

CSHB

70

SENATE COMMITTEE REPORT

FURTHER:

5/7/87

DATE TURNED INTO OFFICE

5/16/87

Mr. President:

FINANCE

Committee considered CSHB 70(Fin)am

State Medical Board and to services provided for boards established under AS 08; amending Rule 504(d) of the Alaska Rules of Evidence; efd.

and recommended:

[ ] replace with CS FOR ) [x] same title
[x] or adopt CS FOR CS HB 70 (Jud) ) [ ] new title

[x] attached amendment(s)

[x] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to

[ ] letter of intent adopted

Committee [x] attached or [ ] adopted fiscal note(s)

[ ] new [ ] updated or [x] previous
[ ] zero [x] fiscal impact

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

Handwritten signatures of committee members: Robert A. ... Paul ... Rich ... W. ...

Empty lines for other recommendations.

Handwritten signature and 'DO PASS' recommendation.

[ ] Committee Backup Attached

STATE OF ALASKA 1987 LEGISLATIVE SESSION No. 2  
FISCAL NOTE

Bill Version: CSHB 70(Fin)  
Publish Date: HOUSE 4/3/87

REQUEST: \_\_\_\_\_

Revision Date: \_\_\_\_\_  
Title: An Act relating to the State  
Medical Board and amending Rule 504 (d)  
Sponsor: \_\_\_\_\_  
Requestor: \_\_\_\_\_

Agency Affected: Commerce & Economic Dev.  
BRU: Occupational Licensing  
Components: \_\_\_\_\_

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0	88.4	88.4	88.4	88.4	88.4
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	1.4	1.4	1.4	1.4	1.4
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
<b>TOTAL OPERATING</b>	<b>0</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>

CAPITAL	0	0	0	0	0	0
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REVENUE	0	89.8	89.8	89.8	89.8	89.8
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**FUNDING:** (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	89.8	89.8	89.8	89.8	89.8
<b>TOTAL</b>	<b>0</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>

**POSITIONS:**

FULL-TIME	0	2	2	2	2	2
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

**ANALYSIS :** (Attach a separate page if necessary)

Prepared by: Al Adams, Chair *APA* Phone: 465-3706  
Division: House Finance Committee Date: 4/2/87

Approved by Commissioner: \_\_\_\_\_ Date: \_\_\_\_\_  
Agency: \_\_\_\_\_

**Distribution (by preparer):**

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

Fiscal Note (analysis)  
draft CS HB 70 (Fin)

The fiscal note on CS HB 70 reflects a total cost of \$ 89,723.00 to be covered by program receipts. The following is a breakdown of the \$ 89,723.00.

1 Executive Secretary, Range 18A, PX position (11 months):

34,419	Salary
9,873	Benefits
<hr/>	
44,292	Total

1 Investigator III, Range 18A, GGU position (11 months):

34,243	Salary
9,838	Benefits
<hr/>	
44,081	Total

Subtotal - Personal Services: \$ 88,373.00

The bill also grants the board authority to order a licensee to submit to a medical or psychiatric examination by an appointee of the board, at the board's expense. The following costs are associated with these examinations:

2 medical examinations at \$175.00 each - \$ 350.00  
2 psychiatric examinations at \$500.00 each - \$ 1,000.00

Subtotal - Examinations: \$ 1,350.00

TOTAL: \$89,723.00

Surcharge Calculation:

945 active physicians (as of 3-31-87)  
Projected decline of 25% = 709 active physicians  
\$89,723 divided by 709 = \$ 126.54 (per license surcharge)

Note: currently doctors pay \$150 per year

*Rep. Sund*  
5/16/87

A M E N D M E N T

Offered in the SENATE

TO: SCS CSHB 70 (Judiciary)

Page 1, lines 11 - 26:

Delete all material

Page 1, line 27:

Delete "Sec. 2"

Insert "Section 1"

Renumber following bill sections accordingly.

Page 2, after line 24:

Insert a new bill section to read:

"\* Sec. 4. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.103. INVESTIGATOR; EXECUTIVE SECRETARY. After consulting with the board, the department shall employ two persons who are not members of the board; one shall be assigned as the investigator for the board; the other shall be assigned as the executive secretary for the board. The investigator shall

(1) conduct investigations into alleged violations of this chapter, and into alleged violations of regulations and orders of the board;

(2) at the request of the board, conduct investigations

based on complaints filed with the department or with the board; and  
(3) be directly responsible and accountable to the board, except that only the department has authority to terminate the investigator's employment and the department shall provide day to day and administrative supervision of the investigator."

Page 10, line 13, after "\* Sec. 21.":

Insert "AS 08.01.050(c);"

Page 10, lines 18 - 19:

Delete "AS 08.01.050(c), as amended by sec. 1"

Insert "AS 08.64.103, as added by sec. 4"

Page 10, line 26:

Delete "AS 08.01.050(c), as amended by sec. 1"

Insert "AS 08.64.103, as added by sec. 4"

Original sponsors: Sund, Koponen,  
Taylor and Zawacki

1 IN THE HOUSE BY THE JUDICIARY COMMITTEE  
2 SENATE CS FOR CS FOR HOUSE BILL NO. 70 (Judiciary)  
3 IN THE LEGISLATURE OF THE STATE OF ALASKA  
4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the State Medical Board and to  
7 services provided for boards established under AS 08;  
8 amending Rule 504(d) of the Alaska Rules of Evidence;  
9 and providing for an effective date."

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

11 \* Section 1. AS 08.01.050(c) is amended to read:

12 (c) After consulting with the State Medical Board (AS 08.64.-  
13 010), the department shall employ two persons [AN INDIVIDUAL] who are  
14 not members [IS NOT A MEMBER] of the board; one shall [TO] be assigned  
15 as the investigator for the board; the other shall be assigned as the  
16 executive secretary for the board. The investigator shall

17 (2) at the request of the State Medical Board, conduct  
18 investigations based on complaints filed with the department or with  
19 the board; and

20 (1) conduct investigations into alleged violations of AS  
21 08.64, and into alleged violations of regulations and orders of the  
22 State Medical Board;

23 (3) be directly responsible and accountable to the State  
24 Medical Board, except that only the department has authority to termi-  
25 nate the investigator's employment and the department shall provide  
26 day to day and administrative supervision of the investigator.

27 \* Sec. 2. AS 08.01.065(c) is amended to read:

28 (c) A fee established under this section must reflect, to the  
29 extent possible, the actual costs to the department of the activity

1 for which the fee is charged. The actual or anticipated costs to the  
2 department of services provided to or on behalf of a board must re-  
3 fect, to the extent possible, the amount of fees the department  
4 collects from persons in occupations regulated by the board.

5 \* Sec. 3. AS 08.03.010(c)(11) is amended to read:

6 (11) State Medical Board (AS 08.64.010) -- June 30, 1991  
7 [JUNE 30, 1987].

8 \* Sec. 4. AS 08.64.101 is amended to read:

9 Sec. 08.64.101. DUTIES. The board shall

10 (1) examine and issue licenses to applicants;

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

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

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

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

22 (6) coordinate with private professional organizations to  
23 establish an impaired medical professionals program to treat persons  
24 licensed under this chapter who abuse addictive substances.

25 \* Sec. 5. AS 08.64.200 is amended by adding a new subsection to read:

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

29 \* Sec. 6. AS 08.64.210(b) is repealed and reenacted to read:

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

3 \* Sec. 7. AS 08.64.220(a) is repealed and reenacted to read:

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

6 \* Sec. 8. AS 08.64.255 is amended to read:

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

14 \* Sec. 9. AS 08.64.270 is amended to read:

15           Sec. 08.64.270. TEMPORARY PERMITS. (a) The board may issue a  
16 temporary permit to a physician applicant, osteopath applicant, or  
17 podiatry [AN] applicant who meets the requirements of AS 08.64.200,  
18 08.64.205, or 08.64.209 and pays the required fee.

19           (b) A temporary permit issued under this section is valid for  
20 eight months or until the board meets to consider the application,  
21 whichever occurs first.

22           (c) A temporary permit issued under this section may be renewed  
23 at the board's discretion one time only.

24 \* Sec. 10. AS 08.64.272 is repealed and reenacted to read:

25           Sec. 08.64.272. RESIDENCY AND INTERNSHIP PERMITS. (a) A person  
26 may not serve as a resident or intern without a permit issued under  
27 this section.

28           (b) For the limited purpose of residency or internship, the  
29 board may issue a permit to an applicant without examination if the

1 applicant meets the requirements of AS 08.64.200(a)(2) and applicable  
2 regulations of the board, pays the required fee, and has been accepted  
3 by an eligible institution in the state for the purpose of residency  
4 or internship.

5 (c) A permit issued under this section is valid for the period  
6 specified by the board, but not to exceed one year after the date of  
7 issue.

8 \* Sec. 11. AS 08.64.311 is repealed and reenacted to read:

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

12 \* Sec. 12. AS 08.64.313 is repealed and reenacted to read:

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

17 \* Sec. 13. AS 08.64.331(a) is amended to read:

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

20 (1) permanently revoke a license to practice;

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

22 (3) censure a licensee;

23 (4) issue a letter of reprimand;

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

25 licensee to

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

28 (B) limit practice to those areas prescribed;

29 (C) continue professional education until a

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

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

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

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

8       \* Sec. 14. AS 08.64.332 is repealed and reenacted to read:

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

19       \* Sec. 15. AS 08.64 is amended by adding a new section to read:

20          Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUS-  
21          PENSION OR SURRENDER. The board shall promptly report to the Federa-  
22          tion of State Medical Boards for inclusion in the nationwide disci-  
23          plinary data bank license refusals under AS 08.64.240, actions taken  
24          by the board under AS 08.64.331, and license suspensions or surrenders  
25          under AS 08.64.332 or 08.64.334.

26       \* Sec. 16. AS 08.64.336 is repealed and reenacted to read:

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

1 or for mental, emotional, or personality disorders, shall report it to  
2 the board if there is probable cause that the person may constitute a  
3 danger to the health and welfare of that person's patients or the  
4 public if that person continues in practice. The report shall state  
5 the name and address of the person and the condition found.

6 (b) A hospital that revokes, suspends, conditions, restricts,  
7 or refuses to grant hospital privileges to, or imposes a consultation  
8 requirement on, a person licensed to practice medicine or osteopathy  
9 in the state shall report to the board the name and address of the  
10 person and the reasons for the action within seven working days after  
11 the action is taken. A hospital shall also report to the board the  
12 name and address of a person licensed to practice medicine or osteo-  
13 pathy in the state if the person resigns hospital staff privileges  
14 while under investigation by the hospital or a committee of the hospi-  
15 tal and the investigation could result in the revocation, suspension,  
16 conditioning, or restricting of, or the refusal to grant, hospital  
17 privileges, or in the imposition of a consultation requirement. A  
18 report is required under this subsection regardless of whether the  
19 person voluntarily agrees to the action taken by the hospital. A  
20 report is not required if the sole reason for the action is the per-  
21 son's failure to complete hospital records in a timely manner or to  
22 attend staff or committee meetings. In this subsection "consultation  
23 requirement" means a restriction placed on a person's existing hospi-  
24 tal privileges requiring consultation with a designated physician or  
25 group of physicians in order to continue to exercise the hospital  
26 privileges.

27 (c) Upon receipt of a report under (a) or (b) of this section,  
28 the board shall investigate the matter and, upon a finding that there  
29 is reasonable cause to believe that the person who is the subject of

1 the report is a danger to the health or welfare of the public or to  
2 the person's patients, the board may appoint a committee of three  
3 qualified physicians to examine the person and report its findings to  
4 the board. Notwithstanding the provisions of this subsection, the  
5 board may summarily suspend a license under AS 08.64.331(c) before  
6 appointing an examining committee or before the committee makes or  
7 reports its findings.

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

14 (e) A physician, hospital, or hospital committee that in good  
15 faith submits a report under this section or participates in an inves-  
16 tigation or judicial proceeding related to a report submitted under  
17 this section is immune from civil or criminal liability for the sub-  
18 mission or participation.

19 (f) A physician or hospital may not refuse to submit a report  
20 under this section or withhold from the board or its investigators  
21 evidence related to an investigation under this section on the grounds  
22 that the report or evidence

23 (1) concerns a matter that was disclosed in the course of a  
24 confidential physician-patient or psychotherapist-patient relationship  
25 or during a meeting of a hospital medical staff, governing body, or  
26 committee that was exempt from the public meeting requirements of  
27 AS 44.62.310; or

28 (2) is required to be kept confidential under AS 18.23.030.

29 \* Sec. 17. AS 08.64 is amended by adding a new section to read:

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

9 \* Sec. 18. AS 18.20.050 is amended to read:

10           Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE.  
11 The department may deny, suspend, or revoke a license in a case in  
12 which it finds that there has been a substantial failure to comply  
13 with the requirements established under AS 08.64.336 or AS 18.20.060 -  
14 18.20.080.

15 \* Sec. 19. AS 18.23.030 is amended by adding a new subsection to read:

16           (d) Notwithstanding the provisions of (b) and (c) of this sec-  
17 tion, information contained in a report submitted to the State Medical  
18 Board, and information gathered by the board during an investigation,  
19 under AS 08.64.336 is not subject to subpoena or discovery unless and  
20 until the board takes action to suspend, revoke, limit, or condition a  
21 license of the person who is the subject of the report or investiga-  
22 tion.

23 \* Sec. 20. Rule 504(d) of the Alaska Rules of Evidence is amended to  
24 read:

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

26           (1) Condition and Element of Claim or Defense. As to  
27 communications relevant to the physical, mental or emotional condition  
28 of the patient in any proceeding in which the condition of the patient  
29 is an element of the claim or defense of the patient, of any party

1 claiming through or under the patient, of any person raising the  
2 patient's condition as an element of his own case, or of any person  
3 claiming as a beneficiary of the patient through a contract to which  
4 the patient is or was a party; or after the patient's death, in any  
5 proceeding in which any party puts the condition in issue.

6 (2) Crime or Fraud. If the services of the physician or  
7 psychotherapist were sought, obtained or used to enable or aid anyone  
8 to commit or plan a crime or fraud or to escape detection or apprehen-  
9 sion after the commission of a crime or a fraud.

