneau, Alaska 99811-0800

2. You must complete the bottom portion of this form and return with your initial application.

HOSPITAL **COMPLETE MAILING ADDRESS**

_____

_____

_____

_____

_____

_____

_____

_____

I certify that listed above are all hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals to submit a letter to the Alaska State Medical Board to complete my application for licensure.

I certify under penalty of perjury that the above information furnished is true and correct.

Warning: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application has committed a Class A misdemeanor.

_____
Signature

Date: _____

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Department of Commerce and Economic Development
State Medical Board
P.O. Box D
Juneau, Alaska 99811

HOSPITAL PRIVILEGES INFORMATION

Mr./Ms.:

I am applying for a license to practice medicine and surgery in the State of Alaska. The State Medical Board requires that this form be completed by each hospital where I have held privileges the last five years. Please complete this form and return it directly to the State Medical Board at the above address.

Name _____ Date of Birth _____

Address _____ SSN# _____

_____

_____

_____

(Below to be completed by hospital staff only)

_____

1. Dates of Hospital Privileges: _____ to _____

2. Has there ever been any disciplinary action against this physician?
   Yes _____ No _____

3. Is there any derogatory information on file?
   Yes _____ No _____

If the answer to any one of these questions is yes, please attach explanation.

Hospital Name and Address:

_____

_____

_____

_____

_____
Signature

_____ Date _____
Title

(Rev. 11/86)

State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
P.O. Box D-Lic
Juneau, Alaska 99811-0800

VERIFICATION OF LICENSURE

Sir:

I am applying for a certificate to practice medicine and surgery in the State of Alaska. The State Medical Board requires that this form be completed by each jurisdiction in which I hold or have held licenses. Please complete the form and return it directly to the Alaska State Medical Board at the above address.

Name _____

Address _____

_____

PLEASE DO NOT DETACH.

The information below must be completed by the state licensing board, not to be completed by the applicant.

State of _____

Name of Licensee _____

Graduate of _____

License No. _____ issued effective _____

By reciprocity/endorsement _____ by examination _____

License is current _____ lapsed _____ expiration date _____

Has the applicant's license ever been suspended or revoked? _____

If so, for what reason? _____

_____

Derogatory information, if any _____

Comments, if any _____

_____

(BOARD SEAL)
(All verifications must have board seal.)

Signed _____

Title _____

State Board _____

Date _____

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TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
2630 West Freeway, Suite 138
Ft. Worth, Texas 76102

Attention: Sherri Watkins
Asst. Quality Assurance Coordinator

Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
P.O. Box D-Lic
Juneau, Alaska 99811-0800

Date: _____

Dear Ms. Watkins:

I am applying for licensure to practice medicine in the State of Alaska. Please indicate on the lower portion of this letter if there is any previous or pending disciplinary action against my license(s) in any state(s) and send this information directly to the Alaska State Medical Board. Thank you for your assistance.

NAME: _____

ADDRESS _____

SSN #: _____

MEDICAL SCHOOL OF GRADUATION: _____

YEAR OF GRADUATION: _____

BIRTHDATE: _____

RESPONSE:

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TO THE APPLICANT

Complete the identifying information and submit to:

Drug Enforcement Administration
220 West Mercer
Seattle, WA 98119

Attention: Phyllis Sherman, Diversion Unit

Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
P.O. Box D-Lic
Juneau, Alaska 99811-0800

Date: _____

Dear Ms. Sherman:

I am applying for licensure to practice medicine in the State of Alaska. Please indicate on the lower portion of this letter if there is any derogatory information on file against me and send this information directly to the Alaska State Medical Board. Thank you for your assistance.

NAME: _____

DATE OF BIRTH: _____

DEA REGISTRATION NUMBER: _____

ADDRESS WHERE DEA NUMBER IS REGISTERED: _____

_____
Signature of Applicant

RESPONSE:

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TO THE APPLICANT:

Complete the following information and submit to:

Data Release Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

— — — — — — — — — — — — — — — —

DATE _____

To Whom it May Concern:

I am applying for licensure to practice medicine in the State of Alaska and am required to request an **AMA Physician Profile** for inclusion in my application file. I have completed all the identifying data below. Please send the **Physician Profile** to the address listed at the bottom of the page. Thank you for your assistance.

PLEASE TYPE OR PRINT

Name: _____

SSN# _____

Medical School of Graduation: _____

Birthdate: _____

— — — — — — — — — — — — — — — —

Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
P.O. Box D-Lic
Juneau, Alaska 99811-0800

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MEDICAL BOARD CONTACTS

Alabama State Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36102-0946
(205) 261-4116

Alaska Board of Medical Examiners
Division of Occupational Licensing
P.O. Box D
Juneau, AK 99811
(907) 465-2541

Arizona State Board of Medical Examiners
1990 W. Camelback Rd., #401
Phoenix, AZ 85015
(602) 255-3751

Arizona Board of Osteopathic Examiners
in Medicine and Surgery
5060 N. 19th Ave., Suite 408
Phoenix, AZ 85015
(602) 255-1747

Arkansas State Medical Board
P.O. Box 102
Harrisburg, AR 72432-0102
(501) 578-2448

California Board of Medical Quality Assurance
1430 Howe Avenue
Sacramento, CA 95825
(916) 920-6393

California Board of Osteopathic Examiners
921 11th Street, #1201
Sacramento, CA 95814
(916) 322-4306

Colorado Board of Medical Examiners
132 State Services Building
1525 Sherman Street
Denver, CO 80203
(303) 866-3988

Connecticut Medical Examining Board
Division of Medical Quality Assurance
150 Washington Street
Hartford, CT 06106
(203) 566-1482

Delaware Board of Medical Practice
O'Neill Building, Third Floor
P.O. Box 1401
Dover, DE 19901
(302) 736-4753

District of Columbia Commission on Licensing
to Practice the Healing Art
Room 202, Lower Level
605 G Street, N.W.
Washington, DC 20001
(202) 727-9794

Florida Board of Medical Examiners
130 N. Monroe Street
Tallahassee, FL 32301
(904) 488-0595

Florida Board of Osteopathic Medical
Examiners
130 N. Monroe Street
Tallahassee, FL 32301
(904) 488-7546

Georgia Composite Board of Medical
Examiners
166 Pryor Street, S.W.
Atlanta, GA 30303
(404) 656-3913

Hawaii Board of Medical Examiners
Department of Commerce & Consumer Affairs
P.O. Box 541
Honolulu, HI 96809
(808) 548-4392

Idaho State Board of Medicine
Room 102-A
650 West State
Boise, ID 83702

Illinois Department of Registration
and Education
320 W. Washington Street
Springfield, IL 62786
(217) 785-0820

Illinois Department of Registration
and Education
100 W. Randolph St., #9-300
Chicago, IL 60601
(312) 917-4500

Indiana Health Professions Service Bureau
964 N. Pennsylvania
Indianapolis, IN 46204
(317) 232-2960

Iowa State Board of Medical Examiners
State Capitol Complex, Executive Hills W.
1209 E. Court Avenue
Des Monies, IA 50319
(515) 281-6493

Kansas State Board of Healing Arts
503 Kansas Avenue, #500
Topeka, KS 66603-3449
(913) 296-7413

Kentucky State Board of Medical Licensing
Mall Office Center
400 Sherburn Lane, #222
Louisville, KY 40207
(502) 896-1516

Louisiana State Board of Medical Examiners
830 Union Street, #100
New Orleans, LA 70112
(504) 524-6763

Maine Board of Registration in Medicine
Eastside Professional Building
RFD #3, Box 461
Waterville, ME 04901
(207) 873-2184

Maryland Board of Medical Examiners
201 W. Preston Street
Baltimore, MD 21201
(301) 225-5900

Massachusetts Board of Registration in Medicine
100 Cambridge, Room 1507
Boston, MA 02202
(617) 727-3086

Michigan Board of Medicine
611 W. Ottawa Street
P.O. Box 30018
Lansing, MI 48909
(517) 373-1655

Michigan Board of Osteopathic Medicine and Surgery
611 W. Ottawa Street
P.O. Box 30018
Lansing, MI 48909
(517) 373-0680

Minnesota Board of Medical Examiners
2700 University Ave., W., #106
St. Paul, MN 55114-1080
(612) 642-0538

Mississippi State Board of Medical Licensure
2688-D Insurance Center Drive
Jackson, MS 39216
(601) 354-6645

Missouri State Board of Registration for the Healing Arts
P.O. Box 4
Jefferson City, MO 65102
(314) 751-2334

Montana Board of Medical Examiners
1424 9th Avenue
Helena, MT 59620-0407
(406) 444-4284

Nebraska State Board of Examiners in Medicine and Surgery
P.O. Box 95007
Lincoln, NE 68509
(402) 471-2115

Nevada State Board of Medical Examiners
1281 Terminal Way, Suite 211
P.O. Box 7238
Reno, NV 89510

New Hampshire Board of Registration in Medicine
Health & Welfare Building
Hazen Drive
Concord, NH 03301
(603) 271-4501

New Jersey State Board of Medical Examiners
28 W. State Street, Room 914
Trenton, NJ 08608
(609) 292-4843

New Mexico State Board of Medical Examiners
Bataan Memorial Building, Third Floor
P.O. Box 1388
Santa Fe, NM 87504-1388
(505) 827-9933

New Mexico Board of Osteopathic Medical Examiners
P.O. Drawer 1388
Santa Fe, NM 87504-1388
(505) 827-7351

New York State Board for Medicine
Cultural Education Center, Room 3029
Empire State Plaza
Albany, NY 12230
(518) 474-3841

North Carolina Board of Medical Examiners
222 N. Person Street, #214
Raleigh, NC 27601
(919) 833-5321

North Dakota State Board of Medical Examiners
City Center Plaza
418 E. Broadway, #C-10
Bismarck, ND 58501
(701) 223-9485

Ohio State Medical Board
65 S. Front Street, #510
Columbus, OH 43266-0315
(614) 466-3938

Oklahoma Board of Medical Examiners
P.O. Box 18256
Oklahoma City, OK 73154
(405) 848-6841

Oklahoma Board of Osteopathic Examiners
4848 N. Lincoln Boulevard
Oklahoma City, OK 73105-3321
(405) 528-8625

Oregon Board of Medical Examiners
1002 Loyalty Building
317 S.W. Alder Street
Portland, OR 97204
(503) 229-5770

Pennsylvania State Board of Medical Education and Licensure
P.O. Box 2649
Harrisburg, PA 17105-2649
(717) 787-2381

Pennsylvania State Board of Osteopathic Medical Examiners
P.O. Box 2649
Harrisburg, PA 17105-2649
(717) 783-1389

Puerto Rico Board of Medical Examiners
Program of Quality Control of Health Services
Box 9342
Santurce, PR 00908
(809) 722-2028

Rhode Island Department of Health
104 Cannon Building
75 Davis Street
Providence, RI 02908
(401) 277-2827

Rhode Island Board of Medical Review
100 India Street
Providence, RI 02903
(401) 277-3855/56/2507

South Carolina State Board of Medical Examiners
1315 Blanding Street
Columbia, SC 29201
(803) 758-3361

South Dakota State Board of Medical and Osteopathic Examiners
608 West Avenue N.
Sioux Falls, SD 57104
(605) 336-1965

Tennessee State Board of Medical Examiners
283 Plus Park Boulevard
Nashville, TN 37219-5407
(615) 367-6200

Tennessee State Board of Osteopathic Examiners
283 Plus Park Boulevard
Nashville, TN 37219-5407
(615) 367-6200

Texas State Board of Medical Examiners
P.O. Box 13562
Capitol Station
Austin, TX 78711
(512) 452-1078

Utah Physicians Licensing Board
Division of Occupational and Professional Licensing
160 East 300 South
P.O. Box 45802
Salt Lake City, UT 84145
(801) 530-6628

Vermont Board of Medical Practice
Licensing and Registration
Redstone Building
26 Terrace Street
Montpelier, VT 05602
(802) 828-2363

Virginia State Board of Medicine
517 West Grace Street
P.O. Box 27708
Richmond, VA 23261
(804) 786-0575

Washington Department of Licensing
Medical Board
P.O. Box 9649
Olympia, WA 98504
(206) 753-3779

STATE MEDICAL BOARD

AS 08.64 — seven (7) members; four year term, serves until new member is appointed and qualified.

George R. Brenneman, M.D. — July 8, 1988
AIL - CDC
225 Eagle Street
Anchorage, Alaska 99501
(work) 271-4011
(home) 272-5384

Bonnie Coghlan (Public Member) — August 13, 1988
741 Eighth Avenue
Fairbanks, Alaska 99701
(work) 452-1165
(home) 456-1609

T. L. Conley, M.D., (Chairperson) — April 21, 1990
Ketchikan Medical Clinic, Inc.
3612 Tongass
Ketchikan, Alaska 99901
(work) 225-5146
(home) 225-4483

Abigale Ryan Hemsley (Public Member) — January 9, 1989
P.O. Box 710
Kotzebue, Alaska 99752
(work & home) 442-3669

Jeffrey A. Partnow, M.D. — November 6, 1988
1919 Lathrop, Drawer 2
Fairbanks, Alaska 99701
(work) 452-4769
(home) 457-4724

George S. Rhyneer, M.D. — April 21, 1988
Suite 552
3340 Providence Drive
Anchorage, Alaska 99508
(work) 561-3211
(home) 694-9600

State Medical Board
Status of Investigative Cases
FY83-FY87
(February 10, 1987)

	FY83	FY84	FY85	FY86	FY87	Total
INVESTIGATIONS:						
Total # of cases	37	40	47	56	26	206
no violation	25	26	38	38	5	132
declined by AG	2			4	2	8
to litigation	4	6	4	10	8	32
cease and desist issued	2	5	2			9
warning letter sent	1	3	3	2		9
Voluntary compliance	2			2		4
appealed	1					1
Total Closed	37	40	47	56	15	195
Current Open Cases					11	11
Totals	37	40	47	56	26	206
LITIGATIONS OPENED:	4	6	4	10	8	32
C & D issued		1	3	1	2	7
cease and desist appealed		1				1
license restricted		1		1		2
license denied	3	2	1		1	7
license suspended					1	1
license revoked		1				1
dismissed - no action	1					1
Cases pending cpmpletion of hearing				8	4	12

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

BILL SHEFFIELD, GOVERNOR

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2534

July 31, 1986

Ms. Kathy Marshall
Division of Occupational
Licensing
Department of Commerce and
Economic Development
P.O. Box D
Juneau, AK 99811

Dear Ms. Marshall:

Enclosed is the Annual Report of the State Medical Board for Fiscal Year 1986. The board has continued to address licensing, regulatory and investigatory problems as they have arisen. It has also, in the last year, embarked on an ambitious program to address the problem of impaired practitioners.

