ALASKA LEGISLATURE COMMITTEE BILL FILES - 1987 - 1988 8879

HB 70 228

HB
70

# HOUSE COMMITTEE REPORT

(11)

Date referred: 3/11/87

FURTHER REFERRALS:

DATE: 4-2-87

The Finance Committee has considered HB 70

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

**RECOMMENDS:**

[X] replace with C.S. HB 70 (FINANCE)

[ ] the same title

[X] a new title

[ ] attached amendment(s)

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ____________ Committee

**ADOPTS:** [ ] ________ letter of intent

**ATTACHES NEW FISCAL NOTE(s):**

[X] fiscal impact

[ ] zero fiscal note

[ ] zero with analysis

[ ] same as previous fiscal note published ________

[ ] same as previous zero fiscal note published ________

**SIGNING DO PASS:**

Adams Al Adams

Pourchot Pat Pourchot

Larson [signature]

Gall [signature]

Swack [signature]

Boyer Mark Boyer

Rieger Steve Rieger

Frank [signature]

Wallis [signature]

Brown Kay Brown

Davis Mike Davis

**SIGNING OTHER RECOMMENDATIONS:**

Albert P. Adams
Chairman's signature

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 : Al Adams, Chair AA
Division : House Finance Committee
Phone : 465-3706
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

page ___ of ___

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

Original sponsors: Sund, Koponen, Taylor and Zawacki

1 IN THE HOUSE BY THE FINANCE COMMITTEE

2 CS FOR HOUSE BILL NO. 70 (Finance)

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 <u>two persons</u> [AN INDIVIDUAL] who <u>are</u>
14 <u>not members</u> [IS NOT A MEMBER] of the board<u>; one shall</u> [TO] be assigned
15 as the investigator for the board<u>; the other shall be assigned as the</u>
16 <u>executive secretary for the board</u>. The investigator shall

17 (1) conduct investigations into alleged violations of AS
18 08.64, and into alleged violations of regulations and orders of the
19 State Medical Board;

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

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

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

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

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

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

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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

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

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

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

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

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

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

* Sec. 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) [(1) - (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

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

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

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

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

person's existing hospital privileges requiring consultation with a designated physician or group of physicians in order to continue to exercise the hospital privileges.

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

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

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

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

(1) concerns a matter that was disclosed in the course of a

confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STATE OF ALASKA 1987 LEGISLATIVE SESSION
## FISCAL NOTE

Bill Version : CSHB 70 (Jud.)
Publish Date : 3/11/87

**REQUEST:**

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

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

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

| OPERATING | FY 87 | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 48.8 | 48.8 | 48.8 | 48.8 |
| 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 | 1.4 | 50.2 | 50.2 | 50.2 | 50.2 |
| CAPITAL | | | | | | |
| REVENUE | 0 | 0 | 50.2 | 50.2 | 50.2 | 50.2 |

**FUNDING:** (Thousands of Dollars)

| | FY 87 | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 |
|---|---|---|---|---|---|---|
| GENERAL FUND | 0 | 1.4 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 50.2 | 50.2 | 50.2 | 50.2 |
| TOTAL | 0 | 1.4 | 50.2 | 50.2 | 50.2 | 50.2 |

**POSITIONS:**

| | FY 87 | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 1 | 1 | 1 | 1 |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

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

(See Attached)

Prepared by : Jennifer Strickler, Management Analyst
Phone : 465-2144
Division : Occupational Licensing
Date : 3/16/87

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

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

Funding for the State Medical Board is currently budgeted in the department's operating budget and, therefore, new funds are not required for the remainder of FY 87.

Section 13 of the bill grants the board the authority to order a licensee to submit to a medical or psychiatric examination. In FY 88, the board will require approximately $1,400.00 in general funds to cover examination costs. During FY 88, medical licensing fees will be adjusted in order to support the hiring of an Executive Secretary and to cover the medical or psychiatric examination costs through program receipts for FY 89. This does not mean to imply that licensing fees will be carried from one fiscal year to the next but instead, medical licenses are due for renewal in FY 89 and the adjusted fees should be able to support the new costs incurred with hiring of an Executive Secretary and ordering examinations.

# STATE OF ALASKA 1987 LEGISLATIVE SESSION
# FISCAL NOTE

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

**REQUEST:**

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 | | | | | | |
| TOTAL OPERATING | | -0- | -0- | -0- | -0- | -0- |

| | | | | | | |
|---|---|---|---|---|---|---|
| CAPITAL | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| REVENUE | | | | | | |

**FUNDING:** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | | -0- | -0- | -0- | -0- | -0- |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | | | | | | |

**POSITIONS:**

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

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

Please see attached analysis.