10 (3) Breach of Duty Arising Out of Physician-Patient Rela-  
11 tionship. As to a communication relevant to an issue of breach, by  
12 the physician, or by the psychotherapist, or by the patient, of a duty  
13 arising out of the physician-patient or psychotherapist-patient rela-  
14 tionship.

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

20 (5) Required Report. As to information that the physician  
21 or psychotherapist or the patient is required to report to a public  
22 employee, or as to information required to be recorded in a public  
23 office, if such report or record is open to public inspection, or as  
24 to information or matters contained in or reasonably raised by a  
25 report submitted under AS 08.64.336, other than information that would  
26 establish the identity of a patient, unless the court finds that it is  
27 necessary to admit the identifying information in order to serve the  
28 interests of justice.

29 (6) Examination by Order of Judge. As to communications

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

10 (7) Criminal Proceeding. For physician-patient communica-  
11 tions in a criminal proceeding. This exception does not apply to the  
12 psychotherapist-patient privilege.

13 \* Sec. 21. AS 08.64.260(b), 08.64.260(c), 08.64.260(d), 08.64.370(4),  
14 and AS 18.20.076 are repealed.

15 \* Sec. 22. The commissioner of commerce and economic development may  
16 impose a one-time surcharge on persons licensed under AS 08.64 to cover the  
17 costs during fiscal year 1988 of employing an investigator and an executive  
18 secretary for the State Medical Board required under AS 08.01.050(c), as  
19 amended by sec. 1 of this Act. In subsequent fiscal years, these positions  
20 shall be considered services to the State Medical Board for purposes of  
21 establishing fees under AS 08.01.065.

22 \* Sec. 23. Section 22 of this Act takes effect on the effective date of  
23 the section or sections of a version of the bill containing the operating  
24 budget for fiscal year 1988 that authorizes fiscal year 1988 funding for  
25 the positions of investigator and executive secretary of the State Medical  
26 Board, established under AS 08.01.050(c), as amended by sec. 1 of this Act.

**JOHN SUND, REPRESENTATIVE**

2504 2nd Avenue  
Ketchikan, Alaska 99901  
(907) 225-5552

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While in Juneau  
P. O. Box V  
Juneau, Alaska 99811  
(907) 465-4919

M E M O R A N D U M

TO: Senate Judiciary Committee members

FROM: Rep. John Sund

DATE: May 7, 1987

RE: Changes made to CS HB 70 (Finance) am in Senate CS for  
CS HB 70 (Judiciary)

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Essentially three changes were made in this bill in the proposed Senate Judiciary committee substitute. These changes appear in five places in the bill and are explained below:

- 1) Sec. 9; Page 3, Line 15: Rewriting of AS 08.64.270 was added to the bill in order to clarify temporary permits. This change was made to accomodate the clarification of resident and intern permits as described below.
- 2) Sec. 10; Page 3, Line 25: Present statute was inconsistent regarding resident and intern permits. One statute, AS 08.64.374 (4), exempted residents and interns from licensing under the State Medical Board while AS 08.64.272 stated that the Board may issue temporary permits to residents and interns.

This section clarifies that residents and interns must have a permit in order to train in the state and lists the requirements for the permit. Note that much of the requirements are subject to Board regulations.

This section also changes the term from "temporary permit" to "permit" to avoid confusion with temporary permits issued under AS 08.64.270.

AS 08.64.374 (4) is also repealed to clean up the inconsistency in present statute.

3) Sec. 16; Page 6, Line 10: This change specifies that hospitals must report to the Board within seven working days after the hospital has taken action against a physician. This change accomplishes two things: sets a parameter on the reporting requirement in the bill and complies with hospital reporting requirements under Title 18, the health statutes. Those statutes were also amended to better conform to this bill. That change is explained below.

4) Sec. 18; Page 8, Line 10: This change adds to the Department of Health and Social Services the power to revoke a hospital license for noncompliance with the reporting requirements of this bill.

5) Sec. 21; Page 10, Line 13: Added to the repealers are AS 08.64.360(4), as explained above, and AS 18.20.076. The latter statute specifies that hospitals must report their physician-restriction actions to the Board within seven days. That has been written into AS 08.64.336 in this bill so the Title 18 statute is not needed.

Senate CS For CS For HB 70 (Judiciary)

SECTIONAL ANALYSIS  
Revised May 8, 1987

Prepared by Rep. John Sund's office.

(Note: Changes made in the Senate Judiciary CS are marked with an asterisk. They are also explained in the accompanying memo.)

Section 1 (Page 1, Line 11) amends present statute to allow the Department of Commerce and Economic Development to hire an executive secretary for the State Medical Board in addition to the investigator that is already specified in statute. The executive secretary will enable the Board to more effectively perform its investigative functions, thereby strengthening the Board. It is worth noting that although present statute specifies that the Department will hire an investigator for the Board, there is presently no employee of the Division of Occupational Licensing assigned solely to the Board. One investigator covers the Medical, Dental, Nursing and Pharmaceutical boards. One major purpose of this legislation is to provide the funds, through increased license fees, to enforce present statute and improve the Board's investigation process.

Section 2 (Page 1, Line 27) attempts to ensure that licensees under all boards in the division are getting their money's worth in terms of services from their respective boards. Present statute requires that license fees reflect services. This section adds the reciprocal concept that services reflect fees, to the extent possible. Note that this section applies to all boards -- not just the Medical Board. In essence, this asks the division to allocate to each board the amount collected from that board.

Section 3 (Page 2, Line 5) extends the State Medical Board to June 30, 1991. It is due for sunset on June 30 of this year.

Section 4 (Page 2, Line 8) adds to the Medical Board's duties the ability to coordinate with a private organization a treatment program for physicians with substance abuse problems. Impaired physicians now have the ability to seek voluntary treatment, thereby preventing formal license restricting action by the board. But this would enable the Board to have a program on line and increase the Board's ability to monitor the treatment. The private organization that would establish the program would most likely be the Alaska Medical Association.

Section 5 (Page 2, Line 25) requires that all applicants be checked through the Federation of State Medical Boards disciplinary data bank for any previous problems.

Section 6 (Page 2, Line 29) repeals the 40-day requirement for exam applications and requires that the application deadline will be established by regulation.

Section 7 (Page 3, Line 3) eliminates oral examinations for licenses to practice medicine or osteopathy.

Section 8 (Page 3, Line 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 9 (Page 3, Line 14) amends the statute on temporary permits to more clearly define to whom they are issued.

\*Section 10 (Page 3, Line 25) amends the statute on residency and internship permits to require permits for those trainees.

Section 11 (Page 4, Line 8) 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 12 (Page 4, Line 12) 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 13 (Page 4, Line 17) 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 14 (Page 5, Line 8) is a housekeeping measure to remove the term "surgery" from statute. Surgeons do not hold separate licenses from other physicians.

Section 15 (Page 5, Line 19) 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 16 (Page 5, Line 26) increases the mandatory reporting to the Board and offers immunity for reporting.

Specifically, this section 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 within seven working days 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. 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 AS 18.23.030, which is the statute that makes review organization reports confidential. Also not grounds for refusing to report is that the matter that is required to be reported was the subject of a meeting exempt from the public meeting law.

Section 17 (Page 7, Line 29) 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 18 (Page 8, Line 9) amends AS 18.20.050 which grants to the Department of Health and Social Services the power to deny, suspend or revoke a hospital license for noncompliance with certain statutes. This section adds to the reasons noncompliance with the reporting requirements of this bill, found in AS 08.64.336 (Section 16 of the bill).

Section 19 (Page 8, Line 15) amends AS 18.23.030, which makes confidential reports of review organizations, to ensure that everything reported to the Board is confidential and undiscoverable unless the Board takes formal action. Subparagraphs (b) and (c) in AS 18.23.030 offer exceptions to the confidentiality law, but this section states that required reports to the Board are not privileged to those exceptions, thereby tightening the confidentiality already offered in AS 18.23.030. This section is intended to maintain open and candid reporting within review organizations by ensuring confidentiality.

Section 20 (Page 8, Line 23) 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 21 (Page 10, Line 13) repeals provisions relating to license examinations to reflect the board's current examining practices. It also repeals AS 08.64.370(4) which stated that residents and interns did not need permits and AS 18.20.076 the intent of which (reporting to the Board) is covered in the bill under AS 08.64.336.

Section 22 (Page 10, Line 15) allows the Department to levy a one-time Medical Board licensee surcharge to cover the costs of the investigator and executive secretary. The surcharge will be for fiscal year '88. Upon the next license renewal (Dec. '88) the surcharge to cover the positions will be part of the license fee.

Section 23 (Page 10, line 22) makes the surcharge effective on the same date as the FY '88 budget bill if the budget provides for the investigator and executive secretary positions.

CSHB 70 (FIN) AM "An Act relating to the State Medical Board and to services provided for boards established under AS 08; amending Rule 504(d) of the Alaska Rules of Evidence; and providing for an effective date."

The Medical Board is in its sunset year and is scheduled to terminate on June 30, 1987. The department concurs with the 1986 performance audit by the Division of Legislative Audit that the board is necessary for the protection of the health, safety and welfare of the public and should be reestablished.

CSHB 70 (FIN) AM also makes a number of amendments to the medical statute, AS 08.64, to increase the board's enforcement capability. Section 1 of the bill allows the Department of Commerce and Economic Development to hire an executive secretary and a full-time investigator.

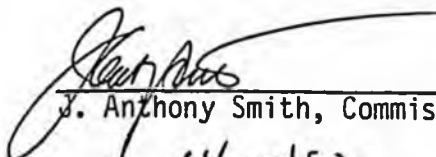
The executive secretary will enable the board to more effectively enforce disciplinary actions taken against physicians and will coordinate a treatment program for physicians who have substance abuse problems.

The full-time investigator will strengthen the investigative functions of the board. Currently, one investigator has responsibility for Medical, Dental, Nursing and Pharmacy investigations. This legislation will provide the necessary funds, through increased license fees to enable the board to have adequate staff to enforce the statutes.

Section 11 standardizes and increases the disciplinary actions the board may take against a licensee, including imposing a civil fine of up to \$10,000.

The legislation also requires hospitals that revoke, suspend or condition a physician's hospital privileges to report their action to the Medical Board and provides immunity from criminal and civil liability for submitting a report in good faith.

In summary, the department supports this legislation since it will greatly enhance the effectiveness of the State Medical Board.

  
\_\_\_\_\_  
J. Anthony Smith, Commissioner  
DATE: 4/24/87

**JOHN SUND, REPRESENTATIVE**  
2504 2nd Avenue  
Ketchikan, Alaska 99901  
(907) 225-5552

---

*While in Juneau*  
P. O. Box V  
Juneau, Alaska 99811  
(907) 465-4919

M E M O R A N D U M

TO: Senator John Binkley  
FROM: Rep. John Sund  
DATE: May 5, 1987  
RE: HB 70  
"An Act relating to the State Medical Board . . ."

-----

I am hoping you can schedule HB 70 for a hearing in Senate Finance pending referral from Senate Judiciary. The bill is scheduled in Judiciary Thursday, May 7.

The bill increases the powers and duties of the Medical Board so the doctors can better police their own ranks.

I haven't met with any opposition on this bill yet. The Board, doctors, hospitals and Division of Occupational Licensing all support it -- as does the House. It passed the floor unanimously. The Senate Labor and Commerce Committee passed it out with four do pass recommendations.

I have passed backup information onto your staff. Please let Shari on my staff know if you need anything else.

Thanks in advance for your time on this bill.

JOHN SUND, REPRESENTATIVE

2504 2nd Avenue  
Ketchikan, Alaska 99901  
(907) 225-5552

---

While in Juneau  
P. O. Box V  
Juneau, Alaska 99811  
(907) 465-4919

M E M O R A N D U M

TO: Senator Tim Kelly  
FROM: Rep. John Sund  
DATE: April 7, 1987  
RE: HB 70  
"An Act relating to the State Medical Board . . ."

---

I am hoping you can schedule HB 70 for a hearing in Senate Labor and Commerce as soon as possible.

The bill increases the powers and duties of the Medical Board so the doctors can better police their own ranks.

I haven't met with any opposition on this bill yet. The Board, doctors, hospitals and Division of Occupational Licensing all support it -- as does the House. It passed the floor Monday unanimously.

I have passed backup information onto your staff. Please let Shari on my staff know if you need anything else.

Thanks in advance for your time on this bill.

SECTIONAL ANALYSIS

Revised April 7, 1987

Prepared by Rep. John Sund's office.

Section 1 (Page 1, Line 11) amends present statute to allow the Department of Commerce and Economic Development to hire an executive secretary for the State Medical Board in addition to the investigator that is already specified in statute. The executive secretary will enable the Board to more effectively perform its investigative functions, thereby strengthening the Board. It is worth noting that although present statute specifies that the Department will hire an investigator for the Board, there is presently no employee of the Division of Occupational Licensing assigned solely to the Board. One investigator covers the Medical, Dental, Nursing and Pharmaceutical boards. One major purpose of this legislation is to provide the funds through increased license fees, to enforce present statute and improve the Board's investigation process.

Section 2 (Page 1, Line 27) attempts to ensure that licensees under all boards in the division are getting their money's worth in terms of services from their respective boards. Present statute requires that license fees reflect services. This section adds the reciprocal concept that services reflect fees, to the extent possible. Note that this section applies to all boards -- not just the Medical Board. In essence, this asks the division to allocate to each board the amount collected from that board.

Section 3 (Page 2, Line 5) extends the State Medical Board to June 30, 1991. It is due for sunset on June 30 of this year.

Section 4 (Page 2, Line 8) adds to the Medical Board's duties the ability to coordinate with a private organization a treatment program for physicians with substance abuse problems. Impaired physicians now have the ability to seek voluntary treatment, thereby preventing formal license restricting action by the board. But this would enable the Board to have a program on line and increase the Board's ability to monitor the treatment. The private organization that would establish the program would most likely be the Alaska Medical Association.

Section 5 (Page 2, Line 25) requires that all applicants be checked through the Federation of State Medical Boards disciplinary data bank for any previous problems.

Section 6 (Page 2, Line 29) repeals the 40-day requirement for exam applications and requires that the application deadline will be established by regulation.

Section 7 (Page 3, Line 3) eliminates oral examinations for licenses to practice medicine or osteopathy.

Section 8 (Page 3, Line 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 9 (Page 3, Line 14) 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 10 (Page 3, Line 18) 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 11 (Page 3, Line 23) 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).

