HB
70

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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.

CS For HB 70 (Finance) am

SECTIONAL ANALYSIS
Revised April 7, 1987

Prepared by Rep. John Suna'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).

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

Section 13 (Page 4, Line 25) 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 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 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 15 (Page 7, Line 6) 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 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.

Section 17 (Page 7, 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 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

Bill Version : CS HB 70 (Finance)
Publish Date :

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
TOTAL OPERATING	0	89.8	89.8	89.8	89.8	89.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	89.8	89.8	89.8	89.8	89.8

FUNDING: (Thousands of Dollars)

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
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
TOTAL	0	89.8	89.8	89.8	89.8	89.8

POSITIONS:

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
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
44,292	Total

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

34,243	Salary
9,838	Benefits
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

ALASKA STATE MEDICAL BOARD

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

November 3, 1986

Dear Alaska Physician:

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

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

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

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

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

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

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

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

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

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

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

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

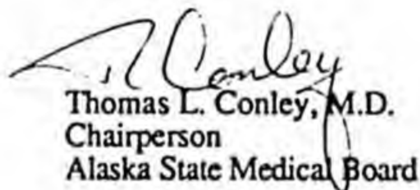
Practitioners should also be aware of board plans to institute a monitored treatment program in conjunction with the Alaska State Medical Association. This would be directed at physicians impaired by drug and alcohol use. Good studies show that up to 90% of at least alcohol impaired physicians can achieve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

   for 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.

Department of Commerce & Economic Development / POSITION PAPER

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.

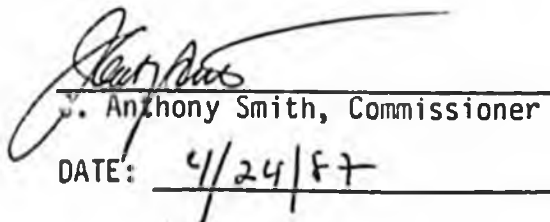
The executive secretary will enable the board to more effectively enforce disciplinary actions taken against physicians and will coordinate a treatment program for physicians who have substance abuse problems.

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

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