Prepared by: Richard I. Peques, Director
Phone: 465-3672
Division: Administrative Services
Date: April 13, 1987
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

RECEIVED
APR 13 1987
LEGISLATIVE FINANCE

## CONTINUATION of FISCAL NOTE ANALYSIS

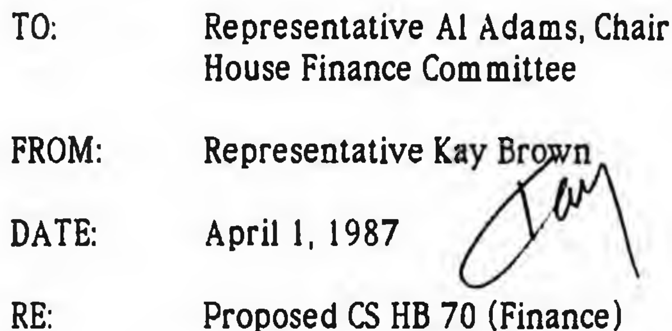
For Bill/Resolution No. CSHB 70 (Fin)

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.

# Kay Brown

**Alaska State Legislature**
**House of Representatives**


**M E M O R A N D U M**



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

CS For HB 70 ( )
Revised March 30, 1987

SECTIONAL ANALYSIS

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).

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.

CHANGES MADE TO CS HB 70 (Judiciary) IN PROPOSED FINANCE SUBCOMMITTEE CS

March 30, 1987
Version #2

(Prepared by Rep. John Sund's office)

1. TITLE

The title of the bill was changed to allow for the change in section 2 of the proposed CS which applies to all occupational licensing boards, not just the State Medical Board.

2. FUNDING MECHANISM

Section 1 of CS HB 70 (Judiciary) was deleted. That section specified that the State Medical Board would receive in allocations the amount collected by the Board for licensing. It also gave the Department of Commerce and Economic Development the authority to transfer funds within its appropriations to the Board without approval of the Office of Management and Budget as specified in AS 37.07.080(e).

The intent of this section was replaced with sections 2, 19 and 20 in the proposed Finance Subcommittee CS.

Section 2 of the subcommittee CS (Page 1, Line 27) adds to present statute that services provided by all state occupational licensing boards will reflect the fees collected by the boards. Note that this section applies to all boards -- not just the Medical Board.

Section 19 of the subcommitee CS (Page 9, Line 14) allows the Department to levy a one-time Medical Board licensee surcharge to cover the costs of additional Board staff as provided for in this bill. All physician licenses are expiring Dec. 31, 1988. The surcharge for fiscal year '88 is needed to cover the additional expenses of the Board between the effective date of the bill and the licensee renewal date.

Section 20 of the subcommittee CS (Page 9, Line 21) makes the surcharge effective on the same date as the FY'88 budget bill if the budget provides for the added positions under the bill.

3. ADDITIONAL STAFF

Section 1 of the subcommittee CS (Page 1, Line 11) is a rewrite of the provision in the present bill for the hiring of an executive secretary for the Board. This version requires that the Department hire the executive secretary after consulting with the Board. The present bill allows the Board to hire on its own, which is not the process with other Boards. This version is also a cleaner way to write the provision because it adds to present statute regarding the hiring of an investigator.

4. BOARD EXTENSION

Section 3 of the subcommittee CS (Page 2, Line 5) extends the board to June 30, 1991. The board is due for sunset June 30 of this year.

5. BOARD DUTIES

<u>Section 4 of the subcommittee CS</u> (Page 2, Line 8) changes the term "contract" to "coordinate" in terms of the Board's ability to work with a private organization to establish an impaired physicians' treatment program. Though this duty will not carry a fiscal impact for the Board, the term "contract" was misleading and inferred an exchange of money.

6. CONFIDENTIALITY OF REPORTS

<u>Sections 14 and 16 of the subcommittee CS</u> (Page 6, Line 25-Page 7, Line 5 and Page 7, Lines 15-22) further defines the confidentiality of reports submitted to the board and ensures that reports will be submitted.

Section 14, subparagraph (f) prohibits a review organization from refusing to submit a required report to the Board on the grounds of confidentiality as given in AS 18.23.030.

Section 16 tightens the confidentiality of reports of review organizations as already stated in AS 18.23.030. This section prohibits some exceptions to the confidentiality law in terms of reports that review organizations are required to submit to the Board.

**Sec. 18.23.030. Confidentiality of records of review organization.** (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, a person described in AS 18.23.020 may not disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter that is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness may not be asked about the witness's testimony before a review organization or opinions formed by the witness as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization. (§ 40 ch 102 SLA 1976)

**Sec. 18.23.040. Penalty for violation.** Other than as authorized by AS 18.23.030, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable by imprisonment for not more than one year or by a fine of not more than $500. (§ 40 ch 102 SLA 1976; am § 73 ch 6 SLA 1984)

CS For HB 70 (Judiciary)
Revised March 24, 1987

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office.