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Section 14 (Page 5, Line 3) increases the mandatory reporting to the Board and offers immunity for reporting.

Specifically, this section 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 led 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. 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 AS 18.23.030, which is the statute that makes review organization reports confidential. Also not grounds for refusing to report is that the matter that is required to be reported was the subject of a meeting exempt from the public meeting law.

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Section 16 (Page 7, Line 15) amends AS 18.23.030, which makes confidential reports of review organizations, to ensure that everything reported to the Board is confidential and undiscoverable unless the Board takes formal action. Subparagraphs (b) and (c) in AS 18.23.030 offer exceptions to the confidentiality law, but this section states that required reports to the Board are not privileged to those exceptions, thereby tightening the confidentiality already offered in AS 18.23.030. This section is intended to maintain open and candid reporting within review organizations by ensuring confidentiality.

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Section 18 (Page 9, Line 13) repeals provisions relating to license examinations to reflect the board's current examining practices.

Section 19 (Page 9, Line 14) allows the Department to levy a one-time Medical Board licensee surcharge to cover the costs

of the investigator and executive secretary. The surcharge will be for fiscal year '88. Upon the next license renewal (Dec. '88) the surcharge to cover the positions will be part of the license fee.

Section 20 (Page 9, line 21) makes the surcharge effective on the same date as the FY '88 budget bill if the budget provides for the investigator and executive secretary positions.

**STATE OF ALASKA 1987 LEGISLATIVE SESSION  
FISCAL NOTE**

**REQUEST:** \_\_\_\_\_

Bill Version: CS HB 70 (Finance)

Publish Date: \_\_\_\_\_

Revision Date: \_\_\_\_\_

Agency Affected: Commerce & Economic Dev.

Title: An Act relating to the State

BRU: Occupational Licensing

Medical Board and amending Rule 504(d)

Sponsor: \_\_\_\_\_

Components: \_\_\_\_\_

Requestor: \_\_\_\_\_

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0	88.4	88.4	88.4	88.4	88.4
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	1.4	1.4	1.4	1.4	1.4
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
<b>TOTAL OPERATING</b>	<b>0</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>

<b>CAPITAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
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<b>REVENUE</b>	<b>0</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>
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**FUNDING: (Thousands of Dollars)**

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	89.8	89.8	89.8	89.8	89.8
<b>TOTAL</b>	<b>0</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>	<b>89.8</b>

**POSITIONS:**

FULL-TIME	0	2	2	2	2	2
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

**ANALYSIS :** (Attach a separate page if necessary)

Prepared by: \_\_\_\_\_ Phone: \_\_\_\_\_

Division: \_\_\_\_\_ Date: \_\_\_\_\_

Approved by Commissioner: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Distribution (by preparer):

Legislative Finance

Legislative Sponsor

Requestor

Office of Management and Budget

Impacted Agency(ies)

Senate Secretary

Fiscal Note (analysis)  
draft CS HB 70 (Fin)

The fiscal note on CS HB 70 reflects a total cost of \$ 89,723.00 to be covered by program receipts. The following is a breakdown of the \$ 89,723.00.

1 Executive Secretary, Range 18A, PX position (11 months):

34,419	Salary
9,873	Benefits
<hr/>	
44,292	Total

1 Investigator III, Range 18A, GGU position (11 months):

34,243	Salary
9,838	Benefits
<hr/>	
44,081	Total

Subtotal - Personal Services: \$ 88,373.00

The bill also grants the board authority to order a licensee to submit to a medical or psychiatric examination by an appointee of the board, at the board's expense. The following costs are associated with these examinations:

2 medical examinations at \$175.00 each	= \$	350.00
2 psychiatric examinations at \$500.00 each	= \$	<u>1,000.00</u>

Subtotal - Examinations: \$ 1,350.00

TOTAL: \$89,723.00

Surcharge Calculation:

945 active physicians (as of 3-31-87)  
Projected decline of 25% = 709 active physicians  
\$89,723 divided by 709 = \$ 126.54 (per license surcharge)

Note: currently doctors pay \$150 per year

## 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 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 pervue. 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.

Alaska Physicians  
November 3, 1986  
Page Three

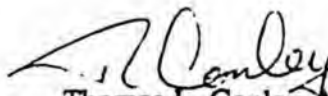
Practitioners should also be aware of board plans to institute a monitored treatment program in conjunction with the Alaska State Medical Association. This would be directed at physicians impaired by drug and alcohol use. Good studies show that up to 90% of at least alcohol impaired physicians can achieve 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

TLC:ts

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REVISED 1985

# A Guide To The Essentials of a Modern Medical Practice Act



THE FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES

**A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT,  
1985 REVISION,**  
was approved by the Board of Directors of the  
Federation of State Medical Boards of the United States, Inc.  
on February 16, 1985.

## TABLE OF CONTENTS

INTRODUCTION: .....	p. iii
PREAMBLE: .....	p. 1
SECTION I : STATEMENT OF PURPOSE .....	p. 2
SECTION II : DEFINITIONS .....	p. 3
SECTION III : THE MEDICAL LICENSING BOARD .....	p. 5
SECTION IV : EXAMINATIONS .....	p. 6
SECTION V : REQUIREMENTS FOR FULL LICENSURE .....	p. 9
SECTION VI : GRADUATES OF FOREIGN MEDICAL SCHOOLS .....	p. 10
SECTION VII : LICENSURE WITHOUT EXAMINATION AND TEMPORARY LICENSURE .....	p. 11
SECTION VIII : LIMITED LICENSURE FOR PHYSICIANS IN GRADUATE TRAINING .....	p. 13
SECTION IX : DISCIPLINARY ACTION AGAINST LICENSEES .....	p. 14
SECTION X : PROCEDURES FOR ENFORCEMENT AND DISCIPLINARY ACTION .....	p. 18
SECTION XI : IMPAIRED PHYSICIANS .....	p. 20
SECTION XII : COMPULSORY REPORTING AND INVESTIGATION .....	p. 22
SECTION XIII : PROTECTED ACTION AND COMMUNICATION .....	p. 24
SECTION XIV : UNLAWFUL PRACTICE OF MEDICINE: VIOLATIONS/PENALTIES .....	p. 25
SECTION XV : PERIODIC REREGISTRATION .....	p. 26
SECTION XVI : PHYSICIAN'S ASSISTANTS .....	p. 28
SECTION XVII : RULES AND REGULATIONS .....	p. 30
SECTION XVIII: FUNDING AND FEES .....	p. 31

## INTRODUCTION

The Federation of State Medical Boards of the United States, Incorporated, and its member boards have long recognized the need for A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT. The initial GUIDE was published in 1956 and revised in 1970 and 1977. Its stated purposes were:

1. to serve as a guide to those states which may adopt new medical practice acts or may amend existing laws; and
2. to encourage the standardization of requirements and of regulations to facilitate endorsement.

While the original GUIDE and the revisions served a useful purpose, changes in medical education, in the practice of medicine, and in the diverse responsibilities which face medical boards necessitate the writing of another revision. Legislation that fails to recognize these changes fails to meet the needs of the public. In the original GUIDE, the intent was "to facilitate reciprocity and endorsement." The need for this still exists despite improvements due to the acceptance of the Federation Licensing Examination (FLEX). Newer concepts of the practice of medicine, the need for appropriate reevaluation of practicing physicians, and other concerns also demand legislative attention.

Though this revision of the GUIDE does not address every issue facing every medical licensing board today, the Federation has attempted to offer in it basic recommendations which will prove useful in the evaluation and revision of medical practice acts. Should a member board find any recommendations contained in the GUIDE not appropriate to its particular medical practice act, the Federation urges those recommendations be thoughtfully considered for inclusion in the board's rules and regulations.

The GUIDE is intended to apply equally to practice acts which govern doctors of medicine and doctors of osteopathic medicine in the same statute or in separate statutes. The terms "medical practice act," "practice of medicine," "medical licensing board," "medical school," "medical training," etc., should be interpreted throughout with this understanding.

A GUIDE TO THE ESSENTIALS  
OF A  
MODERN MEDICAL PRACTICE ACT

PREAMBLE

An essential is that element, quality, or property which is indispensable in making a body, character, or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the eighteen sections of this GUIDE expresses an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

**SECTION I:**

**STATEMENT OF PURPOSE**

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts recommended by the Federation.

- A. The practice of medicine is a privilege granted by the people acting through their elected representatives. It is not a natural right of individuals.
- B. In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.
- C. The primary responsibility and obligation of the medical licensing board is to protect the public.

## SECTION II:

### DEFINITIONS

The medical practice act should provide definitions of the practice of medicine as governed by the act and of exceptions to the act. These provisions of the act should implement or be consistent with the following Federation recommendations.

A. The definition of the practice of medicine should include:

1. advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. offering or undertaking to prescribe, give, or administer any drug or medicine for the use of any other person;
3. offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, devices, or instrumentalities any disease, illness, pain, wound, fracture, infirmity, deformity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
4. offering or undertaking to perform any surgical operation upon any person;
5. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction.

B. The definition of exceptions to the act should include:

1. students while engaged in training in a medical school approved by the medical licensing board or while engaged in graduate medical training under the supervision of the medical staff of a hospital or other health care facility approved by the medical licensing board for such training, except as stipulated in Section VIII (LIMITED LICENSE);
2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged, or received;
3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act;
4. those practicing optometry, psychology, podiatry, dentistry, nursing, or any other of the

healing arts in accord with and as provided by the laws of the jurisdiction;

5. those practicing the religious tenets of a church in ministering to the sick or suffering by mental or spiritual means, provided that no person should be exempt from the sanitary and quarantine laws of the jurisdiction or the federal government;
6. a person administering a lawful domestic or family remedy to a member of his or her own family.

**SECTION III:**  
**THE MEDICAL LICENSING BOARD**

The medical practice act should provide for a separate medical licensing board (referred to hereafter as the Board) for the licensure and regulation of physicians in the jurisdiction. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. Whatever the professional regulatory structure established by the jurisdiction, physicians should bear the responsibility of licensing and regulating the medical profession with due safeguards to protect the public and individual physicians from the abuse of that responsibility.
- B. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity.
- C. Members of the Board should be subject to removal only when found guilty, through due process, of malfeasance, misfeasance, or nonfeasance.
- D. All physician members of the Board should be licensed in the jurisdiction, should be persons of recognized professional ability and integrity, and should have practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).
- E. Whatever the make-up of the Board, physicians should constitute the majority of the membership.
- F. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service.
- G. Members of the Board should receive appropriate reimbursement for expenses and services.
- H. The Board should be authorized to employ an executive secretary or director and other staff, including an adequate staff of investigators, to effectively fulfill its responsibilities under the act. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel.

**SECTION IV:  
EXAMINATIONS**

The medical practice act should provide for medical licensure examination(s), examination application, and examination security. These provisions of the act should implement or be consistent with the following Federation recommendations.

**A. Medical Licensure Examination(s):**

1. No person should receive a license to practice medicine in the jurisdiction unless he or she passes or has passed an examination or examinations satisfactory to the Board.
2. The Board should approve the preparation and administration of an examination or examinations, in English, which it deems must be satisfactorily passed as part of its procedure for determining an applicant's qualification for the practice of medicine.
3. Examinations should be scored in a way to ensure the anonymity of applicants.
4. Examinations should be conducted at least semiannually, provided there is an applicant.
5. The Board should stipulate the score required for passing the examination(s). The required passing score should be set before the administration of the examination(s).
6. Applicants should be required to pass all examinations within a specific period of time after initial application in any jurisdiction. Specific requirements for the satisfactory completion of further medical education should be established by the Board for those applicants seeking to be examined after the specified passing period.
7. The Board should be authorized to limit the number of times an examination may be taken before the satisfactory completion of further medical education is required of an applicant.
8. Fees for any examination should be paid by an applicant before the examination is given and no later than a date set by the Board.

**B. Examination Application:**

To apply for examination(s), an applicant should provide the Board and attest to the following information and documentation no later than a date set by the Board:

1. his or her full name and all aliases or other names ever used, current address, social security number, and date and place of birth;
2. a recent signed photograph and a set of fingerprints of the applicant;
3. notarized photocopies of all documents and credentials required by the Board;

4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has applied for licensure to practice medicine or is authorized or has applied for authorization to practice medicine;
5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or has voluntarily surrendered such licensure or authorization;
6. a list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, which would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;
7. a detailed educational history, including places, institutions, dates, and program descriptions, of all his or her education beginning with secondary schooling and including all college, pre-professional, professional, and professional graduate education;
8. a detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign);
9. any other information or documentation the Board determines is necessary.

C. Examination Security:

1. Any individual found by the board to have engaged in conduct which subverts or attempts to subvert the medical licensing examination process should, at the discretion of the Board, have his or her scores on the licensing examination withheld and/or declared invalid, be disqualified from the practice of medicine, and/or be subject to the imposition of other appropriate sanctions. The Federation of State Medical Boards of the United States should be informed of all such actions.

Conduct which subverts or attempts to subvert the medical licensing examination process should include, but not be limited to:

- a. conduct which violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; and/or
- b. conduct which violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination distributed; and/or

c. conduct which violates the credentialing process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination; impersonating an examinee or having an impersonator take the licensing examination on one's behalf.

2. The Board should provide written notification to all applicants for medical licensure of the prohibitions on conduct which subverts or attempts to subvert the licensing examination process and of the sanctions imposed for such conduct. A copy of such notification attesting that he or she has read and understood the notification should be signed by the applicant and filed with his or her application.

**SECTION V:**  
**REQUIREMENTS FOR FULL LICENSURE**

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. The applicant should possess the degree of Doctor of Medicine or Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada which was approved by the Board or by a private non-profit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school which was not so approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement/reciprocity.
- B. The applicant should have satisfactorily completed at least twelve (12) months of graduate medical training approved by the Board or by a private non-profit accrediting body approved by the Board in an institution in the United States, its territories or possessions, or Canada approved by the Board or by a private non-profit accrediting body approved by the Board.
- C. The applicant should have passed medical licensure examination(s) satisfactory to the Board.
- D. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, or professional competency examination if deemed necessary by the Board.
- E. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct which would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board, at its discretion, should be authorized to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.
- F. The applicant should make a personal appearance before the Board or a representative thereof for interview, examination, or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.
- G. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board should be directed to establish regulations governing the review and verification of medical education credentials.
- H. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board.