In the last fiscal year, the board issued a slightly increased number of physician licenses and approximately the same number of PA and paramedic licenses as in FY 85. This decline in the rate of expansion (FY 83/FY 84 showed exuberant increases) probably reflects a general downturn in the economy; a decline from 268 to 151 in the numbers of temporary and locum tenens licenses probably reflects the downturn even more convincingly given an understanding of medical economics in times of retrenchment.

The number of medically related investigations opened in FY 86 is about equivalent to FY 85. Statistics in this regard should be final by late July. The seriousness of these cases remains, in general, significant and reflects general trends seen nationwide as an excessive number of physicians glut the market and questionable practitioners move toward the periphery. Fortunately, through employment of national data banks and careful screening of applications, it would appear that most of these cases are being picked up prior to permanent licensure.

Various regulatory projects have been undertaken to further tighten licensure with some improvements. The board has, as planned, completed regulations governing paramedic internships and feels it is gaining

rational control over this confusing area. Regulations covering physician assistants have been completely reworked assuring clearer standards, greater compliance, and increased efficiency in dealing with applications.

The board has spent considerable time considering the problem of the impaired physician in FY 86 and is moving ahead in conjunction with the Alaska State Medical Society to set up a program that will permit a more effective means of dealing with cases in this area. An initial meeting to outline plans is scheduled in conjunction with the board's July 1986 meeting. This is being funded by ASMA and the Medical Indemnity Insurance Company of Alaska. State input will involve a number of regulatory and statutory changes to be outlined later.

Again, as in FY 85, the board was unable to meet its statutory obligations to meet quarterly when funding for a fourth meeting proved unavailable. The board declined to participate in the sham of conducting one of its meetings by teleconference and is on record as declining to do so in the future. As in the past, the board's functions continue to be acutely hampered by the lack of a full-time administrator to conduct board business between meetings, lack of adequate investigatory staff, lack of funding to send a member to the annual meeting of the Federation of State Medical Boards, etc. Perhaps in FY 87, a request for a grant from the United Nations' UNICEF organization for deserving Third World Health Organizations would be in order.

Sincerely,

T. L. Conley, M.D.
Chairman

TLC/dg16018D
073186b

ALASKA STATE MEDICAL BOARD

ANNUAL REPORT

STATE MEDICAL BOARD MEMBERS

George R. Brenneman, M.D. — July 8, 1988
AIL-CDC
225 Eagle Street
Anchorage, Alaska 99501
272-5384 (home)
271-4011 (work)

Bonnie Coghlan (Public Member) — August 13, 1988
741 8th Avenue
Fairbanks, Alaska 99701-4401
456-1609 (home)
452-1165 (work)

Thomas L. Conley, M.D. (Chairman) — April 21, 1990
3612 Tongass Avenue
Ketchikan, Alaska 99901
225-4483 (home)
225-5146 (work)

Abigale Hensley (Public Member) — January 9, 1989
P.O. Box 710
Kotzebue, Alaska 99752
442-3669 (home)

Jeffrey A. Partnow, M.D. — November 6, 1988
SR 3, Box 31473
Fairbanks, Alaska 99701
456-4724 (home)
452-4769 (work)

George S. Rhyneer, M.D. — April 21, 1988
3340 Providence Drive, Suite 552
Anchorage, Alaska 99508
561-3211 (work)

Dolores B. White, M.D. (Secretary) — January 12, 1988
3250 Hospital Drive
Juneau, Alaska 99801
780-4893 (home)
586-9508 (work)

NARRATIVE SUMMARY

The functions of the State Board might be viewed as falling into three broad areas:

1. The issuance after scrutinizing qualifications of licenses to physicians, osteopaths and podiatrists and permits to paramedics and physician assistants.

2. The investigation of infractions of rules and statutes, particularly as they relate to malpractice by any members, new applicants or those already licensed or permitted of the regulated groups. On findings of deficiencies, the board is enjoined and empowered to take corrective action up to and including revocations of licenses and permits.

3. The review of existing regulations and the proposal and adoption of new regulations designed to ensure that quality medical care be readily and efficiently available to the population. The board is also expected to advise the Legislature on necessary changes in statutes to ensure the same end.

All three functions are designed to preserve and protect the public health.

In general, the third responsibility is being met effectively with the board within the last year addressing paramedic internships, physician assistant regulations, putting into place various safeguards in the license process, etc.

In process also is the drafting of a housekeeping bill to correct various inconsistencies in statute that leave the state in a difficult position, vis-a-vis, enforcement and litigation. It would appear that the board can achieve success in these areas because they involve only the board's effort, not financial expenditure.

In the first two areas, the board finds itself rapidly losing ground, basically, due to lack of funding. Prospects are that things are likely to get worse in the next fiscal year. As outlined in previous reports, the board fears that it will be unable to meet with sufficient frequency to discharge the function of reviewing applications and dealing with investigatory matters, which the board views as its two pivotal functions. Lack of funding for the four statutorily required meetings for the last two fiscal years and prospects that this will continue to be the case make the board very uneasy.

Last year, we felt there had been some progress in the area of investigations with the provision of increased investigative staff. This progress has now been vitiated by lack of adequate funding to pursue the investigatory matters brought to the board's and division's attention. The division has been attentive to the board's concerns about priorities in assigning its limited funds to the most alarming cases which pose the greatest proximate danger to the public's safety. However, the efforts fall far short of what is minimally acceptable and the number of cases, not investigated or once investigated, not brought to litigation due to lack of funds is appalling. In addition to being inimical to the public health, the situation increases the tort exposure of the state substantially.

Again, as in years past, the board has had to forego representation at the meetings of the Federation of State Medical Boards. Utilization of the federation's facilities, in terms of standardized national testing, access to their centralized computer banks on investigative and licensure matters, utilization of their information on foreign medical schools and foreign training fraud schemes, has been one of the crucial factors, both locally and nationally, in making licensure more secure. Failure to participate in the activities of that organization, thus, continues to be scandalous.

The board is, at present, embarking on an ambitious program to address the problem of impaired physicians. This problem accounts for the bulk of licensure difficulties and poor medical practice, both in Alaska and nationwide. To its credit, the division has seen the wisdom of the board's desire to divert many of these cases from the usual channels.

At present, the board, when presented with a case of deficient practice based on practitioner impairment, must limit, suspend, or revoke the practitioner's license and usually must embark on prolonged and expensive court battles to accomplish this.

The proposed impaired physician program would short circuit the process by permitting the board to enter into voluntary agreement with the practitioner to place the licensee in a supervised status while the individual undergoes treatment (with the cost of treatment, supervision and random testing borne by the licensee). The savings in terms of litigation expenses alone will justify the program; the savings in terms of careers salvaged through voluntary treatment rather than licensure action is incalculable. Treatment should not be the responsibility of the state, but rather the board would hope to enter into agreements with the Alaska State Medical Association to have that organization arrange treatment. Assurance of compliance would, of course, ultimately remain with the board.

A seminar to get both the board and the State Medical Society up to speed in the area is scheduled to coincide with the board's July 1986 meeting (announcement and schedule attached). The division is providing per diem for board members and investigative staff to attend. The seminar itself is at no cost to the state with ASMA and the Medical Indemnity Corporation of Alaska picking up the tab.

As the program is developed, there will be some implementation expenses involved, in terms of travel to Juneau to educate the Legislature and get its concurrence in terms of necessary enabling legislation. Beyond that, the board should be able to handle the program as a routine function at hopefully little expense (and, as noted, substantial savings in terms of litigation avoided).

In regard to legislation, the board ruefully concludes its activities caused more trouble than solved problems this year. Pursuit of a cease and desist order in the case of an individual practicing medicine without a license -- a seemingly trivial case -- was pivotal in sparking the introduction of lay-midwifery and naturopathy licensure bills that eventually won legislative approval.

The state was sustained in the case in question when the individual involved (a naturopath) brought action in Superior Court, but the question was rendered moot by legislative action. The board can only conclude in retrospect that it should have let sleeping dogs lie. After expenditure of significant monies via the Attorney General's office, the end result seems to have been a pyrrhic judicial victory and licensure of two groups whose activities many thinking people view with considerable apprehension. On the other hand, it may prove the system works if people got what they wanted in terms of licensure -- an imponderable since it is unclear if the push for licensure in these areas constituted a ground swell or the voice of a vocal minority.

On a more optimistic note, the board supported successful legislative action to cancel registration of physicians by the Board of Pharmacy in the prescription of controlled substances and continuation of the Marijuana Therapeutic Research Commission. Both were duplicative, costly, and unnecessary schemes.

Finally, board opinion of the fee project of the Division of Occupational Licensing is quite mixed. One faction on the board espouses the position, outlined in last year's report, that licensing fees should commensurate with board funding and that, if inadequate funding for the board is elected (one should say continued), it should be reflected in decreased licensing fees. Another faction on the board argues against decreasing fees as it seems to put a board imprimatur on the Legislature's and Governor's program to inadequately fund the activity.

It is clear that, should the funds generated by licensure to be available to the board, a creditable program would be easy of achievement. It appears that physicians around the state are, in general, not adverse to the higher fees, provided the monies generated are used to regulate medicine.

They are opposed to the fees if they constitute an excise tax and disappear into the general fund, not to be seen again. It does seem odd that both the Executive and Legislature are willing to settle for an inadequate program when those licensed are willing to pay for an adequate one.

The board wishes to commend the ingenuity and resourcefulness of the division, particularly, that of its retiring director, Nancy Dunn, in succoring the board during hard times. Unfortunately, ingenuity has obvious limits when the core problem is lack of adequate funding and the lack of commitment to the protection of the public that this implies.

Historically, the solution was provided at the time of passage of the 1983 Medical Practice Bill when the board entered into a gentleman's agreement with the Legislature and Executive to raise physician fees to $600 quadrennially with the understanding that the increase in revenue would be used by the state to hire a full-time investigator, an executive director for the board, increase investigative and administrative support, permit the board to participate in the national organization, etc. This, of course, has not occurred due to various appropriation's shortfalls and line item vetoes since then, but more significantly, due to the fact that the board lacks a designated budget because of the administrative structure of the Division of Occupational Licensing.

We have finally come to the conclusion that, given present structure and funding, the State Medical Board is not now and will never be in a position to carry out its statutory function and that, by 1990, medical licensure in the state will become a virtual sham. This is all occurring at a time when the public outcry for vigorous enforcement of licensure statutes and assurance of practitioner competency is reaching a crescendo.

Physicians in this state are willing to pay whatever it costs to assure an adequate program and shift no part of the cost to the consumer.

Therefore, a rational course of action is obviously available to the state -- make the State Medical Board a separate entity financially answerable to the executive and Legislature directly, and mandate zero-based budgeting. We can then set fees at whatever level is necessary to hire adequate staff, pursue investigations vigorously and assure the populace that licensure does constitute, to the extent possible in human affairs, a true guarantee that licensees are indeed being properly supervised.

STATE MEDICAL BOARD
STATISTICAL REPORT FY 86

METHOD: LICENSURE BY CREDENTIALS — AS 08.64.250

NEW LICENSES

CATEGORY	NUMBER OF LICENSES
M.D./D.O./Podiatrists	106
Physician Assistants	21
Paramedics	10

TEMPORARY PERMITS ISSUED IN FY 86
M.D.'s and D.O.'s

Locum Tenens		95
Temporary		42
Residency		12
	TOTAL	151
Physician Assistants		60
Paramedics		1

NUMBER OF ACTIVE LICENSES

M.D.'s	890
D.O.'s	44
Podiatrists	11
Physician Assistant	111
Paramedic	85
	1141

NUMBER OF INACTIVE LICENSES

M.D.'s	302
D.O.'s	3
Podiatrists	5
Physician Assistant	N/A
Paramedic	N/A

LAPSED LICENSES

M.D., D.O., D.P.M.'s	1,019
Physician Assistants	41
Paramedics	18

METHOD: LICENSURE BY EXAMINATION — AS 08.64.210

Applicants for examination:	0
Applicants licensed by FLEX examination	1

4200W8486d

MEETINGS

Date and Location

July 11-12, 1986	Homer, Alaska
November 21-22, 1986	Anchorage, Alaska
March 6-7, 1986	Anchorage, Alaska

Work Sheet of Case Summary per Board

DIVISION OF OCCUPATIONAL LICENSING
INVESTIGATIONS SECTION
SUMMARY

FY: 86

7/1/85 to 6/30/86

	INVESTIGATIONS				LITIGATION			
	Pending-start July 1, 1985	Opened	Closed	Pending-end June 30, 1986	Pending-start July 1, 1985	Opened	Closed	Pending-end June 30, 1986
Public Accountancy	4	8	8	4	2	5	4	3
Barbers & HD	12	13	17	8	0	8	8	0
Chiropractors	3	7	6	4	0	1	1	0
Dental	14	5	15	14	0	3	1	2
Electrical	3	6	7	2	1	3	2	2
AELS	44	88	107	25	0	1	1	0
Medical	21	58	38	41	2	10	3	9
Nursing	26	12	33	5	6	2	1	7
Optometry	2	2	3	1	-	-	-	-
Pharmacy	3	7	5	5	0	2	1	1
Veterinary	2	2	1	3	3	0	2	1
Psychology	6	6	4	8	0	1	1	0
Marine Pilots	16	9	8	7	2	0	2	0
Disp. Opt.	1	0	1	0	-	-	-	-
Physical Therapy	1	1	0	1	-	3	3	-
Nursing Home Adm.	-	-	-	-	-	-	-	-
Morticians	0	3	0	3	-	-	-	-
Construction	2	34	32	4	-	1	1	0
Concert Promoters	1	1	1	1	-	1	0	1
Geologist	-	-	-	-	-	-	-	-
Guides	16	41	10	47	6	35	14	27
Collection Agency	5	28	28	5	0	2	1	1
n.s.	172	341	324	189	22	78	46	54
TOTALS	172	341	324	189	22	78	46	54

SUNSET AUDIT RECOMMENDATION

1. Legislative consideration should be given to regulatory changes concerning the disciplinary process and the composition of the board.

