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70

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version: HB 70
Publish Date: 1/23/87

REQUEST: _____

Revision Date: _____
Title: An Act relating to the State

Medical Board and amending Rule 504(d) of the AK Rules of Evidence.

Agency Affected: _____
BRU: Occupational Licensing

Sponsor: Representative 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
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REVENUE	0.0	0.0	0.0	0.0	0.0	0.0
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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
Division: Occupational Licensing

Phone: 465-2144
Date: 2/10/87

Approved by Commissioner: J. Anthony Smith
Agency: Commerce & Economic Development

Date: 2/13/87

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.

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:

amendment #1

Amendment 2

amendment #2 on next page

Amend 2

(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.

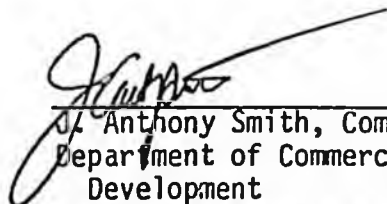
*Section 7: authorizes the board to summarily suspend a license if the board has reason to believe that the licensee poses a danger to the health or welfare of the public or the licensee's patients.

*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.


Anthony Smith, Commissioner
Department of Commerce & Economic
Development

Date: 2/13/87

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

ACTION KIT

JANUARY 1987

ANTITRUST IMMUNITY
FOR HOSPITALS AND
PHYSICIAN PEER
REVIEWERS

HOSPITAL LAW
CHAPTER: AIDS

[Handwritten signature]
FEB 3 1987

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

CC: Towell
HAA Exec Committee

R. JOHN HORTY 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 credentialing 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 profes-

sional 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.

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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-

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Liabile 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 hospital. 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

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-

dar 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 issued for malpractice. ■

How To Take Advantage Of The Act

Since the Quality Improvement Act so fundamentally changes the rules with respect to credentialing 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 anti-trust 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 credentialing 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 credentialing 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 credentialing 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 credentialing 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 credentialing 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.

• Credentialing 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 credentialing cases. The

Due Process Hearings —

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 can-

not 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 credentialing 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

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 quali-

ty. 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

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 credentialing and quality management provisions of any hospi-

tal 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-ER for hospital law is written by members of the firm of Harty, Springer & Matern, PC.

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ALASKA STATE MEDICAL BOARD

Department of Commerce & Economic Development
Division of Occupation Licensing
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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 is 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 Association 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 statutory 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.

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November 3, 1986
Page Three

Practitioners should also 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.

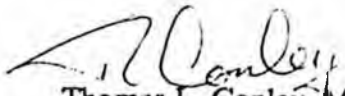
The program envisioned would be biphasic with ASMA running the treatment phase and accepting both voluntary referrals and mandatory referrals of physicians under board supervision. The mandatory referrals would be offered to impaired physicians in lieu of prolonged, disputations and expensive licensing 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,


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

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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 instrumentality 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 statutes, 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 naivete 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 corollary 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 adverse 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 integral 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 08.64.326(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 08.64.335 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."

CITIZENS COALITION FOR TORT REFORM

VOICES RAISED IN UNIFORM

PRIORITY

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

Feb 2, 1987

Representative Sund,

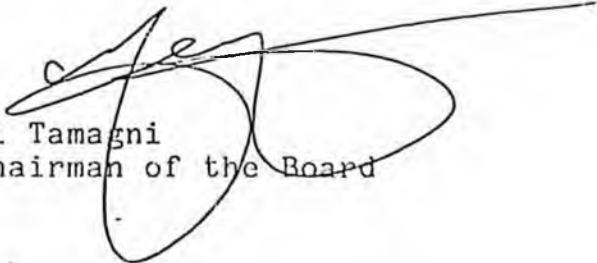
On behalf of the Coalition for Tort Reform I would like to advise you of our very strong support of HB70, An Act relating to the State Medical Board; and amending Rule 540(d) of the Alaska Rules of Evidence. We respectfully request your assistance in moving this important legislation through the system 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

JOHN SUND, REPRESENTATIVE

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January 30, 1987

MEMORANDUM

TO: Representative Dave Donley

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."

.....
I would appreciate it if you would schedule HB70 at your earliest convenience.

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.

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.