Section 1 provides that to the extent possible, one half of the amount of fees collected by the state for medical licenses, permits, and applications during the previous two calendar years shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board. The two-year average is specified because the department renews all licenses at the same time. This will prevent a yearly imbalance of appropriations, i.e., a large appropriation one year followed by a small appropriation the next. This section also allows the Department to transfer allocations within its appropriation without the permission of the Office of Management and Budget in order to comply with the above policy. It should be noted that this provision does not bind the Legislature in terms of appropriations to the Department. It only allows the Department to have minimal line item control over its budget in terms of funding the State Medical Board.

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

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

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

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

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

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

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

Section 12 adds to current law a requirement that a hospital that revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.
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Finally, this section adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter

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

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*While in Juneau*
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*(907) 465-4919*

February 17, 1987

MEMORANDUM

TO: House Judiciary Committee

FROM: Representative John Sund

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

.............................................................

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

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

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

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

Department of Commerce & Economic Development / POSITION PAPER

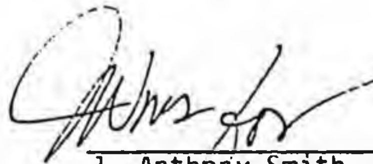
CSHB 70 (JUD): An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence.

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

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STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 24, 1987

SUBJECT: Amendments to CSHB 70 (L&C)

TO: Representative John Sund

FROM: Edward H. Hein EA
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

## 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.

# 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.

Alaska Physicians
November 3, 1986
Page Three

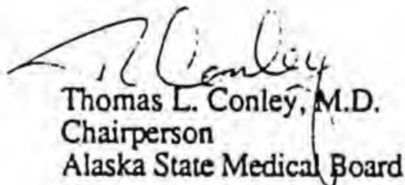
Practitioners should also be aware of board plans to institute a monitored treatment program in conjunction with the Alaska State Medical Association. This would be directed at physicians impaired by drug and alcohol use. Good studies shov' that up to 90% of at least alcohol impaired physicians can achieve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

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

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

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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.

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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

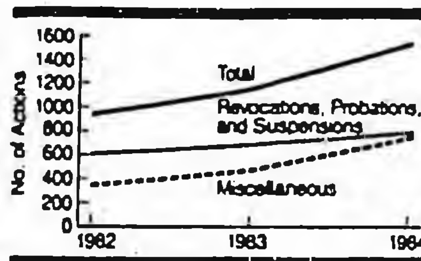
Boards have experienced other significant changes in recent years in addition to rising work loads greater than the resources to deal with them. Both the organizational structure and size of boards have changed. While in 1969, only 16 boards were housed under the aegis of a central agency, currently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

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."[5]) 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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# CORRECTION

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HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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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.[1]

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

## OTHER FORCES INFLUENCING BOARDS

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

### Foreign Medical Graduates

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

While they noted that there are a number of excellent foreign schools, board officials stressed that many of the schools, especially the newer ones, are far inferior to US and Canadian medical schools, which undergo accreditation. They expressed particular concern about inadequate clinical training and minimal admission requirements.[2,3]

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

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

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

### Changed Public Perception and Malpractice

In recent years, public perception about the adequacy of board disciplinary actions has shifted. Newspaper exposés have berated boards for not better protecting the public. Headlines scream, "Doctor Sued 14 Times, But No State Hearing," (*Chicago Tribune*, May 10, 1982, 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."[4]

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.

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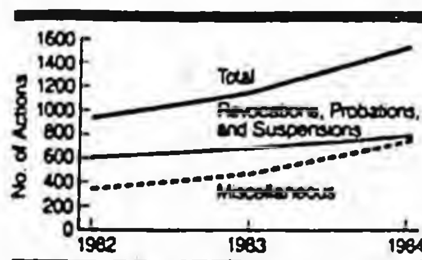


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The remaining types of violations underlying disciplinary actions cover a wide range. Among the most prominent are cases involving conviction for a felony or fraud. Much less prominent are cases involving incompetency or sexual abuse, which are among 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."[5]) 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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between the US Department of Health and Human Services and the states, foster improvement in the centralized reporting and distribution of disciplinary action information, and stimulate more consistent definitions of violations.

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

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

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

As fundamental as the recommendations made by Kusserow et al are, it should be noted that other specific steps are called for. Mandatory reporting to boards exists in one form or another in all but three of the licensing jurisdictions responding to a federation survey.[8-10] Though mandatory reporting should be broadened to include more sources of information in a number of jurisdictions, it is a clear-cut trend. However, enforcement of mandatory reporting has been less than adequate and should be improved. Obviously, liability protection should be offered those reporting to boards in good faith. Forty-two licensing jurisdictions report having some such form of protection now.[8-10] 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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# State Medical Discipline: Defects and Hindrances

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

See also p 820.

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

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

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

ACTION KIT

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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 credentialling and quality management programs of every hospital in this country.