   A. The grounds for imposition of disciplinary sanctions were amended by SLA 83 and are outlined in AS 08.64.326.

   B. In accordance with AS 08.64.336(b), hospitals are now required to report to the Medical Board when hospital privileges are restricted or refused.

   C. The composition of the board remains with five medical doctors and two public members (four male, three female).

REVIEW OF OBJECTIVES - FISCAL YEAR 1986

Our objectives for the last fiscal year and the status of these efforts are as follows:

1. Secure an investigator skilled in investigating medical cases.

   This is unaccomplished with the board continuing to make, do with a 3/4 FTE investigator -- indeed, we have gone backwards in the last twelve months, as funding for investigations has declined and serious allegations brought to the board go uninvestigated, and/or, once investigated, do not go on to litigation due to lack of funds. The state's potential liability for civil suit in this area has reached frightening proportions. The board finds itself in the quite amazing position of having proof of incompetency in a number of cases and being unable to do anything to correct the problem.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems and work with the Attorney General's office to accelerate enforcement time.

   With the decline in funding for investigations, enforcement has concomitantly declined. Efforts directed at diverting some of the impairment cases into channels other than litigation may partially relieve the problem over the next several years, but it is expected that protection of the public will continue to decline for the foreseeable future.

   Cooperation with the Attorney General's office has been more effective and visible in the last twelve months.

3. Continue to review applications of physicians and midlevel providers.

   This we continue to do, but, at a decelerating pace given, lack of funding in the area of investigations and lack of funding for quarterly meetings.

4. Hold four well advertised meetings per year; these shall be face-to-face meetings. Broaden coverage of the Medical Board activities in existing newsletters and circulate to the media. Use public radio and television to advertise meetings at no cost.

Due to lack of funds, only three meetings, face-to-face, were held in FY 86. Given funding cuts, it has been decided to hold all future meetings in Anchorage rather than various locations around the state. This limits public access to the board and is in conflict with the state policy directives, but does save considerably on travel funds. Success in advertising meetings has been limited. We find we have more success with this outside Anchorage and Juneau, but no longer meet elsewhere.

5. Send one member of the board to Federation meetings each year with emphasis on new trends in statutes, regulations and enforcement.

   Again, the board failed to accomplish this when funds proved unavailable.

6. Hold two examinations per year, in June and in December.

   These were offered, but there were no applicants. Considering there are never more than a few applicants and that the exam is available nationally, the state might consider the savings possible in not offering the FLEX exam in-state.

7. The board will continue to review its actions to ensure that no discriminatory decisions are made, including ensuring there will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

   We are doing this and have received no complaints in this regard. Considering this is a goal that is never really "completed," it will be carried over to FY 87.

8. Cooperate with the Boards of Nursing and Pharmacy on solving mutual problems.

   We continue to do this informally, but lack of funding has militated against formal efforts in this area during the last fiscal year.

9. Review, in general, regulations and statutes relating to medicine and ancillary service and rectify inconsistencies and conflicts.

   The board prepared a bill to accomplish this for introduction during the legislative session after being informed by the division that this was the proper course of action. The bill

was not introduced due to the shortness of the session and the board has subsequently learned that prefiling the bill with the Governor's office is the proper procedure. This will be done in the fall of 1986 after revision of the present list to cover some recently appreciated problems in the area of lapsed licenses. This will be addressed with help from the Attorney General's office. The previous list called for repeal of AS 08.64.280; this has been accomplished in other legislation.

10. The board will investigate ways to become involved in offering help to impaired physicians and other licensees and permittees.

    This is discussed in the narrative summary and is a project now being started after much preliminary investigation by the board in FY 86.

11. The board will review physician assistant regulations this fiscal year and achieve definition of what constitutes an acceptable paramedic internship.

    This has been accomplished in FY 86 and is considered a completed goal.

12. The board will, if adequate funding for its activities proves unavoidable, review its functions with a view to eliminating those activities of lower priority. It will give priority to meeting face-to-face four times yearly to review applications and consider the investigative report and the status of prosecutions/litigations.

    It has been discovered that it is precisely those functions that require funding, investigations, quarterly meetings, attendance at annual meetings, adequate administrative support, etc., which are the priority items. Items of lower priority in the areas of regulatory revision, responses to other agencies, etc., generally tend to be low ticket items. Thus, lack of funding militates against accomplishing this goal and indeed precludes the board from carrying out its statutory obligations.

GOALS AND OBJECTIVES - FISCAL YEAR 1987

Goal I - Meet the requirements of the Alaska Medical Statutes, AS 08.64.

A. To enforce statutes and regulations in issues of discipline and quality assurance.

1. To secure the services of a full-time medical investigator in FY 87.

2. To investigate and take action on complaints within three months of the complaint.

3. To work cooperatively with the Attorney General's office in the timely enforcement of disciplinary actions.

B. To review applications of medical practitioners on a timely and impartial basis.

1. To review within three months all completed applications for licensure in the State of Alaska of:

Medical Doctors
Osteopathic Doctors
Podiatrists
Physician Assistants
Paramedics

2. To evaluate, on an ongoing basis, ways to improve the application and licensing process.

C. To have four (4) face-to-face meetings every year.

1. To advertise board meetings well in advance and widely in various media.

4. To inform the public of board activities through a periodic newsletter.

D. To provide FLEX examinations.

1. To hold two FLEX examinations yearly (June and December).

Goal II - Improve the performance of the board and ensure that existing statutes and regulations are relevant.

A. To evaluate the relevance of existing medical practice statutes and regulations.

1. To examine, rewrite, and put into effect policies and regulations that will rectify inconsistencies and conflicts in present regulations and policies.

2. To recommend, when appropriate, statutory changes to the present Alaska Medical Statutes, AS 08.64.

B. To improve the board's knowledge and action in ensuring safe health care for the citizens of the State of Alaska.

1. To send one board member to the annual meeting of the Federation of State Medical Boards.

2. To cooperate with Nursing and Pharmacy Boards to ensure coordinated regulations relating to health care.

3. To develop procedures to identify and rehabilitate impaired practitioners.

4. To prioritize the board's activities and seek adequate funding to meet its statutory responsibilities.

BUDGET RECOMMENDATIONS

1.	Four two-day meetings per year, travel and per diem for board members; each meeting at approximately $5,000 (this is based on Anchorage rates and does not include possible increases of air fares)	$ 20,000
2.	Licensing examiner travel and per diem to attend four two-day meetings approximately	$ 2,000
3.	Air fare and per diem to send one board member to national meeting of Federation of State Medical Boards	$ 2,400
4.	Full-time investigator - salary/support/ travel	$150,000
5.	Attorney (estimate)	$ 75,000
6.	Funds for start-up costs of impaired physician program ("Lobbying" trip to Juneau to explain program to Legislature, etc.)	$ 4,000
7.	Executive Director - salary/support/travel....	$100,000

LEGISLATIVE RECOMMENDATIONS

1. Repeal AS 08.64.370(5) as this is covered under AS 08.64.270 and .272. The two statutes are in conflict.

2. Delete the following in AS 08.02.010(a) ". . . appropriate specialist designation (if any, such as "dermatologist," "radiologist," "audiologist," "naturopath," or the like). The language is unnecessary and has caused trouble in litigation.

3. AS 08.64.313 should be reworded so a physician residing in Alaska could hold an inactive license, however, clarify that he/she could not practice with an inactive license.

4. Delete AS 08.64.210(b) as 40 days is insufficient lead time for ordering exams. Currently, an application deadline of 120 days prior to exam is set by regulation (12 AAC 40 015(b)), so, at present, statute and regulation are in conflict.

5. Delete requirement of oral exam as stated in AS 08.64.220. We do not as a rule require this at present, and it could easily be considered arbitrary and capricious given precedents in case law.

6. Revise AS 08.64.255 to read ". . . all applicants for licensure (under AS 08.64.250) . . . ," grammatical concision.

7. Delete reexamination authority AS 08.64.260(b)(c)(d). AS 08.64.250(a) should remain as is. This matter is covered in various regulatory changes.

8. Revise AS 08.64.311 to read ". . . licenses shall be renewed every four years after the date of (issue) first renewal." Delete word "issue." At first issue, the license granted is valid until the next quadrennial, statewide renewal date.

9. Revise 08.64.336(b) to read ". . . a hospital that places a consultation requirement upon, revokes, suspends, restricts, conditions, or refuses to grant hospital privileges to a person licensed to practice medicine or surgery or osteopathy in this state (because that person poses danger to the public) shall report to the board the name and address of the person and the reasons for restricting, revoking, suspending, conditioning or refusing to grant hospital privileges or for placing upon the practitioner a consultation requirement. This shall occur in all cases whether the action taken was agreed to voluntarily by the practitioner or not.

10. Revise 08.64.336(c) to read "Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and upon (a finding of reasonable cause) a finding that reasonable cause exists to believe the practitioner may constitute a danger to the health and welfare of his/her own patients or the public, may appoint a committee of three qualified physicians to examine the licensee and report their findings to the board."

Add 08.64.336(e) to read "Nothing in this section shall preclude the board from invoking the provisions of 08.64.331(c) if deemed necessary."

Justification: We are finding that hospital administrators and hospital staffs and committees, fearful that the reported physician will initiate civil suit, have tended to adopt a very narrow interpretation of what they are required to report. They argue that either the action taken isn't restriction or a refusal to grant privileges (but rather a conditioning, consultation requirement, suspension or revocation) or that the practitioner involved could be said (usually by liberal interpretation) not to be endangering his/her patients or the public.

To obviate the problem, we propose requiring all actions be reported -- some, such as brief suspension for delinquent medical records, failure to attend staff or committee meetings, etc., we can quickly dismiss. It is more work, but, at least, we can be sure we aren't missing things. The change will remove discretion from the hospital staff, and, thus, insulate them from torts.

Given sovereign immunity (which should clearly apply in this situation), the state does not take on the liability shed by the hospital staff. AS 08.64.336(e) in added to block a potential loophole -- if egregious misconduct is involved, we don't wish to be stopped by a requirement to filter the matter through an appointed committee, etc., with resultant delays if the matter may result in serious harm or death.

11. Add new section 08.64.337. POWER OF BOARD TO COMMAND APPEARANCE. The board shall have the authority to require a licensee or permittee under its jurisdiction to appear before the board to answer questions about his/her licensure status, prohibitive acts, allegations or impairment or incompetence or other matters at the board's discretion. The requirement to appear shall be in writing with assured service. The reason for the appearance shall be stated in writing and shall be a part of the permanent record. Where possible, the decision to require appearance will be voted on by the whole board; between board

meetings, it shall be the responsibility of the chairperson, in consultation with the Assistant Attorney General assigned to this function and with the concurrence in writing of two other board members, to determine that sufficient cause exists to command appearance of a licensee or permittee. Rights to representation by counsel and full resource to judicial remedies is assured.

Failure of a licensee or permittee to appear before the board when commanded to do so shall constitute grounds to impose disciplinary sanctions under 08.64.326(a)(7) and 08.64.331.

Justification: We may use this once in five to ten years, but it should obviously be available if someone decides to thumb his or her nose to the board. Curiously, we have no authority to require anyone to appear at present or so the Attorney General's office informs the board. Obviously, we aren't barbarians and we will, of course, ask first, then try to persuade and only as a final recourse command.

12. Revise 08.64.331(a) -- delete present (7) and replace with new (7), to wit:

AS 08.64.331(a)(7) "impose a fine not to exceed $10,000; or (new 08.64.331(a)(8)) impose one or more of the sanctions set out in (1)-(7) of this subsection."

Justification: The price of oil is down to $10/barrel. This authority could prove very useful in dealing with physicians who use midlevel practitioners in inappropriate ways, etc. There are, of course, perfectly competent but sociopathic physicians just like there are competent but sociopathic gas station attendants and corporate executives -- frequently, the only way to deal with these people is a financial "2 x 4" applied to the head. Anything we generate this way will be applied to "good work."

Impaired Physicians Program

The Impaired Medical Professional: A Program For Alaska?

Featured Speaker:
John Ulwelling

Saturday, July 19, 1986
9:00 a.m. - 3:00 p.m.

Hotel Captain Cook
- Mid Deck

Luncheon

Impaired Medical Professional Seminar

Sponsored by:

Medical Indemnity Corporation of Alaska
Alaska State Medical Association
ASMA Impaired Physicians Committee

The Impaired Medical Professional:

Program for Alaska?

ıpai ed Medical

Profession al Seminar

Guest Speaker:
John Ulwelling

Executive Secretary
Oregon State
Board of Medical
Examiners

Former lobbyist

Oregon State
Medical Association

9:00 a.m.

Introduction.
Jan Xarlella, M.D.

Chairman, ASMA
Impaired Physician:
Committee

9:15 a.m.

The History of Impaired
Physician Programs

The Oregon
State Program

John Ulwelling

Guest Speaker

10:15 a.m.

Coffee

10:30 a.m.

Needs of Malpractice
Insurers

Fred Hood, M.D.

Chairman. Risk
Management
Committee

MICA

10:45 a.m.

Oregon Medical
Association

Monitored Treatment
Program

John Ulwelling

12:15 p.m.

Lunch

1:30 p.m.

Dealing with the
Impaired M.D.

Delores White, M.D.

Alaska Medical Board

1:45 p.m.

Tailoring a Program
for the Needs of
Alaska:

Implementation
Legislation
Remuneration

John Ulwelling

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2534

August 22, 1985

Mr. Harry D. Treager, Director
Division of Occupational Licensing
Department of Commerce and Economic
Development
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager:

Enclosed is the annual report of the State Medical Board for Fiscal Year 1985. I will pass briefly over the achievements of the board, which are significant, in order to focus attention on the board's needs in order to keep up with its job which is the main message of the annual report.

The board issued a slightly smaller number of permanent licenses in all categories for FY'85 than in FY'84, but this is felt to be a small glitch in the curve occassioned by some regulatory changes put into effect late in FY'85 that briefly delayed permanent licenses in some cases. Considering the marked increase in temporary licenses and number of applications "in the hopper" as FY'86 commmences, the steady increase seen in prior years should continue. The number of M.D., D.O. and physician assistant temporary permits and locum tenens permits issued this fiscal year is 268, an increase from Fiscal Year 1984. As this increase settles itself out over the next six months in the form of permanent licenses it will more than offset the decline of 19 permanent licenses from 150 to 131 seen in FY'85.