SECTION VI:  
GRADUATES OF FOREIGN MEDICAL SCHOOLS

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. Such applicants should possess the degree of Doctor of Medicine or Osteopathy, Bachelor of Medicine or Osteopathy, or the equivalent from a medical college or school whose full training program and curriculum are available to and approved by the Board on the basis of criteria approved by the Board. Necessary information regarding such schools should be gathered by the Board or by a qualified private non-profit body approved by the Board with which the Board has entered into a written agreement for such a purpose. The information gathering process should be permitted to include a site-visit to the institution if deemed necessary by the Board, though the cost of such a visit should not be borne by the licensing jurisdiction.
- B. Such applicants should be eligible by virtue of education and training for unrestricted licensure or authorization to practice medicine in the country in which they received the medical degree.
- C. Such applicants should have passed a screening examination in basic medical knowledge acceptable to the Board (e.g., the Foreign Medical Graduates Examination in the Medical Sciences).
- D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or by its Board approved successor(s).
- E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
- F. The Board should be authorized to establish regulations requiring all such applicants to satisfactorily complete more than twelve (12) months and up to thirty-six (36) months of Board approved graduate medical training if it determines such a requirement is necessary for the protection of the public health and welfare.
- G. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by notarized English translations acceptable to the Board.
- H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

## SECTION VII:

### LICENSURE WITHOUT EXAMINATION AND TEMPORARY LICENSURE

The medical practice act should provide for licensure without examination in certain clearly defined cases and for temporary licensure. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. **Endorsement/Reciprocity:** The Board should be authorized, at its discretion, to issue a license by endorsement/reciprocity to an applicant who:
1. has complied with all current medical licensure requirements save that for examination; and
  2. has passed a medical licensure examination given in English in another state, the District of Columbia, a territory or possession of the United States, or Canada, provided the Board determines that examination was equivalent to its own current examination; and
  3. has a valid current medical license in another state, the District of Columbia, a territory or possession of the United States, or Canada.
- B. **Certifying Agencies:** The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:
1. has complied with all current medical licensure requirements save that for examination; and
  2. has passed the examination of and been certified by a certifying agency recognized by the Board (e.g., the National Board of Medical Examiners or the National Board of Examiners for Osteopathic Physicians and Surgeons), provided the Board determines that examination was equivalent to its own current examination and was not a specialty board examination.
- C. **Endorsement/Reciprocity Examination:** Notwithstanding any other provision of the act, the Board should be authorized to require applicants for full and unrestricted medical licensure without examination who have not been formally tested by a United States or Canadian medical licensing jurisdiction, a Board approved medical certifying agency, or a Board approved medical specialty board within a specific period of time before application (e.g., eight or ten years) to pass a written and/or oral medical examination approved by the Board. Such an examination could be all or part of the Board's current licensure examination.
- D. **Temporary Licensure:** The Board should be authorized to establish regulations for the issuance of temporary medical licenses for the intervals between Board meetings in order to meet specific needs. If a temporary medical license is issued, it should:
1. be issued only to an applicant who is qualified for full and unrestricted medical licensure

under the requirements established by the Board and the medical practice act; and

2. automatically terminate on the date of the next Board meeting following its issuance at which the applicant could be considered for full and unrestricted medical licensure.

## SECTION VIII:

### LIMITED LICENSURE FOR PHYSICIANS IN GRADUATE TRAINING

The medical practice act should provide that all physicians in Board approved graduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except graduate education and/or licensure examination.
- B. The application for limited licensure should be made through the Board approved institution which is to supervise the applicant's graduate training and that institution should be required to verify the applicant's fulfillment of the requirements for limited licensure. The demonstrated failure of an approved supervising institution to properly and effectively verify an applicant's fulfillment of the requirements for limited licensure should be grounds for the Board, at its discretion, to withdraw or limit its approval of that institution for graduate training until such time as the institution can demonstrate to the Board's satisfaction the implementation of an acceptable verification process. Proof of an institution's failure to properly and effectively verify the requirements for limited licensure should be established by the presence in graduate training of an individual whose medical or other required documents or credentials are shown to be fraudulent or to have been obtained through fraud, deception, or dishonesty, or by the identification of such an individual after the completion of his or her graduate training.
- C. The Board should be directed to establish by regulation restrictions for the limited license to assure the holder will practice only under appropriate supervision acceptable to the Board.
- D. The limited license should be renewable annually with the approval of the Board and upon the written recommendation of the supervising institution until such time as Board regulations require the achievement of full and unrestricted medical licensure.
- E. The disciplinary provisions of the medical practice act should apply to the holders of the limited license as if they held full and unrestricted medical licensure.
- F. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license will be issued at any future date.

## SECTION IX:

### DISCIPLINARY ACTION AGAINST LICENSEES

The medical practice act should provide for disciplinary action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. A range of disciplinary actions should be made available to the Board. These should include, but not be limited to, the following:
1. revocation of the medical license;
  2. suspension of the medical license;
  3. probation;
  4. stipulations, limitations, and conditions relating to practice;
  5. fines (including costs);
  6. reprimands;
  7. letters of censure; and
  8. letters of concern.

The Board should be authorized, at its discretion, to take such actions singly or in combination as the nature of the violation requires.

- B. The Board should be authorized to require a licensee to be examined on his or her medical knowledge and skills should the Board have reason to believe the licensee may be deficient in such knowledge and skills. It should also be authorized to require a licensee to be physically or mentally examined should it have reason to believe the licensee's physical or mental condition may adversely affect his or her practice of medicine.
- C. The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:
1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic reregistration of a medical license;
  2. cheating on or attempting to subvert the medical licensing examination(s);
  3. the commission or conviction of a gross misdemeanor or a felony, whether or not related to the practice of medicine, or the entry of a guilty or nolo contendere plea to a gross misdemeanor or a felony charge;

4. conduct likely to deceive, defraud, or harm the public;
5. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;
6. representing to a patient that a manifestly incurable condition, sickness, disease, or injury can be cured;
7. willfully or negligently violating the confidentiality between physician and patient except as required by law;
8. gross negligence in the practice of medicine as determined by the Board;
9. being found mentally incompetent or insane by any court of competent jurisdiction;
10. a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;
11. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;
12. practicing medicine under a false or assumed name;
13. aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;
14. allowing another person or organization to use his or her license to practice medicine;
15. commission of any act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;
16. being addicted or habituated to a drug or intoxicant;
17. prescribing, selling, administering, distributing, or giving any drug legally classified as a controlled substance or as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
18. except as otherwise permitted by law, prescribing, selling, administering, distributing, or giving to a habitue or addict any drug legally classified as a controlled substance or as an addictive or dangerous drug;
19. prescribing, selling, administering, distributing, or giving a drug legally classified as a controlled substance or as an addictive or dangerous drug to a family member or to himself or herself;
20. violating any state or federal law or regulation relating to controlled substances;
21. obtaining any fee by fraud, deceit, or misrepresentation;
22. directly or indirectly giving or receiving any fee, commission, rebate, or other

compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;

23. disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine based upon acts or conduct by the licensee similar to acts or conduct which would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;
24. sanctions or disciplinary actions taken by a peer review body, a hospital or other health care institution, or a medical or professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
25. failure to report to the Board any adverse action taken against him or her by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
26. surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
27. failure to report to the Board surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
28. any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
29. failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;
30. failure to transfer medical records to another physician when requested to do so by the subject patient or by his or her legally designated representative;
31. failure to report to the Board the relocation of his or her office, in or out of the jurisdiction;
32. failure to furnish the Board, its investigators or representatives, information legally requested by the Board;

33. violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board.

## SECTION X:

### PROCEDURES FOR ENFORCEMENT AND DISCIPLINARY ACTION

The medical practice act should provide for procedures which will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. **Board Authority:** The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions.
- B. **Separation of Functions:** In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary sanctions.
- C. **Administrative Procedures:** The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for investigation of charges by the Board; notice of charges to the accused; an opportunity for a fair and impartial hearing for the accused before the Board or its examining committee; representation of the accused by counsel; the presentation of testimony, evidence, and argument; subpoena power and attendance of witnesses; a record of proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review.
- D. **Informal Conference:** Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with an accused licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee as a result of such an informal conference and agreed to in writing by the Board and the accused licensee should be binding and a matter of public record. However, license revocation and suspension should be dealt with in open hearing. The holding of an informal conference should not preclude an open hearing if the Board determines such is necessary.
- E. **Summary Suspension:** The Board should be authorized to summarily suspend a license prior to a formal hearing when it believes such action is required to protect the public health and safety. The Board should be permitted to summarily suspend a license by means of a vote conducted by telephone conference call if the Board president or executive believes such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time (e.g., fifteen to thirty days) of the date of the summary suspension.
- F. **Injunctions:** The Board should be authorized to obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating the provisions

of the medical practice act. Violation of such an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of such an injunction, nor should its issuance relieve those enjoined from criminal prosecution for violation of the medical practice act.

- G. **Board Action Reports:** All final disciplinary actions taken by the Board, including license denials, should be matters of public record and should be promptly reported by the Board to the central disciplinary data bank of the Federation of State Medical Boards of the United States. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be a matter of public record and should also be reported to the Federation of State Medical Boards of the United States.

SECTION XI:  
IMPAIRED PHYSICIANS

The medical practice act should provide for the restriction, suspension, or revocation of the medical license of any physician whose mental or physical ability to practice medicine with reasonable skill and safety is impaired. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. Impairment should be defined as the inability of a licensee to practice medicine with reasonable skill and safety by reason of:
1. mental illness; or
  2. physical illness, including, but not limited to, physical deterioration which adversely affects cognitive, motor, or perceptive skills; or
  3. habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of other substances which impair ability.
- B. The Board should be authorized, upon probable cause, to require a licensee or applicant to submit to a mental or physical examination by physicians designated by the Board. The results of the examination should be admissible in any hearing before the Board, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination when properly directed to do so by the Board, unless failure was due to circumstances deemed to be beyond the licensee's control, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.
- C. If the Board finds, after examination and hearing, that a licensee is impaired, it should be authorized to take one or more of the following actions:
1. direct the licensee to submit to care, counseling, or treatment acceptable to the Board;
  2. suspend, limit, or restrict the physician's medical license for the duration of the impairment;
  3. revoke the physician's medical license.
- D. Any licensee or applicant who is prohibited from practicing medicine under this provision, should, at reasonable intervals, be afforded an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. Licensure should not be reinstated, however, without the payment of all

applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited.

- E. While all impaired physicians should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired physicians should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of medically directed, non-profit, voluntary treatment programs for impaired physicians which meet standards set by the Board. Those conducting a Board approved treatment program should be exempt from the mandatory reporting requirement relating to an impaired physician who is participating satisfactorily in the program, or their report should be held in confidence and without action by the Board unless or until the impaired physician ceases to participate satisfactorily in the program. The standards set by the Board should require that any impaired physician whose participation in an approved treatment program is unsatisfactory should be reported to the Board as soon as that determination is made. Participation in an approved treatment program should not protect an impaired physician from Board action resulting from a report of his or her impairment from another source. The Board should be the final judge of a treatment program's acceptability, it should review its approved programs on a regular basis, and it should be permitted to withdraw or deny its approval at its discretion.

**SECTION XII:  
COMPULSORY REPORTING AND INVESTIGATION**

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. Any person should be permitted to report to the Board any information which appears to show that a medical licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine. The following should be required to promptly report such information to the Board:
1. all physicians licensed under the act;
  2. the state medical association and its components;
  3. all health care institutions in the state;
  4. all state agencies;
  5. all law enforcement agencies in the state;
  6. all courts in the state.
- B. A medical licensee's voluntary resignation from the staff of a health care institution or voluntary limitation of his or her staff privileges at such an institution should be promptly reported to the Board by the institution and the licensee if that action occurs while the licensee is under formal or informal investigation by the institution or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.
- C. Malpractice insurance carriers and affected licensees should be required to file with the Board a report of each final judgment, settlement, or award against insured licensees. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within thirty days).
- D. Upon receiving reports concerning a licensee, or on its own motion, the Board should be permitted to investigate any evidence which appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.
- E. Any person, institution, agency, or organization required to report under this provision of the medical practice act who does so in good faith should not be subject to civil damages or criminal prosecution for so reporting.

F. To assure compliance with compulsory reporting requirements, specific penalties should be established for demonstrated failure to report.

## SECTION XIII:

### PROTECTED ACTION AND COMMUNICATION

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. No member of the Board, its committees, or its staff should bear liability or be subject to civil damages or criminal prosecution for any action undertaken or performed within the scope of the functions of the Board under the medical practice act and the rules and regulations of the Board when acting without malice and in the reasonable belief the action was warranted.
- B. Every communication, oral or written, made by or on behalf of any person, institution, agency, or organization to the Board or to any person designated by the Board to investigate or otherwise hear matters relating to any disciplinary action, whether by way of report, complaint, or testimony, should be privileged. No action or proceeding, civil or criminal, should be permitted to lie against any such person, institution, agency, or organization by whom or on whose behalf such a communication was made, except upon proof that the communication was made with malice.
- C. The protections afforded in these provisions should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law, or as prohibiting the respondent from normal access to the charges and evidence filed against him or her as a part of due process under the law.

#### SECTION XIV:

#### UNLAWFUL PRACTICE OF MEDICINE: VIOLATIONS/PENALTIES

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. It should be declared unlawful for any person, corporation, or association to do or perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board.
- B. The Board should be authorized to obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.
- C. A person, corporation, or association violating the provisions of the medical practice act, or causing or aiding and abetting such violation, should be deemed guilty of a crime.