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

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

## IMMUNITY PROVISIONS

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

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

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

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

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

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

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

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

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

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# Due Process Hearings — New Care Needed

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

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

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

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

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# Liable For Radiation Therapy Service

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

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

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

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

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

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

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

The record also showed that the X-ray department was located on the main floor of the defendant 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

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# Improvement Act of 1986 (con't)

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

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

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

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

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

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

## REPORTING REQUIREMENTS

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

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

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

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

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

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

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

# How To Take Advantage Of The Act

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

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

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

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

continued page 4

## Due Process Hearings — (cont.)

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

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

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

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

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

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

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

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

## Therapy Service (cont.)

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

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

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

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

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

## Advantage Of The Act (cont.)

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

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

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

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(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 (e).

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 (18).

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 (18) 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)

# Chapter 64. Medicine.

Article
1. State Medical Board (§§ 08.64.010 — 08.64.040, 08.64.085, 08.64.101, 08.64.140)
2. Licensing (§§ 08.64.170, 08.64.200, 08.64.240, 08.64.250, 08.64.260, 08.64.270, 08.64.275 — 08.64.290, 08.64.311, 08.64.315, 08.64.320, 08.64.325, 08.64.326, 08.64.330, 08.64.331, 08.64.336, 08.64.350)
3. Unlawful Acts (§ 08.64.360)
4. Miscellaneous Provisions (§ 08.64.366)
5. General Provisions (§§ 08.64.370, 08.64.380)

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

**Sec. 08.64.010. 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 ACLA 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," substituted "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 ACLA 1949; am § 4 ch 107 SLA 1969; am § 12 ch 102 SLA 1976; am § 4 ch 48 SLA 1983)

Effect of amendments. — The 1983 terms" for "a term" in the first [illegible]
amendment substituted "staggered and rewrote the second sentence.

*Sec. 08.64.030. Substitution of members. [Repealed, § 19 ch 48 SLA 1983.]*

**Sec. 08.64.040. 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 ACLA 1949; am § 5 ch 48 SLA 1983)

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

**Sec. 08.64.050. 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 ACLA 1949; am § 1 ch 77 SLA 1969; am § 1 ch 101 SLA 1974)

**Sec. 08.64.060. Seal.** The board shall adopt a seal. (§ 35-3-83 ACLA 1949)

**Sec. 08.64.070. Officers.** The board shall elect a president and secretary from among its members. The president and secretary may administer oaths. (§ 35-3-83 ACLA 1949; am § 2 ch 77 SLA 1969)

**Sec. 08.64.080. Meetings of board.**
Repealed by § 3 ch 59 SLA 1966.

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

**Sec. 08.64.085. Meetings of the board.** The board shall meet at least four times a year. (§ 6 ch 48 SLA 1983)

**Sec. 08.64.090. Quorum.** Four members of the board constitute a quorum for the transaction of all business properly before the board. (§ 35-3-83 ACLA 1949; am § 3 ch 148 SLA 1970; am § 13 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.

**Sec. 08.64.100. 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 ACLA 1949)

Sec. 08.64.101. Duties. The board shall

(1) examine and issue licenses to applicants;

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

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

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

(5) adopt regulations insuring that renewal of licenses is contingent upon proof of continued competency on the part of the licensee. (§ 7 ch 48 SLA 1983)

Sec. 08.64.105. 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. Att'y 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 ACLA 1949)

Revisor's note. — This section was impliedly amended by § 1, ch. 130, SLA 1953, as amended by § 1, ch. 34, 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, ACLA 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 ACLA 1949)

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

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

Sec. 08.64.150. Bond of secretary-treasurer. Repealed by § 28 ch 77 SLA 1969.

Editor's notes. — The repealed section derived from § 35-3-84, ACLA 1949.

**Sec. 08.64.160. Applicability of Administrative Procedure Act.** The board shall comply with the Administrative Procedure Act (AS 44.62).



## Article 2. Licensing.


Section
170. License to practice medicine or osteopathy
200. Qualifications of physician applicants
210. License refused
250. License by credentials
260. Re-examination
270. Temporary permits
275. Temporary permit for locum tenens practice
280. [Repealed]
290. [Repealed]
311. License renewal
315. Fees
320. [Repealed]
325. [Repealed]
326. Grounds for imposition of disciplinary sanctions
330. [Repealed]
331. Disciplinary sanctions
336. Duty of physicians and hospitals to report
350. [Repealed]


**Sec. 08.64.170. License to practice medicine or osteopathy.** (a) A person may not practice medicine, podiatry, osteopathy, or acupuncture in the state unless the person is licensed under this chapter, except that

(1) a physician assistant may examine, diagnose or treat persons under the supervision, control, and responsibility of either a physician licensed under this chapter or a physician exempted from licensing under AS 08.64.370;

(2) a physician-trained mobile intensive care paramedic may render emergency lifesaving service;

(3) a person licensed under AS 08.36 may perform acupuncture in the regular practice of dentistry, subject to the regulations of the Board of Dental Examiners; and

(4) a person who is licensed or authorized under another chapter of this title may engage in a practice that is authorized under that chapter.