A total of 51 medically related investigations were opened this fiscal year compared to 43 in FY'84. The seriousness of these cases also continues to escalate with a significant number of them involving alleged felonious conduct. The board has continued to review regulations for physician assistants and paramedics especially with a view to providing paramedic internships in Alaska with significant progress made which we hope to consolidate in FY'86.

The annual report points out the problems of more license applicants and more unqualified practitioners. Board members are being swamped by applicants for temporary licenses which are granted by individual board members. Through regulatory changes the mechanism for

investigating applicants for temporary licenses has improved considerably in this fiscal year with, we feel, a concomitant increase in safety for the public. The price for this, however, has been quite high in terms of markedly increased board and support staff time. The system, especially at the staff level, is near the breaking point.

In last year's annual report, the stress was on the desperate need for a medical investigator. This problem has been partially relieved by the provision of a part-time (approximately 3/4 FTE) position. The board still feels a full-time investigator dedicated exclusively to medical matters would be desirable.

Obversely, a matter on which last year we felt we were doing well, namely meeting regularly to consider licensing, regulations and investigative matters, was this year threatened when inadequate funds were available for our fourth statutorily required meeting of the fiscal year. We did meet briefly by teleconference which proved inadequate and we think potentially dangerous. It is our understanding that the budget for FY '86 may not provide adequate funding for four meetings which will quite seriously hamper our work should it come to pass. Ways to meet this problem are discussed in the report.

In general, the State Medical Board has been asked to, and has been trying to, do more and more work with less and less money. The situation is likely to become critical within the next fiscal year, and the board has been pondering the ageless question of whether it would be better to concentrate on doing a limited number of things well or a large number of things poorly. This, too, will be discussed in the report. One thing we do feel strongly should be done is to send a representative to the annual meeting of the Federation of State Medical Boards, and funding for this will be requested in this report and by separate cover.

With best personal regards,

T.L. Conley
Chairman
State Medical Board

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ALASKA STATE MEDICAL BOARD
ANNUAL REPORT FY '85

INDEX

STATE MEDICAL BOARD MEMBERS

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274-1867 (work)

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Narrative Summary

The functions of the State Medical Board might be viewed as falling into three broad areas:

1. The issuance, after scrutiny of qualifications, of licenses to physicians, osteopaths and podiatrists, permits to paramedics and physician assistants.

2. The investigation of infraction of rules and statutes, particularly as they relate to malpractice, by any member -- new applicants or those already licensed or permitted -- of the regulated groups. On findings of deficiencies, the board is enjoined and empowered to take corrective action up to and including cancellation of licenses and permits.

3. The review of existing regulations and the proposal and adoption of new regulations designed to ensure that quality medical care be readily and efficiently available to the population. All three functions are designed to preserve and protect the public health.

In general, the third responsibility is being met effectively. As of last year, we also felt the first responsibility was being met effectively and in many senses such remains the case even with some improvements in that we are now requiring a computer check on all applicants through a nationwide computer net operated by the Federation of State Medical Boards before issuance of licenses be they permanent or temporary. We are also requiring that all documents and fees be on file in Juneau before granting an interview by an individual board member and issuing a license. Unfortunately, this has quite markedly slowed the process and has given rise to numerous complaints by practitioners. This will abate with time. What will not abate is the marked increase in the board and particularly staff time required to process applications under the new system. Both board and staff are finding that the change is occasioning many more long distance phone calls and letters from applicants trying, generally unsuccessfully, to rush the system. The system is defensible in that it protects public safety and gives us much greater assurance that we will intercept those applicants who have records of license violations in other jurisdictions, but the increased cost to the State, mostly in phone bills and wear, particularly on staff is substantial. It is expected that at some point, probably in this fiscal year, the burden on staff will require staff expansion particularly as applications continue to increase in number (temporary and locum tenens licenses, for instance, increased 63% in the last fiscal year and processing time expenditure per application has doubled since the new regulations were promulgated in May 1985).

Of much more concern than the increased staff and board burden is the fear that we will be unable to meet with sufficient frequency to discharge the function of reviewing applications and dealing with investigatory matters, which we view as our two pivotal functions.

In FY '85, we were forced to forego our fourth statutorily required meeting and instead hold the meeting as a teleconference, with two members in Juneau reviewing applications. This proved highly unsatisfactory and we feel dangerous. The two members reviewing applications soon became numbed by the process and could easily have overlooked problems. They acutely felt the lack of expertise emanating from other board members when questions arose and in a number of cases simply tabled certain applications until the full board could meet. Additionally, after reviewing applications a teleconference was held to try to act on routine matters. This proved a travesty when, as seems usual, the communications system broke down.

In any case, it is the sense of the board that, in the future, we will not substitute teleconferences for regularly scheduled meetings, but use them only to address specific matters. We realize this is in conflict with budgetary directives to hold one meeting a year in this manner. We have yet to decide whether we will simply forego a spring meeting figuring it is better to take no official actions rather than to risk making poor decisions or whether there might be adequate funds to hold three one-day sessions and one two-day session during the year in lieu of four two-day sessions. At the one-day sessions we could only consider licenses and investigatory matters due to time limitations and would have to forego other pending matters, answers to other State agencies, regulatory changes, etc. However, thereby we would be discharging our two primary functions well rather than discharging all our responsibilities poorly.

As to the second responsibility, namely investigation of infractions, there has been improvement since the assignment in the fall of 1984 of a part-time investigator for medical matters. Working out of Anchorage, with help from the Juneau office on Southeast and statewide investigations, the "new" investigator is providing the board with about 3/4 FTE's in investigative work. This is still less than adequate by national standards, which would demand 1 to 1 1/2 FTE's, for a State this size, but it is definitely an improvement. It is also clear that a full-time investigator dedicated only to board matters is considerably more than 25% more effective than a 3/4 FTE investigator for obvious reasons. There has been no abatement, but, rather as expected, an increase in investigatory matters and the seriousness of the cases, many of them involving allegations of felonious conduct, has increased apace. It seems the more we look the more we uncover. For anyone following national medical trends this is not surprising. With more and more physicians being graduated out of proportion to the population growth, they are quickly becoming somewhat of a glut on the market and, thus, income drops. As night follows day the result is migration of physicians to more remote areas, excessive and questionable practice, temptation into fraudulent practices, etc. Alaska, like the rest of the nation, is starting to reap this harvest which is likely to grow more abundant over the coming years. Additionally, Alaska suffers by having a reputation of being wide open and rather lawless. Whether deserved or not, this reputation tends to attract physicians who have failed or gotten into trouble in other jurisdictions.

Aware of the problem we are striving to check it with more success than in the past. We still have much work to do and will in the future need more investigative and legal support in this effort.

The relationship of the Medical Board and the Nursing Board in regard to advanced nurse practitioners has, as predicted in last year's annual report, terminated with the Nursing Board assuming full responsibility for their regulation. Two projects with the Pharmacy Board -- registration of physicians for the prescription and dispensing of controlled substances and the creation of a Marijuana Therapeutic Research Commission -- have gotten off to very shaky starts within the last year. It is the understanding of all concerned that the Legislature will be asked to cancel the latter project in the next session, probably by the Pharmacy Board.

In regard to legislation, several bills seemed important to the Medical Board. We supported and welcomed the passage of CSHB 78 which vested authority for determining fee structures within the Division of Occupational Licensing. It is the sense of the board, as adopted by resolution in our July 1985 meeting, that licensing fees should be commensurate with board funding and that, if inadequate funding for the board is elected, it should be reflected in decreased licensing fees (see attached letter to Charles Steiner, M.D., of April 4, 1985). The board also became involved with the various House and Senate Bills regarding lay-midwifery and participated in the eventual compromise measure. We also continue to work with the Optometry Board on proposed legislation affecting the use of drugs by optometrists and expect to see compromise legislation introduced in the next session permitting the use of diagnostic but not therapeutic medication that will, hopefully, resolve this conflict.

To do the job necessary, the board needs more staff and more funds dedicated to this function. It is noted that revenues presently being generated by licensing fees from those under board authority are adequate to the task but are not being appropriated (see attached letter to Charles Steiner, M.D., April 4, 1985). It is also clear that greater efforts are needed in coordinating local actions with nationwide trends through the Federation of State Medical Boards. Again, in FY '85, we did not have funds to send a member to the Federation's annual meeting, something we regard as critical. We will again request these funds for FY '86.

Finally, we are becoming more involved in dealing with practitioners impaired by substance abuse and hope to flesh out approaches to this problem in the next fiscal year. In this regard, we will need funding for board training, a very complex area, during the coming year.

Sunset Audit Recommendation

1. Legislative consideration should be given to regulatory changes concerning the disciplinary process and the composition of the board.

   A. The grounds for imposition of disciplinary sanctions were amended by SLA 83 and are outlined in AS 08.64.326.

   B. In accordance with AS 08.64.336(b), hospitals are now required to report to the Medical Board when hospital privileges are restricted or refused.

   C. The composition of the board remains with five medical doctors and two public members (five male, two female).

Thomas L. Conley M.D., F.A.A.P.

Specializing in the care of children and young adults

3612 Tongass Avenue
Ketchikan, Alaska 99901
907 225-5134

April 04, 1985

Charles Steiner, M.D.
Secretary Treasurer
Fairbanks Medical Association
1001 Noble Street
Fairbanks, Alaska 99901

Dear Dr. Steiner:

Your letter of February 25, 1985 requesting an explanation of increased medical licensing fees was forwarded to me for answer. Enclosed please find a copy of the annual report of the Alaska State Medical Board for fiscal year 1984, which will help to give answer to your inquiry by giving an overview and fiscal reports.

Basically, at the time of passage of the new Medical Practice Act in 1983, the board and other interested parties lobbied for, and felt they had a gentleman's agreement to implement a quid pro quo with the legislature and the executive whereby in return for increased fees the board would be given the tools in the form of increased investigative staff and an executive director to carry out its assigned function in an effective way. It was argued that the board should pay its own freight in this regard and the increased fees were designed to insure zero-based budgeting in effect.

Since all funds collected by the state go into the general fund by statute there was no way to ensure by statute that the increased fees would indeed go to provision of adequate support for the regulating agency.

Unfortunately the gentleman's agreement has been partially abregated by the legislature and to an even greater extent by the executive. The legislature did authorize an investigator in the first year after the new practice act but not an executive director - the governor's office vetoed funding for the investigator. In the second year after the act we were provided with a part-time (about 3/4 FTE) investigator. Thus the reasonable attempt to use licensing fees to insure the adequate "policing" of medical practice has been thwarted and the extra funds generated are going to other governmental functions via the general fund.

There is of course no question that this is legal - it is - but the fairness of the policy depends on whether or not you accept the proposition that licensing fees are an excise tax. If they are then it is all reasonable; if not and you believe as does the board that a regulated profession should pay sufficient tax to provide for its own regulation in a directed manner, then of course it is not. Perhaps there is some hope for changing this in the form of CHSB78 now pending which would permit the department to regulate its own fees. Theoretically, the department would then set fees commensurate with needed expenditures on a pro rata basis. The funds would still go to the general fund however and there is no guarantee that if the department required X dollars and generated the same amount by fees that the legislature and executive would budget the same amount to the department. If all worked according to the envisioned scenario and there were no increases in regulatory expenses then theoretically medical licensing fees should fall while those for physicians assistants and paramedics would probably go up.

Extrapolating from present fiscal notes the income from licensing would be estimated as:

1400 Active Licenses at $600/4 ($150/year)	$210,000
400 Inactive Licenses at $200/4 ($50/year)	20,000
200 New Licenses at $200	40,000
Est. Income-Podiatrist, Physicians Assistants & Paramedics	1,000
250 Locum Tenens & Temporary Licenses ($50)	12,500
	$283,500

Estimated Income for FY 85

Expenditures by the board for FY 84 were $20,295.09 and allowing for a 15% increase occasioned by increased investigation, more expensive travel, etc. expenditures for FY 85 might come to $23,337. This does not include the board's share of administrative expenses for support within occupational licensing which by generous estimate would be 3 FTE's at $20,000 per position or $120,000. This would total to $143,337 or an excess of $140,163 of income over expenses. This also does not take into account

the many hours of unreimbursed time the board members contribute (they are of course - as is proper - unpaid). The physician members estimate the time contributed results in $15,000 - $20,000 of lost practice per year each, the public members contribution is probably lower but considerable, this is in effect a contribution to the state treasury.

Hopefully this is helpful to you and you will share it with you colleques. Obviously the above indicates that some changes are needed in the way we operate fiscally and any influence you can bring to bear to help effect change would be welcome.

Sincerely,

Thomas L. Conley, M.D.
Chairman
Alaska State Medical Board

TLC:ts

Enclosures

Review Objectives - Fiscal Year 1985

Our objectives for the last fiscal year and the status of these efforts are as follows:

1. Secure an investigator skilled in investigating medical cases.

   This has been partially accomplished with the provision of approximately a 3/4 FTE position. The board still feels a full-time investigator dedicated exclusively to board matters would yield considerably greater service more than offsetting the relatively minimal increase in funding required.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

   Consonant with improvements in #1 above this has improved. It would improve further with a full-time position. More aggressive support from the Attorney General's Office also is in need in this area as reflected by the fact that we have not had contact or advice from that department since February 1985.

3. Continue to review applications of physicians and midlevel providers.

   This we continue to do. It is noted that as of February 1985, subsequent to Nursing Board regulatory changes, we no longer review advance nurse practitioner applications. At present, we are in the process of increasing the efficiency and reducing the confusion of reviewing physician assistant applications and plan to review the whole regulatory scheme in this area in FY '86.

4. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

   In FY '85, meetings were held September 13-14, 1984 in Fairbanks, December 6-7, 1984 in Anchorage, and February 21-22, 1985 in Juneau. A meeting was scheduled for late April 1985 in Anchorage, but it had to be cancelled due to inadequate funding. Two members (T. L. Conley and D. B. White) did meet in Juneau on May 2, 1985 to review applications and then met by teleconference with the rest of the board who gathered in Anchorage at their own expense to pass on the reviewed applications, approve minutes, and hear a brief distillation of that part of the

investigative report that permitted closure of two cases. The teleconference, as seems the norm for at least half the teleconferences the board has held in the last few years, proved a live-born abortion that quickly expired when the telecommunications system broke down. We are still not sure how legal actions taken at this meeting may have been as we were seldom able to hear each other.