SECTION XV:  
PERIODIC REREGISTRATION

The medical practice act should provide for the periodic reregistration of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. At the time of periodic reregistration, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The application form for license reregistration should be designed to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information.
1. Any action taken against the licensee by:
    - a. any jurisdiction or authority (United States or foreign) which licenses or authorizes the practice of medicine;
    - b. any peer review body;
    - c. any health care institution;
    - d. any professional medical society or association;
    - e. any law enforcement agency;
    - f. any court; or
    - g. any governmental agencyfor acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action.
  2. Any adverse judgment, settlement, or award against the licensee arising from a professional liability claim.
  3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.
  4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.
  5. The licensee's voluntary resignation from the medical staff of any health care institution

or voluntary limitation of his or her staff privileges at such an institution if that action occurred while the licensee was under formal or informal investigation by the institution or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.
  7. Whether the licensee has ever been addicted to or treated for addiction to alcohol or any chemical substance.
  8. Whether the licensee has had any physical injury or disease or mental illness within the registration period which could reasonably be expected to affect his or her practice of medicine.
  9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the registration period.
- B. The Board should be authorized, at its discretion, to require continuing medical education for license reregistration and to require documentation of that education.
  - C. The licensee should be required to sign the application form for license reregistration and have it witnessed. Failure to report fully and correctly should be grounds for disciplinary action by the Board.
  - D. The Board should be directed to establish an effective system for reviewing reregistration forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license reregistration.

**SECTION XVI:  
PHYSICIAN'S ASSISTANTS**

The medical practice act should provide for the certification, registration, and regulation of physician's assistants by the Board. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. **Definitions:** The following terms should have the meanings given them below:
1. "Licensed physician" means a physician licensed to practice medicine in the jurisdiction.
  2. "Physician's assistant" means a skilled person certified by the Board as being qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible, in a manner determined by the Board, for the performance of that person.
- B. **Administration:** The Board should enforce and administer these provisions of the medical practice act.
- C. **Certification and Registration as a Physician's Assistant:**
1. No person should perform or attempt to perform as a physician's assistant without first applying for and obtaining a certificate of qualification from the Board and having his or her employment registered in accordance with Board rules and regulations.
  2. An applicant for a certificate of qualification as a physician's assistant should complete application forms prepared and furnished by the Board and pay a non-returnable fee. Upon being duly certified by the Board, the applicant should have his or her name and address and other pertinent information enrolled by the Board on a roster of physician's assistants.
  3. Each certified physician's assistant should register his or her employment with the Board annually, stating his or her name and current address, the name and office address of both his or her employer and the supervising licensed physician, and submitting a copy of the current protocol governing his or her activities and such additional information as the Board deems necessary. Upon any change of employment as a physician's assistant, such registration should automatically be void. Each annual registration or reregistration of new employment should be accompanied by a fee set by the Board.
- D. **Denial, Suspension or Revocation:** The Board should be empowered to deny or suspend any registration or to deny or revoke any certificate of qualification upon grounds similar to those for such disciplinary actions against licensed physicians.
- E. **Rules and Regulations:** The Board should be empowered to adopt and enforce reasonable rules and regulations for:

1. setting qualifications of education, skill, and experience for certification of a person as a physician's assistant and providing forms and procedures for certificates of qualification and for annual registration of employment;
  2. examining and evaluating applicants for certificates of qualification as physician's assistants as to their skill, knowledge, and experience in the field of medical care; and
  3. establishing criteria for protocols governing the activities of physician's assistants.
- F. **Duties of Physician's Assistants:** A physician's assistant should perform only those acts and duties approved by the Board for which the assistant has been trained and which have been assigned to the assistant by a supervising licensed physician who is fully qualified to perform and to supervise such acts and duties.
- G. **Responsibility of Supervising Physician:** Every physician using, supervising, or employing a registered physician's assistant should be qualified in the medical areas in which the physician's assistant is to perform and should be individually responsible and liable for the performance and the acts and omissions of the physician's assistant. Nothing in these provisions, however, should be construed to relieve the physician's assistant of any responsibility and liability for any of his or her own acts and omissions. No physician should have under his or her supervision more than two currently registered physician's assistants.

**SECTION XVII:  
RULES AND REGULATIONS**

The medical practice act should provide for rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. The Board should be authorized to adopt and enforce rules and regulations to carry into effect the provisions of the medical practice act and to fulfill its duties under the act.
- B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

**SECTION XVIII:  
FUNDING AND FEES**

The medical practice act should provide for the adequate funding of the Board and for the establishment of fees and charges to cover the costs incurred by the regulation of the practice of medicine under the act. These provisions of the act should implement or be consistent with the following Federation recommendations.

- A. All fees, charges, costs, and fines collected by the Board or on its behalf should be specifically designated for the use of the Board in fulfilling its duties under the medical practice act.
- B. The Board should be authorized to set fees and charges for examination, licensure, certification, registration, reregistration, and other functions and services at levels adequate to support the Board's effective fulfillment of its duties under the medical practice act.

**STATE OF ALASKA 1987 LEGISLATIVE SESSION  
FISCAL NOTE**

**REQUEST:** \_\_\_\_\_

Bill Version: CSHB 70 (Fin.)  
Publish Date: \_\_\_\_\_

Revision Date: \_\_\_\_\_  
Title: "An Act relating to the State  
Medical Board..."  
Sponsor: Representative Sund  
Requestor: House Finance

Agency Affected: Department of Law  
BRU: Legal Services  
Components: Operations

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>		-0-	-0-	-0-	-0-	-0-

<b>CAPITAL</b>						
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<b>REVENUE</b>						
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**FUNDING: (Thousands of Dollars)**

GENERAL FUND		-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>						

**POSITIONS:**

FULL-TIME		-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

**ANALYSIS :** (Attach a separate page if necessary)

Please see attached analysis.

*Richard I. Peques*

Prepared by: Richard I. Peques, Director

Phone: 465-3672

Division: Administrative Services

Date: April 13, 1987

*Richard I. Peques / FAL*

Approved by Commissioner: Grace Berg Schaible, Atty. Gen.

Date: April 13, 1987

Agency: Department of Law

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

## CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 70 (Fin)

This bill adds certain investigative powers and staff to the State Medical Board. To the extent that these new resources are available, the Department of Law's duties in assisting and defending the Board will be made easier. On the other hand, to the extent that new cases are brought to us, the department could see a corresponding increase in workload. Such an increase, however, cannot be predicted at this time. Major cases that arise in this area will be handled on a case-by-case basis, as they have in the past. Budget and staff reductions could result in a supplemental appropriation request on a per case basis, if warranted by a major case.

## 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.

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU, ALASKA 99811  
907 465 3600

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

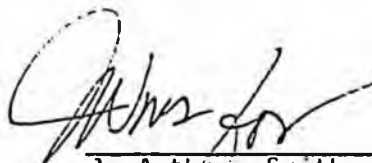
CSHB 70 (JUD): An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence.

The department supports CSHB 70 with the exception of Section 2. Section 2 (6) and (7) give the board, as opposed to the department, the authority to hire an executive secretary and contract with private organizations to establish an impaired physicians program. The department has the fiscal responsibility for all occupational areas including the hiring of state employees and the negotiation of all contracts. The department supports the intent of the legislation but would recommend Section 2, AS 08.64.101 be amended to read:

(6) The department shall, after consultation with the board, hire an executive secretary and contract with private professional organizations to establish an impaired medical professional program to treat persons licensed under this chapter who abuse addictive substances.

This provision would ensure that once the board raised licensing fees to cover the additional costs of having an executive secretary, the department would request the position in the budget. If the Legislature approved the position, the department would utilize the revenue collected from licensing fees to hire the position. This procedure is currently utilized to employ an executive secretary for the Board of Nursing and to monitor impaired nurses.

In summary, the department would support the bill in its entirety if Section 2 were amended as recommended above.



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

DATE: 3/17/87

# 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 fac-

tors 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.

## 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-

From the Office of the Inspector General, US Department of Health and Human Services, Washington, DC. Ms Handley is now with the Health Care Financing Administration, Washington, DC.

Reprint requests to Office of the Inspector General, US Department of Health and Human Services, 330 Independence Ave SW, Washington, DC 20201 (Mr Kusserow).

lent 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.<sup>1</sup>

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.<sup>2,3</sup>

Meanwhile, the number of FMGs receiving initial state licenses was rising, from 3131 in 1981 to 4763 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' educa-

tion 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, p 1) 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."<sup>4</sup>

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

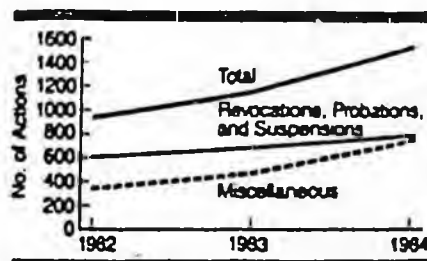
Boards have experienced other significant changes in recent years in addition to rising work loads greater than the resources to deal with them. Both the organizational structure and size of boards have changed. While in 1969, only 16 boards were housed under the aegis of a central agency, currently 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



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

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.

### 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."<sup>8</sup>) 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."<sup>1</sup>

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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<sup>2</sup> 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.<sup>3</sup> 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*,<sup>4</sup> 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<sup>5</sup> 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*<sup>6</sup> 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.<sup>7</sup> 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.<sup>8</sup> 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.<sup>8</sup> 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

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

CC: Towell  
HAA Exec Committee

JANUARY 1987

ANTITRUST IMMUNITY  
FOR HOSPITALS AND  
PHYSICIAN PEER  
REVIEWERS

HOSPITAL LAW  
CHAPTER: AIDS



FEB 3 1987

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## 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.

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

# Liability 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-

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 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 — (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 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 (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 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 (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 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-Kit for hospital law is written by members of the firm of Harty, Springer & Mattem, P.C.

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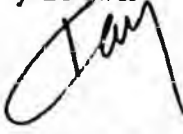
# Kay Brown

## Alaska State Legislature House of Representatives

### MEMORANDUM

TO: Representative Al Adams, Chair  
House Finance Committee

FROM: Representative Kay Brown

DATE: April 1, 1987 

RE: Proposed CS HB 70 (Finance)

The House Finance subcommittee on HB 70 recommends the attached draft CS for consideration by the full committee. Also attached are a sectional analysis of the draft CS, as well as a sectional which identifies the specific changes made to the Judiciary version of the bill.

#### Changes to the Judiciary version of HB 70:

Briefly, the significant changes include:

1. An alternative funding mechanism which allows the Department of Commerce to levy a one-time surcharge to raise funds sufficient to cover additional staff for the Medical Board (this will be accompanied by the authorization of two new positions in the budget). Also, the Division of Occupational Licensing statutes are changed to ensure that services provided by the Division to a particular Board reflect the fees collected from that profession.
2. Incorporation of an extension of the sunset date for the Medical Board to June 30, 1991.
3. Modification of the language of the Judiciary version to provide that the Medical Board "coordinate" (rather than "contract") with private organizations to establish an impaired physicians program. Also, the draft CS requires that the Department, rather than the Board, hire the new personnel.

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4. Further definition and conditioning of the the circumstances under which certain reports to the Medical Board may become public.

Please refer to the attached sectional analyses for additional detail on the changes.

Fiscal Note

A fiscal note in the amount of \$89.8 thousand is also attached. The costs would be entirely funded with new program receipts (i.e., with the surcharge in FY 88 and by increased license fees in future years).

Attachments

(2) at the request of the State Medical Board, conduct investigations based on complaints filed with the department or with the board; and

(3) be directly responsible and accountable to the State Medical Board, except that only the department has authority to terminate the investigator's employment and the department shall provide day to day and administrative supervision of the investigator. (§ 1 ch 59 SLA 1966; am § 1 ch 102 SLA 1976; am § 39 ch 218 SLA 1976; am § 2 ch 258 SLA 1976; am §§ 1, 2 ch 49 SLA 1980; am § 1 ch 82 SLA 1980; am § 2 ch 141 SLA 1980; am § 1 ch 166 SLA 1980; am § 1 ch 48 SLA 1983; am § 3 ch 56 SLA 1986; am § 3 ch 131 SLA 1986)

Revisor's notes. — Minor word changes were made in 1986 to reconcile amendments made to (a)(4) and (a)(9) of this section by chapters 56 and 131, SLA 1986.

Effect of amendments. — The 1983 amendment added subsection (c).

The first 1986 amendment, effective May 30, 1986, in subsection (a) in the introductory language substituted "perform" for "provide," added "or as determined by the department under AS 08.45 for naturopaths" at the end of paragraph (4), added "or as authorized by the department under AS 08.45 for naturopaths" at the end of paragraph (9), and substituted "that" for "which" in paragraph (15).

The second 1986 amendment in subsection

(a) at the end of paragraph (4) added the language beginning "or as determined," at the end of paragraph (9) added the language beginning "or as authorized," and in paragraph (15) substituted "that" for "which."

Editor's notes. — Section 9, ch. 56, SLA 1986 provides: "The Department of Commerce and Economic Development shall establish a committee to develop recommendations on whether the licensure of naturopaths should be by an existing board, a new board, or the division of occupational licensing. The committee shall provide the legislature with a report of its recommendations on or before the 10th day of the First Session of the Fifteenth Legislature."

Sec. 08.01.065. Fees established by regulation. (a) 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.

(b) The department may not adopt a regulation under (a) of this section unless the board responsible for regulating the affected occupation concurs.

(c) A fee established under this section must reflect, to the extent possible, the actual costs to the department of the activity for which the fee is charged.

(d) The commissioner of administration shall separately account for occupational licensing fees deposited in the general fund by the department. The annual estimated balance in the account may be used by the legislature to make appropriations to the department to carry out the activities of the division of occupational licensing. (§ 2 ch 37 SLA 1985; am § 4 ch 138 SLA 1986)

Scrappers.

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Chapter 64. Medicine.

Article

- 1. State Medical Board (§§ 08.61.010 -- 08.61.010, 08.61.085, 08.61.101, 08.61.101)
- 2. Licensing (§§ 08.61.170, 08.61.200, 08.61.210, 08.61.250, 08.61.300, 08.61.270, 08.61.275 -- 08.61.290, 08.61.311, 08.61.315, 08.61.320, 08.61.325, 08.61.326, 08.61.330, 08.61.331, 08.61.336, 08.61.350)
- 3. Unlawful Acts (§ 08.61.300)
- 4. Miscellaneous Provisions (§ 08.61.366)
- 5. General Provisions (§§ 08.61.370, 08.61.380)

Editor's notes. — Section 7, ch. 33, SLA 1985 provides: "Notwithstanding AS 08.64, a lay midwife practicing in this state on May 24, 1985 who is not registered by the Department of Health and Social Services may continue to practice

until the department adopts regulations under AS 18.05.010 for the practice of lay midwifery and completes any review of the midwife's credentials required by the regulations. The midwife shall cooperate with the department in the review."