(b) *[Repealed, § 4 ch 101 SLA 1974.]*

(c) A chiropodist practicing in the state on May 16, 1972 is exempt from this section.

(d) A podiatrist practicing in the state on March 26, 1976 is exempt from this section, and shall be issued a license without examination if application is made within one year of March 26, 1976. (§ 35-3-81 ACLA 1949; am § 4 ch 148 SLA 1970; am § 1 ch 5 SLA 1972; am § 1 ch 21 SLA 1974; am §§ 3, 4 ch 101 SLA 1974; am §§ 1, 2 ch 24 SLA 1976; am § 8 ch 48 SLA 1983)

Effect of amendments. — The 1983 amendment, in subsection (a), substituted "licensing" for "licensure," in paragraph (1), added paragraph (4), and made other minor, stylistic changes.

Sec. 08.64.180. 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 ACLA 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 ACLA 1949; am § 1 ch 22 SLA 1960; am § 4 ch 77 SLA 1969)



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 ACLA 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

(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 08.64.209, submits 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. 08.64.260. 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).

**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 notes.

**Sec. 08.64.270. 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)

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**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.

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. 08.64.313. 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 ....... 200

(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 ..... 200

(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; or

(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, 467 U.S. 937, 104 S. Ct. 346, 78 L. Ed. 2d 312 (1983).

*Sec. 08.64.330. Grounds for revocation of license. [Repealed, § 19 ch 48 SLA 1983.]*

**Sec. 08.64.331. Disciplinary sanctions.** (a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may

(1) permanently revoke a license to practice;

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

(3) censure a licensee;

(4) issue a letter of reprimand;

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

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

(B) limit practice to those areas prescribed;

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

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

(7) impose 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)

**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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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. 08.64.326. 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.

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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)

*Sec. 08.64.350. Certification of revocation. [Repealed, § 10 ch 37 SLA 1986.]*

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

## Article 4. Miscellaneous Provisions.

Section
366. Liability for services rendered by a 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 service to a person who is in need of immediate aid in order to avoid serious harm or loss of life does not" for "while rendering emergency lifesaving service to a person who is in immediate danger of loss of life shall" near the beginning of the section.

**Sec. 08.64.367. 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 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. 08.64.368. Permits for isolated areas.**

Repealed by § 27 ch 148 SLA 1970.

## Article 5. General Provisions.


Section
370. Persons not affected
380. Definitions


**Sec. 08.64.370. 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;

(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 (1) and (5) and added present paragraph (6).

Sec. 08.64.380. 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).

Offered: 3/11/87
Referred: Finance

5-0291L

Original sponsors: Sund, Koponen,
Taylor and Zawacki

1 IN THE HOUSE BY THE JUDICIARY COMMITTEE

2 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
7 amending Rule 504(d) of the Alaska Rules of Evi-
8 dence."

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

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

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

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

22 Sec. 08.64.101. DUTIES. The board shall

23 (1) examine and issue licenses to applicants;

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

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

29 (4) after a hearing, impose disciplinary sanctions on

1 persons who violate this chapter, or the regulations or orders of the
2 board;
3 (5) adopt regulations insuring that renewal of licenses is
4 contingent upon proof of continued competency on the part of the
5 licensee;
6 (6) hire an executive secretary and necessary staff;
7 (7) contract with private professional organizations to
8 establish an impaired medical professionals program to treat persons
9 licensed under this chapter who abuse addictive substances.
10 * Sec. 3. AS 08.64.200 is amended by adding a new subsection to read:
11 (b) The board shall determine whether each physician applicant
12 has any disciplinary or other actions recorded in the nationwide
13 disciplinary data bank of the Federation of State Medical Boards.
14 * Sec. 4. AS 08.64.210(b) is repealed and reenacted to read:
15 (b) The deadline for submitting an exam application to the board
16 shall be established by regulation.
17 * Sec. 5. AS 08.64.220(a) is repealed and reenacted to read:
18 (a) The board shall offer a written examination sufficient to
19 test the applicant's fitness to practice medicine or osteopathy.
20 * Sec. 6. AS 08.64.255 is amended to read:
21 Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licen-
22 sure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in
23 person by at least one member of the board before a license will be
24 issued. The interview must [SHALL] be recorded. If [, AND, IF] the
25 application is denied on the basis of the interview, the denial must
26 [SHALL] be stated in writing, with the reasons for it, and the record
27 must [SHALL] be preserved.
28 * Sec. 7. AS 08.64.311 is repealed and reenacted to read:
29 Sec. 08.64.311. LICENSE RENEWAL. The department shall establish