As one consequence of the aborted meeting, we were unable to consider the annual report until mid-July and thus were urable to meet the August 1 deadline for its completion.

We have been moderately successful in terms of advertising the meetings. We will strive to continue meeting face-to-face four times a year if funding permits. We will probably elect to forego meeting in geographically different areas to save funds despite directives from the State Ombudsman and meet exclusively in Anchorage as it is cheaper from the standpoint of travel to congregate there.

It is as yet unclear how we will handle matters if funding for the year's fourth meeting again proves unavailable as discussed in the narrative summary.

5. Send two members of the board to the federation meetings each year with emphasis on new trends in statutes, regulations and enforcement.

   Again, we failed in this important goal in FY '85 when funds were unavailable to send even one member to the meeting despite his willingness to pay all but transportation and registration out-of-pocket. The chairman is beginning to become embarrassed to talk to the National Federation of State Medical Boards. He feels like the representative of a banana republic.

   To its credit, the division tried diligently to facilitate this goal but legislative funding failed.

6. Hold two examinations per year, in June and December.

   We continue to do this and held an exam in Anchorage in June 1984 and offered one in Juneau for December 1984 for which no candidates applied.

7. Participate in computer system for the Division of Occupational Licensing.

   We are doing this and consider it a completed goal which will be carried on administratively.

8. Continue working with the division on emergency medical training (Division of Emergency Medical Services/Department of Health and Social Services).

   We are doing this and consider it a completed goal which will be carried on administratively.

9. The board will continue to review its actions to insure that no discriminatory decisions are made including insuring there will be no restriction of licensure on a numerical bas s (i.e., restriction in restraint of trade).

   We are doing this and have received no complaints in this regard. Considering this is a goal that is never really "completed" it will be carried over to FY '86.

10. Continue to hold joint board meetings with the Board of Nursing and Board of Pharmacy.

    In FY '85 we were scheduled initially to hold a joint meeting in Juneau in February but had to cancel it when the Board of Pharmacy had last minute scheduling problems. We did meet informally with the Board of Nursing which was in Juneau simultaneously.

    In the future, we will endeavor to maintain ties to both boards for consideration of problems of mutual concern but contraction of funding probably militates against conjoint meetings.

11. Adopt the new FLEX exam (Federation of State Medical Boards Licensing Exam) as one of two pathways to licensure (the other being the National Board of Medical Examiner's test). Additionally, adopt the necessary regulations and request alterations in statutes to facilitate this.

    This has been accomplished and is considered a completed goal (12 AAC 40.010, 12 AAC 40.015 and 12 AAC 04.020)

12. Review, in general, regulations and statutes relating to medicine and ancillary services and rectify inconsistencies and conflicts.

    This is an ongoing goal. Please see "Legislative Recommendations" for actions recommended in this area.

13. Review regulations relating to temporary permits and tighten up control in this area, both as it applied to locum tenens permits and permits for physicians working for short periods of time in emergency rooms, temporary industrial encampments, and other temporary need situations.

This is mostly accomplished in regulations adopted within the last fiscal year (12 AAC 40.035 and 12 AAC 40.036). Some technical problems have cropped up with 12 AAC 40.035 and it is in the process of being fine tuned.

The changes have resulted in a substantial increase in the staff's workload as discussed in the Narrative Summary.

14. The board will work with the Attorney General's Office to accelerate enforcement time.

This goal seems to be accomplished in fits and spurts and is, of course, partly dependent on the court's over which we have no control. We have been discouraged by the fact that Attorney General's Office representation has been lacking at our May and July meetings (the former probably understandable as it was essentially a nonmeeting). Hopefully, meeting in Anchorage will facilitate matters.

15. The board will investigate ways to become involved in offering help to impaired physicians and other licensees and permittees.

This goal is in process under the direction of Board Member Dolores White, M.D. who is investigating various programs around the country. It is hoped that the board will be able to cooperate in this endeavor with the Friends of Medicine Committee of the Alaska State Medical Association.

The subject is complex and delicate and is an area in which the board requires special training to be effective. It is hoped funding will be available to send a board member to national meetings on the subject with the view to having the member trained in the area instruct the other board members.

Hopefully, we shall have more to say about the goal at the time of the FY '86 annual report.

FISCAL YEAR 1986 GOALS AND OBJECTIVES

1. Secure an investigator skilled in investigating medical cases.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems, and work with the Attorney General's Office to accelerate enforcement time.

3. Continue to review applications of physicians and midlevel providers.

4. Hold four well-advertised meetings per year; these shall be face-to-face meetings. Broaden coverage of the Medical Board activities, in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

5. Send one member of the board to the Federation meetings each year with emphasis on new trends in statutes, regulations, and enforcement.

6. Hold two examinations per year, in June and December.

7. The board will continue to review its actions to insure that no discriminatory decisions are made, including insuring there will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

8. Cooperate with the Boards of Nursing and Pharmacy on solving mutual problems.

9. Review in general regulations and statutes relating to medicine and ancillary services and rectify inconsistencies and conflicts.

10. The board will investigate ways to become involved in offering help to impaired physicians and other licensees and permittees.

11. The board will review physician assistant regulations this fiscal year and achieve definition of what constitutes an acceptable paramedic internship.

12. The board will, if adequate funding for its activities proves unavailable, review its functions with a view to eliminating those activities of lowest priority. It will give primacy of place to meeting face-to-face four times yearly to review applications and consider the investigative report and the status of prosecutions/litigations.

Budget Recommendations

1. Four two-day meetings per year, travel and per diem for board members; each meeting at approximately $4,000 (this is based on Anchorage rates and does not include possible increase of air fares)..... $16,000

2. Licensing examiner travel and per diem for attending four two-day meetings, approximately..... 1,600

3. Air fare and per diem to send one board member to national meeting of Federation of State Medical Boards..... 1,800

4. Full-time investigator..... 75,000

5. Attorney (estimate)..... 75,000

7. Air fare, per diem, and registration to send one board member to a national meeting on dealing with impaired physicians..... 1,800

Legislative Recommendations

1. Repeal AS 08.64.370(5) as this is covered under AS 08.64.270 and .272. The two statutes are in conflict.

2. Delete the following in AS 08.02.010(a) ". . . appropriate specialist designation, [if any, such as "dermatologist", "radiologist", "audiologist", "naturopath", or the like]." The language is unnecessary and has caused trouble in litigation.

3. AS 08.64.313 should be reworded so a physician residing in Alaska could hold an inactive license, however, clarify that they could not practice with an inactive license.

4. Delete AS 08.64.210(b) as 40 days is insufficient lead time for ordering exams. Currently, application deadline of 120 days prior to exam is set by regulation (12 AAC 40.015(b)) so at present statute and regulation are in conflict.

5. Delete requirement of <u>oral</u> exam as stated in AS 08.64.220. We do not as a rule require this at present, and it could easily be considered arbitrary and capricious.

6. Revise AS 08.64.255 to read ". . . all applicants for <u>licensure</u> under AS 08.64.250[. . . ," grammatical concision.

7. Delete reexamination authority AS 08.64.260(b)(c)(d). AS 08.64.260(a) should remain as is. This matter is covered in various regulatory changes.

8. Revise AS 08.64.311 to read ". . . licenses shall be renewed <u>every</u> four years after the date of [issue] first renewal." Delete word "issue." At first issue, the license granted is valid until the next quadrennial, statewide renewal date.

9. Repeal AS 08.64.280 in entirety. This is a statute requiring registration of licenses with local court districts and appears to be a noldover from territorial days when statewide communications were poorer. It serves no discernible purpose given centralized licensing, and informal checking indicates essentially no physicians are aware of or in conformity with the statute. Basically, it's a dead letter and is best removed from the books.

STATISTICAL INFORMATION

Date Completed: July 1, 1985

LICENSE DATA

Method: Check the appropriate method in which licenses are issued (not including examination), and provide specific statutory authority.

Credentials	X	AS 08.64.250
Reciprocity		AS 08.
Comity		AS 08.
Endorsement		AS 08.

Be specific in identifying each category of licensure:

Category:	New Licenses Issued:
1) M.D., D.O., Podiatrist	98
2) Physician Assistants	21
3) Paramedics	12
4) Temporary Licenses	268
5)	
6)	
TOTAL LICENSEES FROM ABOVE:	399

Method: EXAMINATION Statute authority: 08.64.210

Date & Place: December 1984/Juneau - No one applied

Type of Exam:	# PASSED	# FAILED
FLEX		

Date & Place: June 1985/Juneau

Type of Exam:	# PASSED	# FAILED
FLEX	2	0

Date & Place:

Type of Exam:	# PASSED	# FAILED

Date & Place:

Type of Exam:	# PASSED	# FAILED

TOTAL LICENSED BY EXAM: 0

EXPIRATION DATE OF LICENSES: (See below)

If expiration date is different for the various categories, indicate category and date(s) here:

M.D., D.O., Podiatrist - December 31, 1988

Paramedics - June 30, 1985 (in renewal, licenses will expire 6/30/87)

Physician Assistants - June 30, 1985 (in renewal, licenses will expire 6/30/87)

(Total - meaning since issuance of the first license)

	M.D., D.O., Podiatrist	P.A.'s	Paramedics
Total Number of CURRENT licensees:	815	111	78
Total Number of LAPSED licensees:	1,037	20	15
Total Number of INACTIVE licensees:	317	N/A	N/A

Renewal Period: If presently in a renewal period, complete the above and check here. [X]

	P.A.'s	Paramedics
Total of current licensees 'prior' to renewal.	111	78

EXPENDITURES

Board Authorization for FY '85: _____

Based on the Monthly Expenditure Journal dated the month of 6/30/85.

Board Travel/Per Diem (In-State): $ 9,397

Board Travel (Out-of-State): $ .00
Board Per Diem (Out-of-State): $ .00

Licensing Examiner Travel: $ 11,911
Licensing Examiner Per Diem: $ .00

Contractual Services: $ 10,370 (identifiable estimate as of 6/30/85

Revenues: $516,020 (per 5/31/85 printout

MEETINGS: Date(s) and Location(s):

September 13 & 14, 1984 Fairbanks
December 6 & 7, 1984 Anchorage
February 21 & 22, 1985 Juneau

TELECONFERENCES: Date(s) and Location(s):

May 2, 1985 Juneau and Anchorage

HEARINGS: Date(s) and Location(s):

Other:

STATE MEDICAL BOARD

Annual Statistics-Investigations

FY 1985

Cases:

Begin:	15
Opened:	51
Closed:	51
	15 pending

Closures analysis:

Closed, AG declined to prosecute	1
Closed, cease and desist issued	4
Closed, warning letter sent	2
Closed by voluntary compliance	1
Closed, appealed to Superior Court	1
Closed, to litigation	5
Closed, no violation	37
	51

Litigation analysis:

Cease and Desist Order appealed to Superior Court, not completed, carried into FY '86	1
Litigation process carried into FY '86	1
Hearing completed, license restricted	1
Hearing completed, license denied	1
Hearing completed, license revoked	1
	5

Actions based on use or abuse of drugs:

1 license denied (personal illegal use)
1 license revoked (illegal distribution)

Actions based on incompetence:

1 license restricted

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

POUCH D
JUNEAU, ALASKA 99811
PHONE: (907) 465-2534

August 17, 1984

Mr. Harry D. Treager, Director
Division of Occupational Licensing
Department of Commerce & Economic
Development
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager:

Enclosed is the annual report of the State Medical Board for Fiscal Year 1984. I will pass briefly over the achievements of the Board, which are significant in order to focus attention on the Board's needs in order to keep up with its job which is the main message of the annual report.

The Board increased the number of licenses it issued by approximately 23% over the previous fiscal year to 150 new licenses in all categories. The number of MD and DO temporary permits and locum tenens permits issued this fiscal year is 226; a 4% increase from Fiscal Year 1983.

The total of 43 medical related investigations were opened this fiscal year compared to 30 in Fiscal Year 1983. The seriousness of the cases referred for investigation have also increased. The board has continued to review regulations for Physicians Assistants and Paramedics to provide the possibility of paramedic internships in Alaska and make the licensing of these mid-level practitioners more responsive to the public needs.

The annual report points out the problems of more license applicants and more unqualified practitioners. Board members are being swamped by applicants for temporary licenses which are granted by individual board members. The mechanism for investigating applicants for temporary licenses is completely inadequate. Increased staff support is needed to aid in this phase of licensing.

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The annual report repeats the Board's continual plea for a medical investigator. Although the investigative process has improved in the past year, the present personnel is swamped and there is a need for more legal help in addition to the investigator. Unfortunately, the Governor again vetoed funds for the investigator, but the problem of increased numbers of bad practitioners will not go away through that easy remedy.

In fact, the State Medical Board has been trying to do more and more work with less and less money. In this fiscal year, funds were cut to send a representative to the annual meeting of the Federation of State Licensing Boards where important matters, such as setting up an interstate system to catch license offenders are discussed. We are asking that, in this fiscal year, Alaska once again participate.

With kindest regards,

Hubert J. Gellert
Chairman
State Medical Board

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Enclosures

IDENTIFICATION OF BOARD MEMBERS

Jeffrey A. Patnow, M.D.
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452-4769 (work)

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ALASKA STATE MEDICAL BOARD
ANNUAL REPORT

INDEX

Narrative Summary

The functions of the State Medical Board might be viewed as falling in three broad areas:

1) The issuance, after scrutiny of qualifications, of licenses to physicians, osteopaths and podiatrists, permits to paramedics and physician assistants, and approval of collaborative relationships between physicians and advanced nurse practitioners (licensing, per se, for nurses being the function of the Nursing Board).

2) The investigation of the infraction of rules and statutes, particularly as they relate to malpractice, by any member -- new applicants or those already licensed or permitted -- of the regulated groups. On findings of deficiencies, the board is enjoined and empowered to take corrective action up to and including cancellation of licenses and permits.

3) The review of existing regulations and the proposal and adoption of new regulations designed to ensure that quality medical care be readily and efficiently available to the population. All three functions are designed to preserve and protect the public health.

In general, the first and third responsibilities are being met effectively. Unfortunately, while there have been improvements in the areas of investigation into infractions and enforcement of rules and statutes in the last fiscal year, we are far from feeling comfortable with the effort and find it to be several decades behind efforts in other states. Unfortunately, this comes at a time when the problem is increasing exponentially.