Article 1. State Medical Board.

Section

- 10. Creation and membership of State Medical Board
- 20. Term of office
- 30. [Repealed]

Section

- 40. Removal of members
- 85. Meetings of the board
- 101. Duties
- 140. [Repealed]

Sec. 08.61.010. Creation and membership of State Medical Board. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting 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. (§ 35-3-82 ACIA 1949; am § 1 ch 148 SLA 1970; am § 11 ch 102 SLA 1976; am § 3 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment, deleted "licensed" preceding "physicians," inserted "licensed in the state and" following "physicians," substi-

tuted "geographical areas of the state" for "Alaska judicial districts," and made a minor punctuation change.

Sec. 08.64.020. Term of office. Members shall be appointed for staggered terms of four years, subject to confirmation by a majority of the members of the legislature in joint session, and shall hold office until their successors are appointed and qualified. A person who has served two successive complete terms may not be reappointed until four years after the expiration of the second term. (§ 35-3-82 ACIA 1949; am § 4 ch 107 SLA 1969; am § 12 ch 102 SLA 1976; am § 4 ch 48 SLA 1983)

Effect of amendments. -- The 1983 amendment inserted "a term" and rewrote the second sentence.

*Sec. 08.61.040. Substitution of members. [Repealed, § 19 ch 48 SLA 1983.]*

**Sec. 08.61.040. Removal of members.** The governor may remove a member of the board for cause. The board may by regulation provide that unexcused absences from meetings is cause for removal. (§ 35-3-84 ACIA 1949; am § 5 ch 48 SLA 1983)

Effect of amendments. -- The 1983 amendment added the second sentence.

**Sec. 08.61.050. Oath of office.** Each member shall take an oath of office. The oath shall be filed and preserved in the division of occupational licensing of the department. (§ 35-3-83 ACIA 1949; am § 1 ch 77 SLA 1969; am § 1 ch 101 SLA 1974)

**Sec. 08.61.060. Seal.** The board shall adopt a seal. (§ 35-3-83 ACIA 1949)

**Sec. 08.61.070. Officers.** The board shall elect a president and secretary from among its members. The president and secretary may administer oaths. (§ 35-3-83 ACIA 1949; am § 2 ch 77 SLA 1969)

**Sec. 08.61.080. Meetings of board.**  
Repealed by § 3 ch 59 SLA 1966.

Editor's notes. -- The repealed section derived from § 35-3-83, ACIA 1949.

**Sec. 08.61.085. Meetings of the board.** The board shall meet at least four times a year. (§ 6 ch 48 SLA 1983)

**Sec. 08.61.090. Quorum.** Four members of the board constitute a quorum for the transaction of all business properly before the board. (§ 35-3-83 ACIA 1949; am § 3 ch 148 SLA 1970; am § 13 ch 102 SLA 1976)

Cross references. -- As to notes to AS 09.55.296 and Alas. Const., constitutionality of ch 102, SLA 1976, see art II, § 14.

**Sec. 08.61.100. Power of board to adopt regulations.** The board may prescribe and establish rules and regulations necessary to carry into effect the provisions of this chapter. (§ 35-3-95 ACIA 1949)

Sec. 08.61.101. 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. (§ 7 ch 48 SLA 1983)

Sec. 08.61.105. Regulation of abortion procedures.

Opinions of attorney general. -- Separation of responsibilities in AS 18.16.010 is clear; the approval of facilities is granted to the Department of Health and Social Services; the ethical and professional responsibilities of medical doctors are committed to the supervision of the State Medical Board. No language in this section vitiates any of the responsibilities granted in 18.16.010 (a) (2) to the Department of Health and Social Services. October 7, 1974 Op. Atty Gen.

Sec. 08.64.107. Regulation of physician assistants and intensive care paramedics. The board shall adopt regulations regarding the registration of physician assistants and physician-trained mobile intensive care paramedics, and the medical services that each may

perform, including but not limited to (1) the educational and other qualifications, (2) the application and registration procedures, (3) the scope of activities authorized, and (4) the responsibilities of the supervising or training physician. (§ 2 ch 101 SLA 1974)

Sec. 08.64.110. Per diem and expenses. The members of the board are entitled to per diem and expenses authorized by law. (§ 35-3-95 ACIA 1949)

Revisor's note. -- This section was 1953, as amended by § 1, ch. 34, SLA implicitly amended by § 1, ch. 130, SLA 1960.

Sec. 08.64.120. Coverage of funds and warrants for expenses. Repealed by § 3 ch 59 SLA 1966.

Editor's notes. -- The repealed section derived from § 35-3-95, ACIA 1949.

Sec. 08.64.130. Board records. The board shall preserve a record of its proceedings, which shall contain the name, age, residence and duration of residence of each applicant for a license, the time spent by the applicant in medical study, the place of medical study, and the year and school from which degrees were granted. The record shall also show whether the applicant was granted a license or rejected. (§ 35-3-84 ACIA 1949)

Editor's notes. -- This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 1, Chapter 58, SLA 1982.

Sec. 08.64.140. Annual report to governor. [Repealed, § 19 ch 48 SLA 1983.]



Sec. 08.64.190. Application for license. A person who desires to practice medicine, osteopathy or acupuncture in the state shall apply in writing to the department for a license. (§ 35-3-85 ACIA 1949; am § 1 ch 22 SLA 1960; am § 4 ch 143 SLA 1968; am § 3 ch 77 SLA 1969; am § 2 ch 21 SLA 1974)

Sec. 08.64.190. Contents of application. The application shall state the name, age, residence, the duration of residence, the time spent in medical or osteopathy study, the place, year and school in which degrees were granted, and other information the board considers necessary. The application shall be made under oath. (§ 35-3-85 ACIA 1949; am § 1 ch 22 SLA 1960; am § 4 ch 77 SLA 1969)

§ 08.64.200

ALASKA STATUTES SUPPLEMENT

§ 08.64.250

Sec. 08.64.200. Qualifications of physician applicants. Except for foreign medical graduates as specified in AS 08.64.225, each physician applicant shall

(1) *[Repealed, § 19 ch 48 SLA 1983.]*

(2) submit a certificate of graduation from a legally chartered medical school accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association;

(3) submit a certificate from a recognized hospital certifying that the applicant has satisfactorily performed the duties of resident physician or intern for a period of one year;

(4) not have a license to practice medicine in another state, province, or territory which is currently suspended or revoked for disciplinary reasons; and

(5) be a citizen of the United States or be lawfully admitted for permanent residence. (§ 35-3-85 ACIA 1949; am § 1 ch 22 SLA 1960; am § 1 ch 18 SLA 1963; am § 5 ch 77 SLA 1969; am §§ 5, 6 ch 148 SLA 1970; am § 1 ch 85 SLA 1972; am § 5 ch 101 SLA 1974; am § 19 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment repealed paragraph (1).

Sec. 08.64.205. Qualifications for osteopath applicants. Each osteopath applicant shall meet the qualifications prescribed in AS 08.64.200(1), (4) and (5) and shall

(1) submit a certificate of graduation from the legally chartered school of osteopathy approved by the board;

Sec. 08.64.207. Qualifications for acupuncture applicants. Each acupuncture applicant shall meet all of the qualifications prescribed in AS 08.64.200 and shall meet those requirements of experience or education in the practice of acupuncture as may be required by the board. (§ 3 ch 21 SLA 1974)

(2) submit a certificate from a hospital approved by the American Medical Association or the American Osteopathic Association which certifies that the osteopath has satisfactorily completed and performed the duties of intern or resident physician for one year;

(3) take the examination required by AS 08.64.210 or be certified to practice by the National Board of Examiners for Osteopathic Physicians and Surgeons. (§ 1 ch 56 SLA 1966; am § 6 ch 77 SLA 1969; am § 7 ch 148 SLA 1970; am § 6 ch 101 SLA 1974)

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

**Sec. 08.64.209. Qualifications for podiatry applicants.** (a) Each applicant who desires to practice podiatry shall meet the qualifications prescribed in AS 08.64.200(1) and (4) and shall

(1) submit a certificate of graduation from a legally chartered school of podiatry approved by the board;

(2) take the examination required by AS 08.64.210; the State Medical Board shall call to its aid a podiatrist of known ability who is licensed to practice podiatry to assist in the examination and licensure of applicants for a license to practice podiatry;

(3) meet other qualifications of experience or education which the board may require.

(b) The provisions of AS 08.64.180 — 08.64.190, 08.64.220, and 08.64.230 — 08.64.380 relating to the practice of medicine or osteopathy apply to the application procedure, testing, and practice of podiatry, as appropriate. (§ 3 ch 24 SLA 1976)

**Sec. 08.64.210. Examination required.** (a) The applicant shall take examinations in subjects the board considers necessary, unless excused under provisions of AS 08.64.250.

(b) The application for examination shall be submitted to the board at least 40 days before the examination date. (§ 35-3-85 ACLA 1949; am § 1 ch 22 SLA 1960; am § 7 ch 77 SLA 1969; am § 8 ch 148 SLA 1970)

**Sec. 08.64.215. Insurance required.**

Repealed by § 40 ch 177 SLA 1978.

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Sec. 08.64.220. Contents of examination and grading. (a) The board shall make the examination written and oral and sufficient to test the applicant's fitness to practice medicine or osteopathy.

(b) Repealed by § 27 ch 148 SLA 1970.

(c) The examinations, answers and scores shall be preserved and filed. (§ 35-3-85 ACLA 1949; am § 1 ch 22 SLA 1960; am §§ 8, 9 ch 77 SLA 1969; am §§ 9, 27 ch 148 SLA 1970)

Sec. 08.64.225. Foreign medical graduates. Applicants who are graduates of medical colleges not accredited by the American Medical Association or one of its agencies shall meet the requirements of AS 08.64.200(1), (3), (4) and (5) and must have passed an examination and be certified by the Education Council on Foreign Medical Graduates, or be licensed by examination in another state or territory of the United States or province of Canada. (§ 10 ch 77 SLA 1969; am § 10 ch 148 SLA 1970; am § 7 ch 101 SLA 1974)

Sec. 08.64.230. License granted. (a) If the physician applicant passes the examination and meets the requirements of AS 08.64.200, the board shall grant a license to the applicant to practice medicine in the state.

(b) If the osteopath applicant passes the examination and meets the requirements of AS 08.64.205, the board shall grant a license to the applicant to practice osteopathy in the state.

(c) Each license shall be signed by the secretary and president of the board, and have the seal of the board affixed to it. (§ 35-3-85 ACLA 1949; am § 1 ch 22 SLA 1960; am § 11 ch 77 SLA 1969)

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.64.240. License refused. (a) The board may not grant a license if

- (1) the applicant fails or cheats during the examination;
- (2) the board determines that the applicant is professionally unfit to practice medicine or osteopathy in the state; or
- (3) the applicant fails to comply with a requirement of this chapter.

(b) The board may refuse to grant a license to any applicant for the same reasons that it may impose disciplinary sanctions under AS 08.64.326. (§ 35-3-85 ACLA 1949; am § 1 ch 22 SLA 1960; am § 12 ch 77 SLA 1969; am § 11 ch 148 SLA 1970; am § 9 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment rewrote this section.

Sec. 08.64.250. License by credentials. The board may waive the examination requirement and license by credentials if the physician or podiatry applicant meets the requirements of AS 08.64.200 or 08.64.209, submits proof of continued competence as required by regulation, pays the required fee and has

- (1) an active license from a board of medical examiners established under the laws of a state or territory of the United States or a province of Canada issued after thorough examination; or

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(2) passed an examination given by the National Board of Medical Examiners or the Federation of State Medical Boards of the United States if the applicant is a physician, or passed an examination given by the National Board of Podiatry Examiners if the applicant is a podiatrist. (§ 35-3-85 ACLA 1949; am § 1 ch 22 SLA 1960; am § 13 ch 77 SLA 1969; am § 8 ch 69 SLA 1970; am § 12 ch 148 SLA 1970; am § 10 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment, in the undesignated, introductory language substituted "credentials" for "endorsement," inserted "or podiatry," and inserted "or 08.61.209, sub-

mits proof of continued competence as required by regulation"; and, at the end of paragraph (2), added the language beginning "if the applicant is a physician."

**Sec. 08.64.255. Interview required.** All applicants for 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 shall be recorded, and, if the application is denied on the basis of the interview, the denial shall be stated in writing with the reasons for it, and the record shall be preserved. (§ 14 ch 77 SLA 1969; am § 13 ch 148 SLA 1970)

**Sec. 08.61.260. Re-examination.** (a) If the applicant fails the examination, the applicant may, on the same application and payment of a reexamination fee, take another examination not less than six months nor more than two years after the date of the first examination. If the applicant fails a second examination, the applicant may, after a year or more of further study or training approved by the board, make a new application for licensure.

(b) Applicants failing every portion of the examination shall retake the entire examination and pay the full examination fee.

(c) [See effective date note] Applicants failing portions of part I or part II of the examination may retake the portions failed at a prorated fee.

(d) [See effective date note] Applicants failing part III of the examination shall retake the entire part at a prorated fee. (§ 35-3-92 ACLA 1949; am § 15 ch 77 SLA 1969; am § 14 ch 148 SLA 1970; am §§ 36, 37 ch 37 SLA 1985)

Effect of amendments. -- The 1985 amendment deleted "prescribed in the regulations by the board" at the end of subsections (c) and (d).

ment to this section is effective upon the adoption of regulations under AS 08.01.065. For the law until that date, see the effect of amendments notes.

Effective dates. — The 1985 amend-

**Sec. 08.61.270. Temporary permits.** (a) The board may issue a temporary permit to an applicant who meets the requirements of AS 08.64.200, 08.64.205, or 08.64.209 and pays the required fee.

(b) A temporary permit is valid for eight months or until the board meets to consider the application, whichever occurs first.