1 license renewal dates. Licenses shall be renewed biennially, unless
2 the commissioner, by regulation, provides for more frequent renewals.
3 * Sec. 8. AS 08.64.313 is repealed and reenacted to read:
4 Sec. 08.64.313. INACTIVE LICENSE. A licensee who does not
5 practice in the state may hold an inactive license. A person who
6 practices in the state, however infrequently, shall hold an active
7 license.
8 * Sec. 9. AS 08.64.331(a) is amended to read:
9 (a) If the board finds that a licensee has committed an act set
10 out in AS 08.64.326(a), the board may
11 (1) permanently revoke a license to practice;
12 (2) suspend a license for a determinate period of time;
13 (3) censure a licensee;
14 (4) issue a letter of reprimand;
15 (5) place a licensee on probationary status and require the
16 licensee to
17 (A) report regularly to the board on matters involving
18 the basis of probation;
19 (B) limit practice to those areas prescribed;
20 (C) continue professional education until a satisfac-
21 tory degree of skill has been attained in those areas determined
22 by the board to need improvement;
23 (6) impose limitations or conditions on the practice of a
24 licensee; [OR]
25 (7) impose a civil fine of not more than $10,000; or
26 (8) impose one or more of the sanctions set out in (1) -
27 (7) [(1) - (6)] of this subsection.
28 * Sec. 10. AS 08.64.332 is repealed and reenacted to read:
29 Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR

1 INSANITY. Notwithstanding AS 44.62, if a person holding a license to
2 practice medicine or osteopathy under this chapter is adjudged mental-
3 ly incompetent or insane by a final order or adjudication of a court
4 of competent jurisdiction or by voluntary commitment to an institution
5 for the treatment of mental illness, the person's license shall be
6 suspended by the board. The suspension shall continue in effect until
7 the court finds or adjudges that the person has been restored to
8 reason or until a licensed psychiatrist approved by the board deter-
9 mines that the person has been restored to reason.
10 * Sec. 11. AS 08.64 is amended by adding a new section to rea ·
11 Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUS-
12 PENSION OR SURRENDER. The board shall promptly report to the Federa-
13 tion of State Medical Boards for inclusion in the nationwide disci-
14 plinary data bank license refusals under AS 08.64.240, actions taken
15 by the board under AS 08.64.331, and license suspensions or surrenders
16 under AS 08.64.332 or 08.64.334.
17 * Sec. 12. AS 08.64.336 is repealed and reenacted to read:
18 Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (a)
19 A physician who professionally treats a person licensed to practice
20 medicine or osteopathy in this state for alcoholism or drug addiction,
21 or for mental, emotional, or personality disorders, shall report it to
22 the board if the physician providing treatment feels that the person
23 may constitute a danger to the health and welfare of that person's
24 patients or the public if that person continues in practice. The
25 report shall state the name and address of the person and the condi-
26 tion found.
27 (b) A hospital that revokes, suspends, conditions, restricts,
28 or refuses to grant hospital privileges to, or imposes a consultation
29 requirement on, a person licensed to practice medicine or osteopathy

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

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

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

1 safety to the person's patients or to the public, the board shall
2 initiate action to suspend, revoke, limit, or condition the person's
3 license to the extent necessary for the protection of the person's
4 patients and the public.
5 (e) A physician, hospital, or hospital committee that in good
6 faith submits a report under this section or participates in an inves-
7 tigation or judicial proceeding related to a report submitted under
8 this section is immune from civil or criminal liability for the sub-
9 mission or participation.
10 (f) A physician or hospital may not refuse to submit a report
11 under this section or withhold from the board or its investigators
12 evidence related to an investigation under this section on the grounds
13 that the report or evidence concerns a matter that was disclosed in
14 the course of a confidential physician-patient or psychotherapist-
15 patient relationship or during a meeting of a hospital medical staff,
16 governing body, or committee that was exempt from the public meeting
17 requirements of AS 44.62.310.
18 * Sec. 13. AS 08.64 is amended by adding a new section to read:
19 Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes
20 of an investigation under this chapter, the board may order a person
21 to whom it has issued a license or permit to submit to a medical or
22 psychiatric examination by a physician or other practitioner of the
23 healing arts appointed by the board. An examination shall be at the
24 board's expense. An examination may include the required submission
25 of biological specimens requested by the examining physician or prac-
26 titioner.
27 * Sec. 14. Rule 504(d) of the Alaska Rules of Evidence is amended to
28 read:
29 (d) EXCEPTIONS. There is no privilege under this rule:

1 (1) Condition and Element of Claim or Defense. As to
2 communications relevant to the physical, mental or emotional condition
3 of the patient in any proceeding in which the condition of the patient
4 is an element of the claim or defense of the patient, of any party
5 claiming through or under the patient, of any person raising the
6 patient's condition as an element of his own case, or of any person
7 claiming as a beneficiary of the patient through a contract to which
8 the patient is or was a party; or after the patient's death, in any
9 proceeding in which any party puts the condition in issue.
10 (2) Crime or Fraud. If the services of the physician or
11 psychotherapist were sought, obtained or used to enable or aid anyone
12 to commit or plan a crime or fraud or to escape detection or apprehen-
13 sion after the commission of a crime or a fraud.
14 (3) Breach of Duty Arising Out of Physician-Patient Rela-
15 tionship. As to a communication relevant to an issue of breach, by
16 the physician, or by the psychotherapist, or by the patient, of a duty
17 arising out of the physician-patient or psychotherapist-patient rela-
18 tionship.
19 (4) Proceedings for Hospitalization. For communications
20 relevant to an issue in proceedings to hospitalize the patient for
21 physical, mental or emotional illness, if the physician or psycho-
22 therapist, in the course of diagnosis or treatment, has determined
23 that the patient is in need of hospitalization.
24 (5) Required Report. As to information that the physician
25 or psychotherapist or the patient is required to report to a public
26 employee, or as to information required to be recorded in a public
27 office, if such report or record is open to public inspection<u>, or as</u>
28 <u>to information or matters contained in or reasonably raised by a</u>
29 <u>report submitted under AS 08.64.336, other than information that would</u>

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

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

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

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

Offered: 2/20/87
Referred: Judiciary and
Finance

Original sponsor: Sund



1 IN THE HOUSE — BY THE LABOR AND COMMERCE COMMITTEE

2 CS FOR HOUSE BILL NO. 70 (L&C)

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
7 amending Rule 504(d) of the Alaska Rules of Evi-
8 dence."

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

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

12 (e) An amount equal to the amount of fees collected for applica-
13 tions, licenses, and permits issued under AS 08.64 during the previous
14 calendar year shall be allocated each year by the department for
15 services provided to or on behalf of the State Medical Board by the
16 division of occupational licensing.

17 * Sec. 2. AS 08.64.210(b) is repealed and reenacted to read:

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

20 * Sec. 3. AS 08.64.220(a) is amended to read:

21 (a) The board shall make the examination written and [ORAL AND]
22 sufficient to test the applicant's fitness to practice medicine or
23 osteopathy.

24 * Sec. 4. AS 08.64.311 is amended to read:

25 Sec. 08.64.311. LICENSE RENEWAL. Licenses shall be renewed two
26 [FOUR] years after the date of issue.

27 * Sec. 5. AS 08.64.313 is repealed and reenacted to read:

28 Sec. 08.64.313. INACTIVE LICENSE. A licensee who does not
29 practice in the state may hold an inactive license. A person who

1 practices in the state, however infrequently, shall hold an active
2 license.
3 * Sec. 6. AS 08.64.331(a) is amended to read:
4 (a) If the board finds that a licensee has committed an act set
5 out in AS 08.64.326(a), the board may
6 (1) permanently revoke a license to practice;
7 (2) suspend a license for a determinate period of time;
8 (3) censure a licensee;
9 (4) issue a letter of reprimand;
10 (5) place a licensee on probationary status and require the
11 licensee to
12 (A) report regularly to the board on matters involving
13 the basis of probation;
14 (B) limit practice to those areas prescribed;
15 (C) continue professional education until a satisfac-
16 tory degree of skill has been attained in those areas determined
17 by the board to need improvement;
18 (6) impose limitations or conditions on the practice of a
19 licensee; [OR]
20 (7) impose a civil fine of not more than $10,000; or
21 (8) impose one or more of the sanctions set out in (1) -
22 (7) [(1) - (6)] of this subsection.
23 * Sec. 7. AS 08.64.336(b) is amended to read:
24 (b) A hospital that places a consultation requirement on,
25 revokes, suspends, conditions, restricts, or refuses to grant hospital
26 privileges to a person licensed to practice medicine and surgery or
27 osteopathy in this state [BECAUSE THAT PERSON POSES A DANGER TO THE
28 PUBLIC] shall report to the board the name and address of the person
29 and the reasons for placing a consultation requirement on, revoking,

1 suspending, conditioning, restricting, or refusing to grant hospital
2 privileges. A report is required under this subsection regardless of
3 whether the licensee voluntarily agrees to the action taken by the
4 hospital. A report is not required if the sole reason for the action
5 is the licensee's failure to complete hospital records in a timely
6 manner or to attend staff or committee meetings.
7 * Sec. 8. AS 08.64.336(c) is amended to read:
8 (c) Upon receipt of a report under (a) or (b) of this section,
9 the board shall investigate the matter and, upon a finding that there
10 is [OF] reasonable cause to believe that a practitioner is a danger to
11 the health or welfare of the public or the practitioner's patients,
12 the board [,] may appoint a committee of three qualified physicians to
13 examine the licensee and report their findings to the board. Notwith-
14 standing the provisions of this subsection, the board may summarily
15 suspend a license under AS 08.64.331(c) before appointing an examining
16 committee or before the committee makes or reports their findings.
17 * Sec. 9. AS 08.64.336 is amended by adding new subsections to read:
18 (e) A physician, hospital, or hospital committee that in good
19 faith submits a report under this section or participates in an inves-
20 tigation or judicial proceeding related to a report submitted under
21 this section is immune from civil or criminal liability for the sub-
22 mission or participation.
23 (f) A physician or hospital may not refuse to submit a report
24 under this section or withhold from the board or its investigators
25 evidence related to an investigation under this section on the grounds
26 that the report or evidence concerns a matter that was disclosed in
27 the course of a confidential physician-patient or psychotherapist-
28 patient relationship or during a meeting of a hospital medical staff,
29 governing body, or committee that was exempt from the public meeting

1 requirements of AS 44.62.310.