The board has continued, as in years past, to review new applications for licenses and permits, make alterations and emendations to existing ones, especially where collaborative relationships exist, and put in place new tools for judging competence. We will soon be issuing licenses on a four-year cycle, requiring certification of continuing medical education and putting in place regulations covering a new national licensing exam for physicians. We have spent time in this fiscal year preparing for these developments. We have also spent time getting data on regulated individuals entered into the state's computer banks for rapid recall.

Over the last fiscal year, the board has, after extensive hearings, promulgated new regulations in regard to physician assistants serving in areas of temporary, often seasonal, need (resource extraction camps such as oil fields, timber operations, fishing camps, etc.) to make access to medical care more efficient. The board is also in the process of defining what constitutes adequate training, especially internship, for paramedics -- a group that should see considerable growth in Alaska over the next several years. We have also done

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preliminary work on the growing need to regulate temporay physicians who are not functioning to replace local physicians but are working for short periods in expanding emergency rooms, temporary resource extraction camps, etc. It is an area of growing concern, for, while the numbers are increasing, the quality in some cases may be declining -- i.e., we are concerned that we may be attracting "medical gypsies."

The relationship between the Medical Board and the Nursing Board may be in the process of change in regard to advanced nurse practitioners. Heretofore, a collaborative relationship between a specific nurse practitioner and a specific physician was required. The Nursing Board has adopted regulations -- not yet promulgated -- that will eliminate the relationship in a formal sense and license advanced nurse pratitioners independeltly, albeit with a requirement for a plan of consultation on file. The Medical Board has also been assisting the Pharmacy Board in planning enforcement of regulations covering State registration for the dispensing of controlled substances (with modifications the Medical Board concurs) and the creation of a Marijuana Therapeutic Research Commission (the Medical Board found this irrelevant and a waste of State funds).

In regard to legislation, three bills seemed important to the Medical Board: One, HB 347, sought to create a Board of Naturopathy, an idea the Medical Board found ludicrous. Various bills and modifications of bills were introduced to permit use of drugs by optometrists. We worked hard and long with the optometry professional groups and representatives of the Board of Optometry on these proposals and came out in favor of permitting diagnostic but not therapeutic use of medications. We also tried, hopefully, with some success to act as mediators and facilitators in this area between medical practitioners and optometrists. (We feel, as always, that our role is to serve the public good, not to act as spokepersons for organized medicine).

In all this, we feel we have been mostly successful or at least have improved things. However, as noted above, in the area of investigations, we feel things are rapidly getting out of hand.

In the past several years, the Medical Board has come of age and shed its naivete in regard to malpractice. Part of the romance of the frontier was the idea that you could look an applicant for licensure in the eye, shake his hand, and be sure that if he measured up by that standard, he was a "good guy." If it was ever so, it is no longer.

Just as "the end of the road" syndrome is bringing mass murderers to Manley Hot Springs, so it is bringing charlatans and quacks to Alaska in increasing numbers. There seems to be an idea that if you can't make it elsewhere, you can come to Alaska, where things are still "primitive" and get a license. Sadly, that assessment is true. If we don't take the steps necessary to tighten things up, the next physician you see in an emergency situation may be one of these.

Over the last year, the number and quality of investigations initiated in our Anchorage and Juneau offices have improved markedly. As they have improved, we have sadly had to conclude that we are just scratching the surface. This year, funds for an investigator dedicated to Medical Board cases was approved by the Legislature. However, the money to hire the medical investigator was vetoed by th Governor for the second successive year. To judge by what other states are doing, and uncovering in the process, we probably need two investigators to serve the board, plus extra help from the Attorney General's office to pursue prosecutions.

To do the job necessary, the board needs more staff and more funds dedicated to this function. It will also need to coordinate its efforts with similar nationwide efforts carried on by the Federation of State Medical Boards. In the immediately preceding fiscal year, we had funds to send a member to the federation's annual meeting. Such funding was not available this fiscal year. It needs to be reinstituted. A great deal of our effort in the coming year will be dedicated to fulfilling the goal of better enforcement.

Sunset Audit Recommendation

1. Legislative consideration should be given to regulatory changes concerning the disciplinary process and the composition of the board.

   A. The grounds for imposition of disciplinary sanctions were amended by SLA 83 and are outlined in AS 08.64.326.

   B. In accordance with AS 08.64.336(b), hospitals are now required to report to the Medical Board when hospital privileges are restricted or refused.

   C. The composition of the board remains with five medical doctors, and two public members (six male, one female).

Review Objectives - Fiscal Year 1984

Our objectives for the last fiscal year and the status of these efforts are as follows:

1. Secure an investigator skilled in investigating medical cases.

   The Legislature this year providec funds for an investigator dedicated, to the greatest extent, to the needs of the board (he or she will also serve some functions for other health related boards). Despite etensive lobbying by the Board,

the money for this position was vetoed. However, the hiring of an investigator specializing in Pharmacy Board matters should, over time, help the investigators working on medical matters. The board would like input into the hiring of an investigator which seems reasonable in that it has, of all bodies, the most at stake and the greatest knowledge of what skills are required.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

   We are happy to report that investigations initiated in the Anchorage and Juneau offices this year are more vigorous and effective than was heretofore the case. We would like to warmly praise all involved in this. Continuation and expansion of this effort will depend on implementation of goal #1 and the hiring of an appropriate investigator.

3. Continue to review applications of physicians and mid-level providers and attempt to make the process more efficient by providing more information in Anchorage where many applicants come.

   This is being done.

4. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

   We have managed, barely, to meet our statutory obligation of meeting four times yearly. Inevitably, every year, we have to go as mendicants to the Division of Occupational Licensing to get funding for the fourth meeting. The division, to its credit, has always found the money some place. Apparently, the division has funds for four meeings this year.

   As we are strapped for funds, we have foregone the request of the State's ombudsman that we meet in geographically scattered sites. We meet in Juneau in February. All other meetings in the last two years have been in Anchorage though we will meet in Fairbanks in September 1984 because of specific hearing requirements. Our attempts to get coverage of meetings have been somewhat successful.

5. Send two members of the board to the federation meeting each year with emphasis on new trends in statutes, regulations and enforcement.

   It is vital that the state Medical Board send representatives to participate it the Federation's creation of a system for tracking practitioners who have had licensing problems.

6. Hold two examinations per year - in June and December.

   We are doing this.

7. Participate in the computer system of the Division of Occupational Licensing.

   We are doing this.

8. Continue working with the division on emergency medical training (Division of Emergency Medical Services/Department of Health and Social Services). We continue to do this and are presently working with the Department of Health & Social Services on adoption of regulations covering paramedics.

9. The board will cotninue to review its actions to insure that no discriminatory decisions are made including insuring there will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

   This is being done.

10. Continue to hold joint board meetings with the Board of Nursing and Board of Pharmacy.

    We continue to do this yearly in February in Juneau.

FISCAL YEAR GOALS & OBJECTIVES

Interim _____ Fiscal Year 1985

Final _____ Date _____

1. Secure an investigator skilled in investigating medical cases.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

3. Continue to review applications of physicians and mid-level providers.

4. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetins at no cost.

5. Send two members of the board to the federation meetings each year with emphasis on new trends in statutes, regulations, and enforcement.

6. Hold two examinations per year, in June and December.

7. Participate in computer system for the Division of Occupational Licensing.

8. Continue working with the division on emergency medical training. (Division of Emergency Medical Services/Dept. Health and Social Services).

9. The board will continue to review its actions to insure that no discriminatory decisions are made including insuring the e will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

10. Continue to hold joint board meetings with the Board of Nursing and Board of Pharmacy.

11. Adopt the new FLEX exam (Federation of State Medical Boards Licensing Exam) as one of two pathways to licensure (the other being the National Board of Medical Examiner's test). Additionally, adopt the necessary regulations and request alterations in statutes to facilitate this.

As we come of age as a board, we need a full-time medical administrator to ensure that the board continues to function between quarterly meetings. This is a full-time job and requires a full-time dedicated administrator to see that the work gets done.

An administrator would serve numerous functions in ensuring continuity of investigations, continuity in the area of establishing appropriate regulatory surveillance, etc. The board members serve to set up policy and bring to bear medical expertise. They are unpaid and simply don't have the time to see to the nuts and bolts of ensuring compliance. If this function is to be effective at a State level, we need someone monitoring it fulltime. It seems somehow silly to have to argue for something that makes simple common sense especially when one considers that other state boards and commissions, whose impact on the common welfare is considerably less significant, have had executive directors for years.

Also, the unpaid load on board members of issuing temporary permits is growing severe at the number of applicants increases. An Executive Director could help in this area.

15. <u>As a corollary to #14. An expanded budget is a necessity</u>.

As things now stand, we can barely meet statutory obligations concerning holding quarterly meetings. In addition to securing funds to ensure this will occur without fail, we need funding for an investigator, funding for an executive director, funds for the travel of two board members to national meetings of the federation of state Medical Boards, etc. We anticipate that as investigations develop, there will be increased need for funds to pursue these.

16. <u>The board will work with the Attorney General's office to accelerate enforcement time</u>.

At present, there are frequent, long delays between opening of investigations and eventual resolution. This often permits questionable practice to continue long after a problem is identified. The services of an executive director would be very helpful in this area, and there appears to be a need for more attorney time.

17. <u>The board will investigate ways to become more involved in offering help to impaired physicians and other licensees and permittees</u>.

As things now stand, our relationship to impaired physicians tends to be an adversary one with the impaired individual viewing the board as a threat to financial security through license

actions. The Board, of course, needs to be retained with the power to suspend and revoke when the public is in danger. However, we need to consider ways of entering into voluntary agreements to achieve correction of problems (alcohol and drug abuse, psychiatric problems, etc.) in a more amicable way. It is to be remembered the goal of the board is to protect the public, not to punish offenders.

Budget Recommendations

1. 4 two-day meetings per year, travel & per diem for board members; each meeting at approximately $3,000 (this is based on Anchorage/Juneau rates and does not include possible increase of air fares)..... $12,000

2. Licensing examiner travel and per diem for attending 4 two-day meetings, approximately 1,200

3. Air fare and per diem to send two board members to national meeting 2,500

4. Investigator 75,000

5. Executive Director (estimate) 75,000

6. Attorney (estimate) 50,000

Legislative Recommendations

1. Repeal AS 08.64.370(a)(5) as this is covered under AS 08.64.270 and .272.

2. Provide for condition of renewal or reapplication for licenses which remain lapsed for a long period of time. Example: a license which has remained lapsed for over three years is no longer eligible for renewal. New application must be submitted for consideration.

3. Revise fee structure of AS 08.64.313 to require $50 application fee and $50 bienniel renewal fee for both paramedics and physician assistants.

4. Delete the following in AS 08.02.010(a)..appropriate designation [if any such as, dermatologist, radiologist, audiologist, naturopath or the like].

5. AS 08.64.313, reword so a physician residing in Alaska could hold an inactive license, however, clarify that they could not practice with an inactive license.

6. Revise the examination fee to $ 240.00 to cover increase in charges by the federation. Reexamination fee $240.00 .

7. Delete AS 08.64.210(b) as 40 days is insufficient lead time for ordering exams. Currently, application deadline of 120 days prior to exam is set by regulation.

8. Delete requirement of oral exam as stated in AS 08.64.220.

9. Revise AS 08.64.255 to read ...all applicants for licensure [a license under AS 08.64.250]...

10. Delete reexamination authority AS 08.64.260(b)(c)(d). AS 08.64.260(a) should remain as is.

11. Review AS 08.64.311 to read...licenses shall be renewed every four years after the date of [issue] first renewal.

12. Changes to be submitted regarding temporary licenses and permits.

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STATISTICAL INFORMATION

Date Completed: June 30, 1984

GENERAL INFORMATION

Board members are from the following locations (cities); and approximate airfare to ANCHORAGE:

City:	Fare	City	Fare
1) Fairbanks	$ 212	5) Anchorage	$ 0
2) Fairbanks	$ 212	6) Anchorage	$ 0
3) Ketchikan	$ 452	7) Anchorage	$ 0
4) Juneau	$ 352	8) Lic. Ex./Juneau	$ 352

EXPIRATION DATE OF LICENSES: 12/31/84 (Doctors) 6/30/85 (Parmed. & PA)

LICENSE DATA

Method: (credentials;reciprocity;comity;endorsement) Credentials

Type(s):	New Licenses Issued:
1) Physician, Surgeon	
2) Osteopath	117
3) Podiatrist	2
4) Physician Assistant	17
5) Paramedic	14
6)	

Method: EXAMINATION Number of licensees by Exam: _____

Date & Place: December 1983 Juneau Alaska

Type of Exam:	# PASSED	# FAILED
FLEX	1	3

Date & Place: June 1984 Anchorage Alaska

Type of Exam:	# PASSED	# FAILED
FLEX	(1 applicant for Alaska, 1 applicant proctored for Lousiana--results have not been received)	
Date & Place:		
Type of Exam:	# PASSED	# FAILED
Date & Place:		
Type of Exam:	# PASSED	# FAILED

(Total - meaning since the issuance of the first license)

Total Number of CURRENT licensees: 1,393
Total Number of LAPSED licensees: 858
Total Number of INACTIVE licensees: 366

If presently in a renewal period, complete the above and check here [ ].

Total of current licensees 'prior' to renewal: N/A

EXPENDITURES

Board Authorization for FY 84: 11,100

Board Travel (In-State): $4,912.50
Board Per Diem (In-State): 6,221.36
Board Travel (Out-of-State): n/a
Board Per Diem (Out-of-State): n/a

Licensing Examiner Travel: 1,106.00
Licensing Examiner Per Diem: 1,056.35

CONTRACTUAL SERVICES: 7,096.88

REVENUES: 50,159.50

MEETINGS: Date(s) and Location(s):

October 7 & *, 1983 Anchorage
December 8 & 9, 1983 Anchorage
February 23 & 24, 1984 Juneau
June 27 & 28, 1984 Anchorage

TELECONFERENCES: Date(s) and Location(s):

August 15, 1983

June 20, 1984

HEARINGS: Date(s) and Location(s):

Other: INVESTIGATIONS

Opened: 36

Closed: 27

Litigation Opened : 7
(includes Cease & Desist Orders)

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

POUCH D
JUNEAU, ALASKA 99811
PHONE: (907) 465-2534

August 12, 1983

Mr. Harry D. Treager, Director
Division of Occupational
Licensing
Department of Commerce &
Economic Development
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager:

Enclosed herein is the Annual Report of the State Medical Board for FY '83. Among the highlights of our activities for the past fiscal year are the passage of the new Medical Practice Act, the continued development of regulations for physician assistants, and the handling of an increased number of unqualified applicants. The new Medical Practice Act redefines the practice of medicine and incompetence, vital enforcement tools, along with providing an investigator assigned to the Medical Board. These key provisions will help the Medical Board keep up with the rapid increase of medical practitioners at all levels that Alaska is experiencing, with the accompanying increase in complaints about medical competence.