(c) A temporary permit may be renewed at the board's discretion one time only. (§ 35-3-96 ACLA 1949; am § 16 ch 77 SLA 1969; am § 15 ch 148 SLA 1970; am §§ 2, 3 ch 85 SLA 1972; am § 8 ch 101 SLA 1974; am § 11 ch 48 SLA 1983)

§ 08.64.270

§ 08.64.272

BUSINESS AND PROFESSIONS

§ 08.64.280

Board of Medical  
of the United  
States § 13 ch 77  
(1970)

later enactment

**Sec. 08.64.272. Residency and internship.** For the limited purpose of doing residency or internship work, the board may issue a temporary permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(1) and (2), pays the required fee, and has been accepted by an eligible institution in the state for the purpose of doing residency or internship work. (§ 16 ch 148 SLA 1970)

**Sec. 08.64.275. Temporary permit for locum tenens practice.**  
(a) A member of the board may grant a temporary permit to a physician or osteopath for the purpose of substituting for another physician or osteopath licensed in this state. The permit is valid for 120 consecutive days. If circumstances warrant, an extension of the permit may be granted by the board.

(b) A physician applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.200. In addition, the physician shall submit evidence of holding a license to practice medicine in a state or territory of the United States or in a province of Canada.

(c) An osteopath applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.205. In addition, the osteopath shall submit evidence of holding a license to practice in a state or territory of the United States or in a province of Canada.

(d) [See effective date note] Within 10 days after the permit has been granted, the board member shall forward to the department a report of the issuance of the permit. (§ 17 ch 77 SLA 1969; am §§ 17 -- 19 ch 148 SLA 1970; am § 38 ch 37 SLA 1985)

*Effect of amendments.* -- The 1985 amendment in subsection (d) substituted "after" for "from" and "permit has been granted" for "granting of the permit" and deleted "the fee" following "forward" and "with" following "department."

*Effective dates.* -- The 1985 amendment to this section is effective upon the adoption of regulations under AS 08.01.065. For the law until that date, see the effect of amendments note.

**Sec. 08.64.280. Record of license.** [Repealed, § 10 ch 37 SLA 1986.]

**Sec. 08.64.290. Examination fee.** [See postponed repeal note.]

*Postponed repeal.* -- The 1985 repeal of this section is effective upon the adoption of regulations under AS 08.01.065.

**Sec. 08.64.300. Fee for license by reciprocity.**

Repealed by § 19 ch 77 SLA 1969.

*Editor's notes.* -- The repealed section derived from § 35-3-86, ACLA 1949.

**Sec. 08.64.310. Annual license fee.**

Repealed by § 20 ch 77 SLA 1969.

*Editor's notes.* -- The repealed section derived from § 35-3-87, ACLA 1949.

Sec. 08.64.311. License renewal. Licenses shall be renewed four years after the date of issue. (§ 20 ch 77 SLA 1969; am § 21 ch 148 SLA 1970; am § 12 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment substituted "four years after the date of issue" for "biennially."

Sec. 08.64.312. Continuing education requirements. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by the physician giving evidence satisfactory to the board that the physician is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period. (§ 14 ch 102 SLA 1976)

Cross references. — As to constitutionality of ch. 102, SLA 1976, see notes to AS 09.55.536 and Alas. Const., art. II, § 14. redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Editor's notes. — This section was

Sec. 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 in Alaska, the licensee may not hold an inactive license. (§ 21 ch 148 SLA 1970)

Sec. 08.64.315. Fees [See effective date note]. The 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.

(§ 21 ch 77 SLA 1969; am § 22 ch 148 SLA 1970; am § 13 ch 48 SLA 1983; am § 39 ch 37 SLA 1985)

Effect of amendments. - The 1983 amendment increased the fees imposed under this chapter, in paragraph (3) substituted "credentials" for "endorsement," and in paragraphs (6) and (7) deleted "biennial" following "renewal."

The 1985 amendment rewrote this section, which included a fee schedule.

Effective dates. - The 1985 amendment to this section is effective upon the adoption of regulations under AS 08.01.065. For the law until that date, see the editor's note.

Editor's notes. - Prior to the adoption of regulations under AS 08.01.065, this section reads: "The following fees are imposed under this chapter:

(1) application .....	\$50
(2) license by examination .....	500
(3) license by credentials or waiver of examination .....	200
(4) temporary permit .....	50
(5) locum tenens permit .....	50
(6) license renewal, active .....	600
(7) license renewal, inactive .....	300
(8) license by reexamination .....	150"

Sec. 08.64.320. Disposition of fees. [See postponed repeal note.]

Postponed repeal. - The 1985 repeal of this section is effective upon the adoption of regulations under AS 08.01.065.

Sec. 08.64.325. Limits or conditions on license; discipline. [Repealed, § 19 ch 48 SLA 1983.]

Sec. 08.64.326. Grounds for imposition of disciplinary sanctions. (a) The board may impose a sanction if the board finds after a hearing that a licensee

- (1) secured a license through deceit, fraud, or intentional misrepresentation;
  - (2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities;
  - (3) advertised professional services in a false or misleading manner;
  - (4) has been convicted, including conviction based on a guilty plea or plea of nolo contendere, of
    - (A) a felony or other crime if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee;
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(B) a crime involving the unlawful procurement, sale, prescription or dispensing of drugs;

(5) has procured, sold, prescribed or dispensed drugs in violation of a law, regardless of whether there has been a criminal action;

(6) intentionally or negligently permitted 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) failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board;

(8) has demonstrated

(A) professional incompetence, gross negligence or repeated negligent conduct;

(B) addiction to, severe dependency on, or habitual overuse of alcohol or other drugs which impairs the licensee's ability to practice safely;

(C) unfitness because of physical or mental disability;

(9) engaged in unprofessional conduct or in lewd or immoral conduct in connection with the delivery of professional services to patients;

(10) has violated AS 18.16.010;

(11) has violated any code of ethics adopted by regulation by the board;

(12) has denied care or treatment to a patient or person seeking assistance from the physician if the only reason for the denial is the failure or refusal of the patient to agree to arbitrate as provided in AS 09.55.535(a); or

(13) has had a license or certificate to practice medicine in another state, territory of the United States or a province of Canada suspended or revoked unless the suspension or revocation was caused by the failure of the licensee to pay fees to that state, territory or province.

(b) In a case involving (a)(13) of this section, the final findings of fact, conclusions of law and order of the authority that suspended or revoked a license or certificate constitutes a prima facie case that the license or certificate was suspended or revoked and the grounds under which the suspension or revocation was granted. (§ 14 ch 48 SLA 1983)

#### NOTES TO DECISIONS

Professional incompetence standard not unconstitutionally vague. — Statutory and regulatory standard of "professional incompetence" under which physician's license may be revoked is not unconstitutionally vague. *Storrs v. State*

*Medical Bd.*, Sup. Ct. Op. No. 2661 (File No. 6882), 664 P.2d 547, cert. denied, 464 U.S. 937, 104 S. Ct. 346, 78 L. Ed. 2d 312 (1983), decided under former AS 08.64.330. See *Rosi v. State Medical Bd.*, Sup. Ct. Op. No. 2690 (File No. 7108), 665

P 2d 28, cert. denied, 347 U.S. 937, 104 S. Ct. 336, 78 L. Ed. 2d 512 (1953).

*Sec. 08.61.330. Grounds for revocation of license. [Repealed, § 19 ch 48 SLA 1983.]*

**Sec. 08.61.331. Disciplinary sanctions.** (a) If the board finds that a licensee has committed an act set out in AS 08.61.326(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 one or more of the sanctions set out in (1) - (6) of this subsection.

(b) The board may end the probation of a licensee if it finds that the deficiencies which required this sanction have been remedied.

(c) The board may summarily suspend a license before final hearing or during the appeals process if the board finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice. A person whose license is suspended under this section is entitled to a hearing by the board no later than seven days after the effective date of the order and the person may appeal the suspension after a hearing to a court of competent jurisdiction.

(d) The board may reinstate a license that has been suspended or revoked if the board finds after a hearing that the applicant is able to practice with reasonable skill and safety.

(e) The board may suspend a license upon receipt of a certified copy of evidence that a license to practice medicine in another state or territory of the United States or province of Canada has been suspended or revoked. The suspension remains in effect until a hearing can be held by the board.

(f) The board shall be consistent in the application of disciplinary sanctions. A significant departure from earlier decisions of the board involving similar situations must be explained in findings of fact or orders made by the board. (§ 15 ch 48 SLA 1983)

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Sec. 08.64.332. Automatic suspension for mental incompetency or insanity. Notwithstanding AS 44.62, if a person holding a license to practice medicine and surgery or osteopathy under this chapter is adjudged mentally incompetent or insane by any final order or adjudication by a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the licensee's license shall be automatically suspended by the board.

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§ 08.64.332

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§ 08.64.334

BUSINESS AND PROFESSIONS

§ 08.64.340

The suspension shall continue in effect until the licensee is found or adjudged by the court to be restored to reason or until the licensee is determined to be restored to reason by a licensed psychiatrist approved by the board. (§ 10 ch 101 SLA 1974)

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.64.334. Voluntary surrender. The board, at its discretion, may accept the voluntary surrender of a license. No license may be returned unless the board determines, under regulations established by it, that the licensee is competent to resume practice. However, no license may be returned to the licensee if the voluntary surrender resulted in the dropping or suspension of civil or criminal charges against the physician. (§ 10 ch 101 SLA 1974)

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

**Sec. 08.64.336. Duty of physicians and hospitals to report.** (a) A physician who professionally treats a person licensed to practice medicine and surgery 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 restricts or refuses to grant hospital privileges to a person licensed to practice medicine and 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 reasons for restricting or refusing to grant 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 of reasonable cause, may appoint a committee of three qualified physicians to examine the licensee and report their findings to the board.

(d) If the board finds that the licensee is unable to continue to practice medicine and surgery or osteopathy with reasonable safety to the licensee's patients or the public, it shall initiate action to suspend, revoke, limit or condition the licensee's license to the extent determined necessary for the protection of the public. (§ 10 ch 101 SLA 1974; am § 16 ch 48 SLA 1983)

*Effect of amendments.* - The 1983 amendment rewrote this section.

insane by any final  
action or by volun-  
of mental illness,  
ded by the board.

**Sec. 08.64.340. Statement of grounds of refusal or revocation of license.** If the board refuses to issue a license or revokes a license, it shall file a brief and concise statement of the grounds and reasons for the action in the office of the secretary of the board and in the depart-

ment. The statement, together with the written decision of the board, shall remain of record in the department. (§ 35-3-89 ACLA 1949; am § 23 ch 77 SLA 1969)

Article 3. Unlawful Acts.

Section

360. Penalty for practicing without a license or in violation of chapter

Sec. 08.64.360. Penalty for practicing without a license or in violation of chapter. Except for a physician assistant, a physician-trained mobile intensive care paramedic under AS 08.64.170, or a person licensed or authorized under another chapter of this title who engages in practices for which that person is licensed or authorized under that chapter, a person practicing medicine or osteopathy in the state without a valid license or permit is guilty of a class A misdemeanor. Each day of illegal practice is a separate offense. (§ 35-3-93 ACLA 1949; am § 25 ch 77 SLA 1969; am § 2 ch 5 SLA 1972; am § 11 ch 101 SLA 1974; am § 17 ch 48 SLA 1983)

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§ 08.64.360

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BUSINESS AND PROFESSIONS

§ 08.64.370

Effect of amendments. - The 1983  
amendment revise this section.

Article 4. Miscellaneous Provisions.

Section

366. Liability for services rendered by a

Section

physician-trained mobile intensive  
care paramedic

Sec. 08.64.366. Liability for services rendered by a physician-trained mobile intensive care paramedic. An act or omission of a physician-trained mobile intensive care paramedic done or omitted in good faith while rendering emergency service to a person who is in need of immediate aid in order to avoid serious harm or loss of life does not impose any liability upon the physician-trained mobile intensive care paramedic, the supervising physician, a hospital, the officers, members of the staff, nurses, or other employees of a hospital or upon a federal, state, borough, city or other local governmental unit or upon other employees of a governmental unit; however, this section does not relieve a physician or a hospital of a duty otherwise imposed by law upon the physician or hospital for the designation or training of a physician-trained mobile intensive care paramedic or for the provision or maintenance of equipment to be used by the physician-trained mobile intensive care paramedic. (§ 14 ch 101 SLA 1974; am § 1 ch 122 SLA 1986)

Cross references. - For civil liability  
for emergency aid, see AS 09.65.090.

Effect of amendments. -- The 1986  
amendment substituted "An" for "No" and  
substituted "while rendering emergency  
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Sec. 08.61.367. Prescription or administration of laetrile by physicians. (a) A physician may not be subject to disciplinary action by the State Medical Board for prescribing or administering amygdalin (laetrile) to a patient under the physician's care who has requested the substance unless the State Medical Board in a hearing conducted under the Administrative Procedure Act (AS 44.62) has made a formal finding that the substance is harmful.

(b) A hospital or health facility may not interfere with the physician-patient relationship by restricting or forbidding the use of amygdalin (laetrile) when prescribed or administered by a physician and requested by a patient unless the substance as prescribed or administered by the physician is found to be harmful by the State Medical Board in a hearing conducted under the provisions of the Administrative Procedure Act (AS 44.62). (§§ 1, 2 ch 227 SLA 1976)

Editor's notes. -- This section was with AS 01.05.031(c) and § 4, Chapter 58, redrafted by the revisor of statutes to SLA 1982. remove personal pronouns in conformity

Sec. 08.61.368. Permits for isolated areas.

Repealed by § 27 ch 148 SLA 1970.

#### Article 5. General Provisions.

##### Section

370. Persons not affected

380. Definitions

Sec. 08.61.370. Persons not affected. This chapter does not apply to

(1) officers in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties;

(2) a physician or osteopath, who is not a resident of this state, who is asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case;

(3) the practice of the religious tenets of a church;

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(4) a person while serving as a student, intern, resident physician, or fellow at a hospital, clinic, or medical facility in the state;

(5) a physician in the regular medical service of the United States Public Health Service or the armed services of the United States volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(6) a person who is registered as a lay midwife by the Department of Health and Social Services under AS 18.05.040 or who is excluded from registration under AS 18.05.057 while engaged in the practice of lay midwifery whether or not the person accepts compensation for those services. (§ 35-3-97 ACLA 1949; am § 4 ch 93 SLA 1965; am § 26 ch 77 SLA 1969; am §§ 23, 24 ch 148 SLA 1970; am §§ 1, 2 ch 88 SLA 1972; am § 13 ch 127 SLA 1974; am § 1 ch 33 SLA 1985)

Effect of amendments. -- The 1985 amendment designated former paragraphs (5) and (6) as present paragraphs (4) and (5) and added present paragraph (6).