Over the last few years, Alaska has seen a tremendous increase in the use of physician assistants, mid-level practitioners working with doctors in the cities and in remote locations. Many PAs are providing medical care at installations in the North Slope oilfields as well as at other remote sites. A considerable amount of the Medical Board's time has been spent revising the regulations for physician assistants with increased experience. The board also has exercised its new responsibilities in the licensing of Advanced Nurse Practitioners and Emergency Medical Technicians.

Probably, as a result of Alaska's increased attractiveness relative to the Lower 48, the Medical Baord has had to deal with an increased number of unqualified applicants for medical licenses. Some of these cases have involved investigative time to uncover undisclosed license actions or convictions in other states. Others have required board hearings and consultant advice.

The foregoing are some of the highlights of the State Medical Board's activities for the prior year. Much of the Board's time is spent in licensing applicants for the various types of licenses~~, both in meetings~~ and in overseeing investigative efforts. One of our primary goals for this year is to improve the latter function.

We look forward to the continued support of the Executive Branch and the Legislature.

With kindest regards,

Hubert J. Gellert

Hubert J. Gellert
Chairman

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Enclosure

STATE MEDICAL BOARD

Annual Report

As in years past, the goal of the State Medical Board continues to be the insurance of excellence in the provision of medical services for all Alaskans. The board attempts to fulfill this goal in three major ways:

1. Prompt and nonrestrictive licensing and authorization of physicians, osteopathic physicians, physician assistants, advanced nurse practitioners and paramedics who meet the standards set out in statute and regulation. Thanks to excellent cooperation between the Division of Occupational Licensing and the board, expeditious handling of many licenses, authorizations, temporary permits, and locum tenens permits was achieved and resulted in the placement of additional practitioners in all areas of the State.

2. Ongoing enforcement of statute and regulation in dealing with practitioners who are already licensed or authorized. The board has noted a considerable increase in the number of applicants who, upon investigation, prove to have convictions or questionable backgrounds in practice in other states. Through experience, the board has become more adept at ferreting out these problems in assessing applications. Pivotal to doing an even better job in the future will be provision of adequate investigatory staff. Fortunately, the Medical Practice Act, which passed the Legislature this session (at this writing still unsigned by the Governor, so is still somewhat uncertain), provides the board with a dedicated investigator. The board is optimistic that such support will make its actions in this area more certain and efficient. Just as important will be the effect such investigatory support is expected to have on inquiring into cases of questionable practice by already licensed or authorized health care providers. For the past two years, with some laudable exceptions, this effort has languished for lack of support on the investigatory level. The board expects this aspect of its function to improve markedly with the provision of adequate investigatory staff and the present years of serious harm to the health of the community at the hands of poor practitioners to be significantly allayed.

3. Improvement in statute and regulation. The board has spent considerable time and effort working for the passage of a Medical Practice Act over the last several years. With this session of the Legislature, such was provided. Though less than the board would have liked, the Act goes a long way toward solving ambiguities in the statutory definitions of what constitutes medical practice and how it should be intelligently regulated. The board pushed strongly for an executive secretary position to help the board streamline its functions and bring them into compliance with recognized national standards. Such was not to

be; still, the board was gratified that its other major request of the Legislature, provision of medical investigatory staff, has met with approval. The board will be back in the future requesting approval of an executive secretary position to help provide the excellence of service it feels serves the public interest.

In addition to statutory concerns, the board has been working to provide qualified medical personnel to the far-flung bush population and natural resource extraction sites. We expect that continuing revision of these newer parts of medical practice will be needed. The board has spent a great deal of time reviewing and revising regulations, especially in those areas regarding physician assistants. The board has also continued to work closely with the Division of Emergency Medical Services and has renewed the Memorandum of Agreement between the two agencies for the purpose of better evaluation of paramedic applicants.

Believing that we face many issues in common, the State Medical Board has continued to work closely with the Board of Nursing and the State Pharmacy Board, and this year held a second (hopefully, annual) joint Medical-Nursing-Pharmacy Board meeting in Juneau during the legislative session. The cross-fertilization these meetings offer to all of us has been impressive, and we hope to continue the practice in the future.

Again this year, the board sent one member to the national meeting of the Federation of State Medical Boards, the only Outside travel for board members. The liaison with other State boards of medical licensure has proved most helpful in dealing with common problems such as evaluation of foreign medical schools and technicalities of examination administration.

STATISTICAL OVERVIEW

1. Expenditures

Travel and Per Diem	$ 14,735.24
Contractual	5,423.07

2. Receipts

Licensing fees receipted	103,584.00
Amount allotted for Travel & Per Diem	17,000.00

3. Licenses Issued

Physician initial license	91.00
Physician Assistants initial license	17.00
Paramedic initial license	13.00
Licenses Renewed - all categories	1,139.00
Physician's temporary permits	87.00
Locum Tenens, Physician	130.00
Physician Assistant Locum Tenens & Temporary	18.00

4. Examinations

FLEX Examination, December 1982
4 Candidates - Pass: 2 Fail: 2

FLEX Examination, June 1983
1 Candidate - (results not received at this time)

5. Board Meetings & Locations

a. September 9 & 10, 1982, Nome, Alaska
b. November 18 & 19, 1982, Anchorage, Alaska
c. February 25 & 26, 1983, Juneau, Alaska
d. June 3 & 4, 1983, Anchorage, Alaska

6. Investigations

Anchorage Office Figures:	19 Pending End of FY '82
	17 Opened FY '83
	26 Closed FY '83
	10 Currently Open (End FY '82)
Juneau Office Figures:	13 Opened
	12 Closed
	7 Pending

REVIEW OF FISCAL YEAR GOALS AND OBJECTIVES

Interim ____
Final X

Fiscal Year 1983
Date 6/83

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1. Secure passage of a new Medical Practice Act redefining the practice of medicine and generally updating the present outmoded statute.

   Board has continued frequent contact with the Legislature testifying on various bills regarding continuance of the State Medical Board.

2. Secure an additional investigator and executive secretary skilled in investigating medical cases.

   See above.

3. Through staff, investigate the possibility of obtaining lower-level investigative help from the legal program of the University of Alaska.

   Dropped as a goal upon advisement of the department.

4. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

   This goal is linked with the need for the investigative position. Current investigations are unsatisfactory--this will continue to be a goal of utmost importance.

5. Continue to review applications of physicians and mid-level providers and attempt to make the process more efficient by providing more information in Anchorage where many applicants come.

   Have maintained current statutes and application packets in the Anchorage Field Office. Review of applications is ongoing at each meeting. Temporary permits and locum tenens are issued as needed after personal interview by an individual board member.

6. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

   Continue as a goal: four meetings were held in FY '83. All public notices are now 2"x3" with a black border. The board has written a press release after each meeting, however, the department has not taken steps for the release to be published. Will continue to strive for media coverage.

7. Clarify regulations for physicians' assistants. Obtain input from other states.

   Drafts in process, board has continued work in this area.

8. Send two members of board to the federation meetings per year with emphasis on new trends in statutes, regulations, and enforcement.

   Secretary of the board attended the April 1983 Federation meeting. Continues to be a valuable resource in relationship to other state boards' activity and problem areas; as well as National Examinations and Medical School standards.

9. Hold two examinations per year, in June and December.

   Ongoing; two examinations were held in FY '83.

10. Participate in the computer system for the Division of Occupational Licensing.

    Would like to see the division enter names of licensees who have had licenses revoked or disciplinary action taken in another state; this would be a valuable tool when considering an applicant for a temporary permit or locum tenens.

11. Continue working with the division on emergency medical training.

    Draft proposals have been reviewed and discussed during the past fiscal year--board will continue to work with the Department of Health & Social Services on training requirements.

12. The board will continue to review its actions to insure that no discriminatory decisions are made, including insuring there will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

    Ongoing goal.

13. Continue to hold joint board meetings with the Board of Pharmacy and Board of Nursing.

    Accomplished in February of 1983--will strive to continue this goal each year.

FISCAL YEAR GOALS & OBJECTIVES

Interim _____ Fiscal Year 1984

FINAL _____ Date _____

1. Secure an additional investigator and executive secretary skilled in investigating medical cases.

2. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

3. Continue to review applications of physicians and mid-level providers and attempt to make the process more efficient by providing more information in Anchorage where many applicants come.

4. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

5. Clarify regulations for physicians' assistants. Obtain input from other states.

6. Send two members of the board to the federation meetings each year with emphasis on new trends in statutes, regulations, and enforcement.

7. Hold two examinations per year, in June and December.

8. Participate in computer system for the Division of Occupational Licensing.

9 Continue working with the Division of Occupational Licensing.

10. Continue to review its actions to insure that no discriminatory decisions are made, including insuring there wil be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

11. Continue to hold joint board meetings with the Board of Nursing and Board of Pharmacy.

FISCAL YEAR 1985 BUDGET REQUEST

BOARD TRAVEL AND PER DIEM REQUEST

Budget for four Board meetings, travel and per diem, in the following locations:

Kodiak	$5,318.00
Anchorage	3,272.00
Juneau	3,584.00
Fairbanks	4,280.00
	$16,454.00

Air fare and per diem for two members to attend out-of-state convention: (location unknown)

Air Fare	$1,500.00
Per Diem (4 days)	640.00
	$2,140.00

Air fare and per diem for two members to attend legislative hearings in Juneau (if required).

Air Fare - Fairbanks/Juneau	$402.00
Anchorage/Juneau	336.00
Per Diem (4 days)	640.00
	$1,378.00

Travel and Per Diem for Investigative Position (travel for investigations and four Board meetings--taken from Fiscal Note)

Travel & Per Diem	$7,240

TOTAL REQUESTED: $27,212.00

*Based on air fares as of 7/83.

LEGISLATIVE RECOMMENDATIONS

Board discussed the possibility of changing the statute with regards to FLEX re-examination (requiring passage at one sitting versus retaking portions) as well as possible changes to the statute dealing with laetrile. These changes will be reviewed and discussed for future changes.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

POUCH D
JUNEAU, ALASKA 99811
PHONE: (907) 465-2534

September 6, 1982

Mr. Harry D. Treager, Director
Division of Occupational Licensing
Department of Commerce and
Economic Development
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager:

In compliance with AS 37 and AS 08 and on behalf of the State Medical Board, I am submitting the enclosed Annual Report concerning the board's activities and accomplishments for Fiscal Year 1982.

Should there be any questions concerning this report, please feel free to contact me. Thank you.

Sincerely,

Donald R. Rooney, M.D., Secretary
Alaska State Medical Board

DRR/wfs 5/9

Enclosure

FY '83 Goals and Objectives

GOAL

The goal of the Medical Board's efforts remains as providing the best medical services for all Alaskans.

OBJECTIVES

1. Secure passage of a new Medical Practice Act redefining the practice of medicine and generally updating the present outmoded statute.

2. Secure an additional investigator and executive secretary skilled in investigating medical cases.

3. Through staff, investigate the possibility of obtaining lower-level investigative help from the legal program of the University of Alaska.

4. Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the board is hearing of problems.

5. Continue to review applications of physician mid-level providers and attempt to make the process more efficient by providing more information in Anchorage where many applicants come.

6. Hold four meetings per year, well-advertised and spread around the State. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and television to advertise meetings at no cost.

7. Clarify regulations for physician assistants. Obtain input from other states.

8. Send two members of staff to the federation meetings per year with emphasis on new trends in statutes, regulations, and enforcement.

9. Hold two examinations per year, in June and December.

10. Participate in the computer system for the Division of Occupational Licensing.

11. Continue working with the division on emergency medical training.

12. The board will continue to review its actions to insure that no discriminatory decisions are made including insuring there will be no restriction of licensure on a numerical basis (i.e., restriction in restraint of trade).

13. Continue to hold joint board meetings with the Board of Pharmacy and Board of Nursing.

REVIEW OF PRIOR YEAR OBJECTIVES

1- Pursue proposed statute amendments

The board members actively worked to support the new Medical Practice Act (SB 237) which would have redefined the practice of medicine, a major need for better enforcement. Also, in the proposed bill as originally drafted was a provision for an executive officer and investigator.

The Medical Board has consistently supported medical back-up for lay midwives and so testified in hearings on proposed legislation in the past session.

2- Become more actively involved in the investigative process

Members of the board have become involved in investigating alleged infractions of statutes and regulations at the earliest time. The following is actions taken by the board during the year.

a. Started the year with 38 complaint matters pending, all categories, 7/1/81

b. Opened 24 new complaint matters, all categories

c. Closed 41 as no violation or jurisdiction

d. 21 remained pending investigation as of 6/30/82

One new litigation filed, applicant denied license. Hearing not completed this year, continued to later date. (Ongley)

One hearing scheduled this year, accusation against M.D., unable to complete, continued to later date. (Brown)

Appeal filed by Dr. Peter Rosi protesting the board action against him handled this year, final disposition by court still pending 6/30/82.

Appeal filed by Dr. Henry Storrs protesting revocation order by the board handled this year. In the Superior Court the board order was upheld. A decision is still pending from the Supreme Court.

3- Register all Physician Assistants and EMT's currently practicing in the State

This has been done, as well as reviewing all Advanced Nurse Practitioners' collaborative relationships with physicians.

4- Close out all investigative cases now pending

The number of pending cases has been reduced probably because of lack of investigators in the field and pruning old cases. However, serious cases remain and the board has been informed about the need to strengthen enforcement of the regulations governing mid-level practitioners.

5- Hold four meetings in Kodiak, Fairbanks, Anchorage, and Juneau

The board was able to accomplish this objective this year. The board has repeatedly expressed its dissatisfaction to the staff over the poor advertising of its meetings compared to other boards and has been given the puzzling argument that it would cost too much to run similar ads. Public participation at meetings has been poor.

6- Send one member to the Federation of State Medical Boards' meeting

Dr. Donald Rooney, Secretary of the Board, attended the meeting and has given a full report to the board and staff regarding such matters as licensing Foreign Medical Graduates, some of which will be incorporated in suggested statute and regulation changes.

7- Hold two examinations

Both of the exams cancelled due to no applicants.

8- Initiate a joint meeting with representatives from other health care boards to discuss matters of mutual interest and concern.

Two such meetings were held, first the chairpersons of all the licensing boards met in Anchorage on December 11-12, 1981, followed by a joint membership meeting of the Board of Pharmacy and Board of Nursing held in Juneau on February 25, 1982. Follow-up on issues of mutual concern will be done in the next fiscal year.

STATISTICAL OVERVIEW

Licenses Issued	FY '80	FY '81	FY '82
Osteopath	1	0	4
Physicians	81	74	103
Podiatrists	5	4	2
Physician Assistants	33	31	22
Paramedics	-	47	7
Permits Issued			
Locum tenens	39	71	78
Physician Assistants	-	15	18
Temporary	66	61	76
Licenses Renewed			
Medical	-	862	45
Physician Assistants	-	42	13
Paramedic	-	5	28

Two FLEX examinations were scheduled for FY '82 and were cancelled due to no applicants.

TRAVEL

Expenditures	FY '80	FY '81	FY '82
Outside Transportation (Investigation)	$ -	$ 484.47	$
In-State transportation (Examiner)	1,516.57	697.71	860.00
In-State per diem (Examiner)	1,073.30	553.75	665.80
In-State transportation (Board)	3,330.65	2,479.36	6,478.33
In-State per diem (Board)	2,914.00	1,599.00	4,953.27
Out-of-State travel	-	-	12,266.88
Subtotal - Travel	8,834.52	5,814.29	14,223.68
Postage & Mailing		26.88	Ø
Long Distance telephone	2,133.28	3,342.48	817.75
Messenger Service	92.00	37.00	Ø
Photo Processing	643.25	917.75	Ø
Printing & Binding	115.00	298.00	615.62
Advertising	474.73	882.03	694.51
Professional Services	247.50	255.00	38.30
Membership Dues/Fees	500.00	500.00	770.00
Subtotal	4,205.76	6,259.14	2,936.18
TOTAL EXPENDITURES	$13,404.28	$12,073.43	$17,039.86

INCOME

License & Permit fees	$ 9,070.00	$33,325.00	$28,619.00

FY '83 Budget Recommendations

In addition to the previous budget submitted, the following additional funds were requested:

Executive Secretary	$ 60,000.00
Investigator	45,000.00
Extra publicity coverage	3,000.00
Travel for second person to National	2,000.00
TOTAL	$110,000.00

NARRATIVE STATEMENT

The goal of the State Medical Board has been, and will continue to be, the provision of the best medical services for all Alaskans. We attempt to fulfill this goal in three major activities:

1. Prompt and nonrestrictive licensing and authorization of physicians, physicians assistants, advanced nurse practitioners, and paramedics who meet the standards set out in statute and regulation. With excellent teamwork and cooperation between the Division of Occupational Licensing and the board, expeditious handling of many licenses, authorizations, temporary permits, and locum tenens permits was achieved and resulted in the placement of additional practitioners in all areas of the State.

2. Ongoing enforcement of statute and regulation in dealing with practitioners who are already licensed or authorized. Despite rather serious limitations and investigative resources (see below), the board has maintained ongoing investigations and held several hearings. One physician's license to practice has been revoked, and that revocation has been upheld in Superior Court, though appeal to Supreme Court is currently pending. This is believed to be the first such action ever taken in the State of Alaska. The ongoing investigative and case development efforts of the board have been frustrated by the illness and ultimate retirement of the key investigator who worked with the board. The board feels that important cases have languished and that the failure to have investigators in the field has significantly lessened input to the board concerning poor medical practice. The board feels medical investigations require a certain medical expertise and a definite amount of training and tact. Accordingly, the board has sponsored (unsuccessful) legislation designed to obtain an investigator within the division who would be primarily charged with Medical Board matters. We feel that the State of Alaska has devoted insufficient resources to this area when compared with other states, and we feel the potentially serious harm which can be brought by poor practitioners demands that this area receive a higher priority than it has thus far.

3. Improvement in statute and regulation. The board has spent a great deal of time and energy in formulating revisions of the Alaska Medical Practice Act. The goal of these revisions relates to redefining the practice of medicine and eliminating or clarifying ambiguous sections of the current statute. Additionally, the proposed statute (SB 237) would strengthen the board's investigative staff as above, and add an executive director to provide continuity between board meetings, insure that delegated tasks are performed, and serve as a central repository for medical licensing information. Additionally, the initial version of the bill promoted legislation dealing

with the delivering of babies by individuals without formal medical training (lay midwifery). The board feels that this is an important area of the public interest, and we have yet to see the Legislature or any other agency come to grips with it.

The large body of regulations dealing with physicians assistants has been formalized and provisions have been adopted for the purpose of allowing temporary and locum tenens status for qualified physician assistants. Additionally, the board has worked closely with the Division of Emergency Medical Services and has established a Memorandum of Agreement between the two agencies for the purpose of better evaluation of paramedic applicants.

Believing that we have many issues in common, the State Medical Board has worked quite closely with the Board of Nursing. Further, we suggested and accomplished a joint meeting between the Pharmacy Board, Board of Nursing, and State Medical Board in February 1982 in Juneau. With the passage of new drug legislation, it is anticipated that the areas of cooperation and understanding which have been established between the three boards will be especially important in the future.

Finally, the board has been successful in obtaining funds for a board member to attend a national meeting of the National Federation of Medical Examiners. We were pleased to discover that our efforts in Alaska correspond rather well with efforts in the Lower 48, and that we are dealing with many of the same problems.

Efforts in the upcoming fiscal year will include continuation of the activities noted above, especially in the legislative arena. It is our hope to obtain the investigative staff necessary to expand board surveillance into the area of mid-level providers (advance nurse practitioners, physician assistants). We also hope to adopt a strategy which will lead to increased public participation and input into board matters.

The Licensing Examiner I for the State Medical Board during this period was Mrs. Evelyn Boone.

The Licensing Examiner II (Supervisor) for the Division of Occupational Licensing from July 1, 1981 through June 30, 1982 was Mrs. Jane English.

The Director for the Division of Occupational Licensing during this period was Mr. Harry Treager.

DRAFT

NARRATIVE STATEMENT

FROM JUNE 24,5 MEETING

The goal of the State Medical Board has been and will continue to be the provision of the best medical services for all Alaskans.The main activity of the Board during Fiscal Year 1981-82 in pusuit of this goal has been the licensing of physicians,Physician Assistants,Advanced Nurse Practioners,and ~~Paramedics~~ who meet standards set out in statutes and regulations.With excellent teamwork between staff and Board,expeditious handling of many licenses, authorizations,temporary licenses and locum tenens permits was achieved to place additional practioners in all areas of the State.

Another principal activity has been insuring that standards in the statute and regulations governing medical practice have been followed.Although the backlog of cases has not increased this fiscal year,the investigative effort has been in severe difficulty.The puny effort by the State Government has been further hampered by the illness and retirement of the Medical Board's key investigator and the failure of the government to provide a replacement. Important cases have languished. And it is the belief of the Board and the staff that the failure to have investigators in the field has significantly lessened input about bad practice. The Board has emphasized the poor enforcement effort put on by the State of Alaska in the medical field compared to other states and will continue to do so.

The State Medical Board put major effort into ~~refining~~ improving statutes and regulations. Much time was spent contacting legislators to support SB237,the Medical Practice Act and in redrafting sections of the bill. This bill would do much to further enforcemnt by redefining the practice of medicine,as well as eliminating other unclear sections of the existing antiquated statute. The proposed statute also would strengthen the Board's investigative staff and add an Executive Director as other boards have done. The bill did not pass,but the Board considers it of such vital importance that it plans to spend more time this year in securing its passage.

The Revising the new regulations for Physicians Assistants occupied considerable Board effort.The initial stage of "working in" the regulations is now complete,and the Board expects only changes for general clarification in the new year.

position paper

DRAFT REVIEW OF FISCAL YEAR GOALS AND OBJECTIVES

1-Pursue proposed statute amendments

The Board was not successful in having passed the new Medical Practice Act(SB237) which would have redefined the practice of medicine,a major need for better enforcement. Also in the proposed bill as originally drafted was provision for and executive officer and investigator.

A system for reviewing EMT's in conjunction with the Department of Health and Social Services was developed and is in action.

The Medical Board has consistently supported medical back-up for lay midwives and so testified in hearings on proposed legislation in the past session.

2-Become more actively involved in the investigative process

Members of the Board have become involved in investigating alleged infractions of statutes and regulations at the earliest time.

3-Register all Physicians Assistants and EMT's currently practicing in the state.

This,has been done,as well as reviewing all Advanced Nurse Practitioners' collaborative relationships with physicians.

4-Close out all investigative cases now pending

The number of pending cases has been reduced probably because of lack of investigators in the field and pruning old cases. However, serious cases remain and the Board has been informed about the need to strengthen enforcement of the regulations governing mid-level practitioners.

5-Hold four meetings in Bethel(1),Anchorage(2),Juneau(1).

The Board was able to hold ~~only~~ four ~~three~~ meetings this year ~~because of lack of funds~~. The Board has repeatedly expressed its dissatisfaction to the staff over the poor advertising of its meetings compared to other boards and has been given the puzzling argument that it would cost too much to run similar ads. Public participation at meetings has been poor.

6-Send one member to the Federation of State Medical Boards' meeting

Dr. Donald Rooney,Secretary of the Board,attended the meeting and has given a full report to the Board and staff regarding such matters as licensing Foreign Medical Graduates some of which will be incorporated in suggested statute and regulation changes.

DRAFT REVIEW(2)

7-Hold two examinations

Done

8-Initiate a joint meeting with representatives from other health care boards to discuss matters of mutual interest and concern.

Two such meetings were held.First,the Chairmen of the Boards met in Anchorage,followed by a joint membership meeting in Juneau in February. Follow up on issues of mutual concern will be done.

DRAFT-NEW GOALS AND OBJECTIVES

GOAL

The goal of the Medical Board's efforts remains as providing the best medical services for all Alaskans.

OBJECTIVES

1-Secure passage of a new Medical Practice Act redefining the practice of medicine and generally up-dating the present outmoded statute.

2-Secure an additional investigator skilled in investigating medical cases.

3-Through staff, investigate the possibility of ~~securing~~ obtaining lower-level investigative help ~~through~~ from the legal program of the University of Alaska.

4-Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the Board is hearing of problems.

DRAFT-NEW OBJECTIVES(2)

5-Continue to review applications of physicians and mid-level providers and attempt to make the process more efficient by providing more information in Anchorage where many applicants come.

*Field Office does not have services.

Fairbanks

6-Hold four meetings per year -well advertised and spread around the state. Broaden coverage of Medical Board activities in existing newsletter and circulate to media. Use public radio and televison to advertise meetings at no cost.

7-Clarify regulations for Physicians Assistants.Obtain input from other states.

8-Send one member to meeting per year with emphasis on new trends in statutes, regulations,and ~~investigation~~ enforcement.

DRAFT-NEW OBJECTIVES(3)

9-Hold two examinations per year, in June and December.

10- Participate in Design of Computer Syst.

11- EDIS alliance

12. Avoid any activities NOT UNFAIRLY limiting entry into the profession

13. To

DRAFT-NEW GOALS AND OBJECTIVES

GOAL

The goal of the Medical Board's efforts remains as providing the best medical services for all Alaskans.

OBJECTIVES

1-Secure passage of a new Medical Practice Act redefining the practice of medicine and gene ally up-dating the present outmoded statute.

2-Secure an additional investigator skilled in investigating medical cases.

3-Through staff, investigate the possibility of ~~xxxxxxx~~ obtaining lower-level investigative help ~~xxxxxx~~ from the legal program of the University of Alaska.

4-Place emphasis on vigorous enforcement of medical statutes and regulations, especially in areas where the Board is hearing of problems.

(7)

HOUSE COMMITTEE REPORT

Date referred: 1/23/87

FURTHER REFERRALS: Judiciary
Finance

DATE: 2/17/87

The Labor and Commerce Committee has considered HB 70

"An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence."

RECOMMENDS:

[ ] replace with CSHB ~~70~~ ~~68~~ (L+C)
[ ] attached amendment(s)

[ ] the same title
[ ] a new title

[ ] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[✓] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis

[ ] same as previous fiscal note published _____
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

Alfred Kopman
Dave Donley
Cliff Davidson
Cindy Mennenga
R.C. Bunker

SIGNING OTHER RECOMMENDATIONS:

W. Furnace C.K. Constitutionality

AS 08.01.065 (c) NEEDS CONSTITUTIONAL CLARIFICATION (DEDICATED FUNDS)

Dave Donley
Chairman's signature

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version : HB 70
Publish Date : 1/23/87

REQUEST:

Revision Date:

Agency Affected :

Title : An Act relating to the State Medical Board and amending Rule 504(d) of the AK Rules of Evidence.

BRU : Occupational Licensing

Sponsor : Represenative Sund

Components : Administration

Requestor :

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	1.4	1.4	1.4	1.4	1.4
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	1.4	1.4	1.4	1.4	1.4
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	1.4	0.0	0.0	0.0	0.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	1.4	1.4	1.4	1.4
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

(See Attached)

Prepared by : Jennifer Strickler, Management Analyst
Phone : 465-2144
Division : Occupational Licensing
Date : 2/12/87

Approved by Commissioner : J. Anthony Smith
Date : 2/13/87
Agency : Commerce & Economic Development

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

Funding for the State Medical Board is currently budgeted in the department's operating budget and, therefore, new funds are not required for the remainder of FY 87.

Section 9 of the bill grants the board authority to order a licensee to submit to a medical or psychiatric examination by an appointee of the board. The bill also states that the examination shall be made at the board's expense. Information obtained by a representative of the board has indicated that the board anticipates the need for two to four examinations per year. At approximately $350.00 for two medical exams ($175.00 each) and $1,000.00 for two psychiatric exams (an average of $500.00 per exam), it is estimated that the board will be responsible for $1,400.00 in examination costs. Since the department has the authority to establish fees to cover the costs of the function with concurrence of the respective board, general funds will be needed in FY 88 while allowing the department the opportunity to adjust licensing fees to cover the costs by program receipts beginning in FY 89.