See. 08.61.350. Definitions. As used in this chapter

(1) "board" means the State Medical Board;

(2) "practice of medicine" or "practice of osteopathy" means:

(A) for a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;

(B) to use or publicly display a title in connection with a person's name including "doctor of medicine," "physician," "M.D.," or "doctor of osteopathic medicine" or "D.O." or a specialist designation including "surgeon," "dermatologist," or a similar title, or any title which tends to show that the person is willing or qualified to diagnose or treat the sick or injured;

(3) [Repealed, § 19 ch 48 SLA 1983.]

(4) [Repealed, § 27 ch 148 SLA 1970.]

(5) "department" means the Department of Commerce and Economic Development;

(6) "acupuncture" means a medical practice to cure disease or relieve pain, alter function or induce anesthesia by piercing portions of the body with needles;

(7) "physician-trained mobile intensive care paramedic" means a person who

(A) has successfully completed the advanced first aid course prescribed by the board;

(B) is trained by a licensed physician

(i) to carry out all phases of cardio-pulmonary resuscitation,

(ii) to administer drugs under written or oral authorization of a licensed physician;

(iii) to administer intravenous solutions under written or oral authorization of a licensed physician; and

(C) has been examined and certified as a physician-trained mobile intensive care paramedic by the board or by the board's designated representatives;

(8) "emergency lifesaving service" means medical assistance given to a person whose physical condition, in the opinion of a reasonably prudent person, is such that the person's life is endangered;

(9) "practice of podiatry" means the medical, mechanical, and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the functions of the foot, and superficial lesions of the hand other than those associated with trauma; the use of preparations, medicines, and drugs as are necessary for the treatment of these ailments; the treatment of the local manifestations of systemic diseases as they appear in the hand and foot, except that

(A) a patient shall be concurrently referred to a physician or osteopath for the treatment of the systemic disease itself;

(B) general anaesthetics may be used only in colleges of podiatry approved by the State Medical Board and in hospitals approved by the joint commission on the accreditation of hospitals, or the American Osteopathic Association; and

(C) the use of X-ray or radium for therapeutic purposes is not permitted.

(10) "practice of lay midwifery" has the meaning given in AS 18.05.070. (§§ 35-3-88, 35-3-94 ACLA 1949; am § 27 ch 77 SLA 1969; am § 3 ch 103 SLA 1970; am §§ 25 - 27 ch 148 SLA 1970; am § 9 ch 32 SLA 1971; am § 1 ch 117 SLA 1971; am § 4 ch 85 SLA 1972; am § 4 ch 21 SLA 1974; am §§ 12, 13 ch 101 SLA 1974; am § 1 ch 127 SLA 1975; am § 4 ch 24 SLA 1976; am §§ 27 - 29, 41 ch 177 SLA 1978; am § 6 ch 45 SLA 1982; am §§ 18, 19 ch 48 SLA 1983; am § 2 ch 33 SLA 1985)

Effect of amendments. — The first 1983 amendment, rewrote paragraph (2). The second 1983 amendment repealed paragraph (3). The 1985 amendment added paragraph (10).

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2 CS FOR HOUSE BILL NO. 70 (Finance) am  
3 IN THE LEGISLATURE OF THE STATE OF ALASKA  
4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the State Medical Board and to  
7 services provided for boards established under AS 08;  
8 amending Rule 504(d) of the Alaska Rules of Evidence;  
9 and providing for an effective date."

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

11 \* Section 1. AS 08.01.050(c) is amended to read:

12 (c) After consulting with the State Medical Board (AS 08.64.-  
13 J10), the department shall employ two persons [AN INDIVIDUAL] who are  
14 not members [IS NOT A MEMBER] of the board; one shall [TO] be assigned  
15 as the investigator for the board; the other shall be assigned as the  
16 executive secretary for the board. The investigator shall

17 (2) at the request of the State Medical Board, conduct  
18 investigations based on complaints filed with the department or with  
19 the board; and

20 (1) conduct investigations into alleged violations of AS  
21 08.64, and into alleged violations of regulations and orders of the  
22 State Medical Board;

23 (3) be directly responsible and accountable to the State  
24 Medical Board, except that only the department has authority to termi-  
25 nate the investigator's employment and the department shall provide  
26 day to day and administrative supervision of the investigator.

27 \* Sec. 2. AS 08.01.065(c) is amended to read:

28 (c) A fee established under this section must reflect, to the  
29 extent possible, the actual costs to the department of the activity

1 for which the fee is charged. The actual or anticipated costs to the  
2 department of services provided to or on behalf of a board must re-  
3 fect, to the extent possible, the amount of fees the department  
4 collects from persons in occupations regulated by the board.

5 \* Sec. 3. AS 08.03.010(c)(11) is amended to read:

6 (11) State Medical Board (AS 08.64.010) -- June 30, 1991  
7 [JUNE 30, 1987].

8 \* Sec. 4. AS 08.64.101 is amended to read:

9 Sec. 08.64.101. DUTIES. The board shall

10 (1) examine and issue licenses to applicants;

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

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

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

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

22 (6) coordinate with private professional organizations to  
23 establish an impaired medical professionals program to treat persons  
24 licensed under this chapter who abuse addictive substances.

25 \* Sec. 5. AS 08.64.200 is amended by adding a new subsection to read:

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

29 \* Sec. 6. AS 08.64.210(b) is repealed and reenacted to read:

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

3 \* Sec. 7. AS 08.64.220(a) is repealed and reenacted to read:

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

6 \* Sec. 8. AS 08.64.255 is amended to read:

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

14 \* Sec. 9. AS 08.64.311 is repealed and reenacted to read:

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

18 \* Sec. 10. AS 08.64.313 is repealed and reenacted to read:

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

23 \* Sec. 11. AS 08.64.331(a) is amended to read:

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

- 26 (1) permanently revoke a license to practice;  
27 (2) suspend a license for a determinate period of time;  
28 (3) censure a licensee;  
29 (4) issue a letter of reprimand;

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

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

5 (B) limit practice to those areas prescribed;

6 (C) continue professional education until a satisfac-  
7 tory degree of skill has been attained in those areas determined  
8 by the board to need improvement;

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

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

12 (8) impose one or more of the sanctions set out in (1) -  
13 (7) [(.) - (6)] of this subsection.

14 \* Sec. 12. AS 08.64.332 is repealed and reenacted to read:

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

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

26 Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUS-  
27 PENSION OR SURRENDER. The board shall promptly report to the Federa-  
28 tion of State Medical Boards for inclusion in the nationwide disci-  
29 plinary data bank license refusals under AS 08.64.240, actions taken

1 by the board under AS 08.64.331, and license suspensions or surrenders  
2 under AS 08.64.332 or 08.64.334.

3 \* Sec. 14. AS 08.64.336 is repealed and reenacted to read:

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

12 (b) A hospital that revokes, suspends, conditions, restricts,  
13 or refuses to grant hospital privileges to, or imposes a consultation  
14 requirement on, a person licensed to practice medicine or osteopathy  
15 in the state shall report to the board the name and address of the  
16 person and the reasons for the action. A hospital shall also report  
17 to the board the name and address of a person licensed to practice  
18 medicine or osteopathy in the state if the person resigns hospital  
19 staff privileges while under investigation by the hospital or a com-  
20 mittee of the hospital and the investigation could result in the  
21 revocation, suspension, conditioning, or restricting of, or the re-  
22 fusal to grant, hospital privileges, or in the imposition of a consul-  
23 tation requirement. A report is required under this subsection re-  
24 gardless of whether the person voluntarily agrees to the action taken  
25 by the hospital. A report is not required if the sole reason for the  
26 action is the person's failure to complete hospital records in a  
27 timely manner or to attend staff or committee meetings. In this  
28 subsection "consultation requirement" means a restriction placed on a  
29 person's existing hospital privileges requiring consultation with a

1 designated physician or group of physicians in order to continue to  
2 exercise the hospital privileges.

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

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

19 (e) A physician, hospital, or hospital committee that in good  
20 faith submits a report under this section or participates in an inves-  
21 tigation or judicial proceeding related to a report submitted under  
22 this section is immune from civil or criminal liability for the sub-  
23 mission or participation.

24 (f) A physician or hospital may not refuse to submit a report  
25 under this section or withhold from the board or its investigators  
26 evidence related to an investigation under this section on the grounds  
27 that the report or evidence

28 (1) concerns a matter that was disclosed in the course of a  
29 confidential physician-patient or psychotherapist-patient relationship

1 or during a meeting of a hospital medical staff, governing body, or  
2 committee that was exempt from the public meeting requirements of  
3 AS 44.62.310; or

4 (2) is required to be kept confidential under AS 18.23.030.

5 \* Sec. 15. AS 08.64 is amended by adding a new section to read:

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

14 \* Sec. 16. AS 18.23.030 is amended by adding a new subsection to read:

15 (d) Notwithstanding the provisions of (b) and (c) of this  
16 section, information contained in a report submitted to the State  
17 Medical Board, and information gathered by the board during an inves-  
18 tigation, under AS 08.64.336 is not subject to subpoena or discovery  
19 unless and until the board takes action to suspend, revoke, limit, or  
20 condition a license of the person who is the subject of the report or  
21 investigation.

22 \* Sec. 17. Rule 504(d) of the Alaska Rules of Evidence is amended to  
23 read:

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

25 (1) Condition and Element of Claim or Defense. As to  
26 communications relevant to the physical, mental or emotional condition  
27 of the patient in any proceeding in which the condition of the patient  
28 is an element of the claim or defense of the patient, of any party  
29 claiming through or under the patient, of any person raising the

1 patient's condition as an element of his own case, or of any person  
2 claiming as a beneficiary of the patient through a contract to which  
3 the patient is or was a party; or after the patient's death, in any  
4 proceeding in which any party puts the condition in issue.

5 (2) Crime or Fraud. If the services of the physician or  
6 psychotherapist were sought, obtained or used to enable or aid anyone  
7 to commit or plan a crime or fraud or to escape detection or apprehen-  
8 sion after the commission of a crime or a fraud.

9 (3) Breach of Duty Arising Out of Physician-Patient Rela-  
10 tionship. As to a communication relevant to an issue of breach, by  
11 the physician, or by the psychotherapist, or by the patient, of a duty  
12 arising out of the physician-patient or psychotherapist-patient rela-  
13 tionship.

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

19 (5) Required Report. As to information that the physician  
20 or psychotherapist or the patient is required to report to a public  
21 employee, or as to information required to be recorded in a public  
22 office, if such report or record is open to public inspection, or as  
23 to information or matters contained in or reasonably raised by a  
24 report submitted under AS 08.64.336, other than information that would  
25 establish the identity of a patient, unless the court finds that it is  
26 necessary to admit the identifying information in order to serve the  
27 interests of justice.

28 (6) Examination by Order of Judge. As to communications  
29 made in the course of an examination ordered by the court of the

1 physical, mental or emotional condition of the patient, with respect  
2 to the particular purpose for which the examination is ordered unless  
3 the judge orders otherwise. This exception does not apply where the  
4 examination is by order of the court upon the request of the lawyer  
5 for the defendant in a criminal proceeding in order to provide the  
6 lawyer with information needed so that he may advise the defendant  
7 whether to enter a plea based on insanity or to present a defense  
8 based on his mental or emotional condition.

9 (7) Criminal Proceeding. For physician-patient communica-  
10 tions in a criminal proceeding. This exception does not apply to the  
11 psychotherapist-patient privilege.

12 \* Sec. 18. AS 08.64.260(b), (c), and (d) are repealed.

13 \* Sec. 19. The commissioner of commerce and economic development may  
14 impose a one-time surcharge on persons licensed under AS 08.64 to cover the  
15 costs during fiscal year 1988 of employing an investigator and an executive  
16 secretary for the State Medical Board required under AS 08.01.050(c), as  
17 amended by sec. 1 of this Act. In subsequent fiscal years, these positions  
18 shall be considered services to the State Medical Board for purposes of  
19 establishing fees under AS 08.01.065.

20 \* Sec. 20. Section 19 of this Act takes effect on the effective date of  
21 the section or sections of a version of the bill containing the operating  
22 budget for fiscal year 1988 that authorizes fiscal year 1988 funding for  
23 the positions of investigator and executive secretary of the State Medical  
24 Board, established under AS 08.01.050(c), as amended by sec. 1 of this Act.

SENATE COMMITTEE REPORT

FURTHER: JUDICIARY  
FINANCE

4/7/87

DATE TURNED INTO OFFICE \_\_\_\_\_

Mr. President:

LABOR & COMMERCE

Committee considered \_\_\_\_\_ CSHB 70(Fin) am

State Medical Board and to services provided for boards established under AS 08; amending Rule 504(d) of the Alaska Rules of Evidence; efd.

and recommended:

replace with \_\_\_\_\_ CS FOR \_\_\_\_\_ )  same title  
 or adopt \_\_\_\_\_ CS FOR \_\_\_\_\_ )  new title

attached amendment(s) and

do pass

do not pass

no recommendation

individual recommendations

further referral to \_\_\_\_\_

letter of intent adopted \_\_\_\_\_

Committee  attached or  adopted fiscal note(s)

new  updated or  previous  
 zero  fiscal impact - HOUSE

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

*[Handwritten signatures]*  
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*[Handwritten signature: Tim Kelly-DePau]*  
Chairman signature and recommendation

Committee Backup Attached

SENATE COMMITTEE REPORT

FURTHER: FINANCE

4/28/87

DATE TURNED INTO OFFICE 5/7/87

Mr. President:

JUDICIARY Committee considered CSHB 70(Fin)am

State Medical Board and to services provided for boards established under AS 03; amending Rule 504(d) of the Alaska Rules of Evidence; efd.

and recommended:

replace with SCS FOR CSHB 70 (JUD)  same title  
 or adopt \_\_\_\_\_  CS FOR \_\_\_\_\_  new title

attached amendment(s) and

*majority* do pass

do not pass

no recommendation

individual recommendations

further referral to \_\_\_\_\_

letter of intent adopted \_\_\_\_\_

Committee  attached or  adopted fiscal note(s)

new  updated or  previous  
 zero  fiscal impact *Name*

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

*John Foley*  
*Rep. Joe...*  
*Celia Sturgul...*  
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*[Signature]*  
Chairman signature and recommendation

Committee Backup Attached