2 * Sec. 10. AS 08.64 is amended by adding new sections to read:

3 Sec. 08.64.337. SUBPOENA POWER. For the purposes of an inves-
4 tigation under this chapter, the board may issue a subpoena to, admin-
5 ister or cause to be administered an oath to, and examine or cause to
6 have examined the parts of the books, papers, and records of a person
7 to whom the board has issued a license or permit or to a person the
8 board reasonably believes has information relevant to the investiga-
9 tion. The superior court, on application of the board, shall enforce
10 the attendance and testimony of witnesses and the production and
11 examination of books, papers, and records.

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

20 * Sec. 11. Rule 504(d) of the Alaska Rules of Evidence is amended to
21 read:

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

23 (1) Condition and Element of Claim or Defense. As to
24 communications relevant to the physical, mental or emotional condition
25 of the patient in any proceeding in which the condition of the patient
26 is an element of the claim or defense of the patient, of any party
27 claiming through or under the patient, of any person raising the
28 patient's condition as an element of his own case, or of any person
29 claiming as a beneficiary of the patient through a contract to which

1 the patient is or was a party; or after the patient's death, in any
2 proceeding in which any party puts the condition in issue.
3 (2) Crime or Fraud. If the services of the physician or
4 psychotherapist were sought, obtained or used to enable or aid anyone
5 to commit or plan a crime or fraud or to escape detection or apprehen-
6 sion after the commission of a crime or a fraud.
7 (3) Breach of Duty Arising Out of Physician-Patient Rela-
8 tionship. As to a communication relevant to an issue of breach, by
9 the physician, or by the psychotherapist, or by the patient, of a duty
10 arising out of the physician-patient or psychotherapist-patient rela-
11 tionship.
12 (4) Proceedings for Hospitalization. For communications
13 relevant to an issue in proceedings to hospitalize the patient for
14 physical, mental or emotional illness, if the physician or psycho-
15 therapist, in the course of diagnosis or treatment, has determined
16 that the patient is in need of hospitalization.
17 (5) Required Report. As to information that the physician
18 or psychotherapist or the patient is required to report to a public
19 employee, or as to information required to be recorded in a public
20 office, if such report or record is open to public inspection, or as
21 to information or matters contained in or reasonably raised by a
22 report submitted under AS 08.64.336.
23 (6) Examination by Order of Judge. As to communications
24 made in the course of an examination ordered by the court of the
25 physical, mental or emotional condition of the patient, with respect
26 to the particular purpose for which the examination is ordered unless
27 the judge orders otherwise. This exception does not apply where the
28 examination is by order of the court upon the request of the lawyer
29 for the defendant in a criminal proceeding in order to provide the

1 lawyer with information needed so that he may advise the defendant
2 whether to enter a plea based on insanity or to present a defense
3 based on his mental or emotional condition.
4 (7) Criminal Proceeding. For physician-patient communica-
5 tions in a criminal proceeding. This exception does not apply to the
6 psychotherapist-patient privilege.
7 * Sec. 12. AS 08.64.260(b), (c), and (d) are repealed.

Introduced: 1/23/87
Referred: Labor & Commerce,
Judiciary and Finance

1 IN THE HOUSE BY SUND

2 HOUSE BILL NO. 70

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
7 amending Rule 504(d) of the Alaska Rules of Evi-
8 dence."

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

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11 read:

12 (e) An amount equal to the amount of fees collected for applica-
13 tions, licenses, and permits issued under AS 08.64 during the previous
14 calendar year shall be allocated each year by the department for
15 services provided to or on behalf of the State Medical Board by the
16 division of occupational licensing.

17 * Sec. 2. AS 08.64.210(b) is amended to read:

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

20 * Sec. 3. AS 08.64.220(a) is amended to read:

21 (a) The board shall make the examination written and [ORAL AND]
22 sufficient to test the applicant's fitness to practice medicine or
23 osteopathy.

24 * Sec. 4. AS 08.64.313 is repealed and reenacted to read:

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

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2 out in AS 08.64.326(a), the board may
3 (1) permanently revoke a license to practice;
4 (2) suspend a license for a determinate period of time;
5 (3) censure a licensee;
6 (4) issue a letter of reprimand;
7 (5) place a licensee on probationary status and require the
8 licensee to
9 (A) report regularly to the board on matters involving
10 the basis of probation;
11 (B) limit practice to those areas prescribed;
12 (C) continue professional education until a satisfac-
13 tory degree of skill has been attained in those areas determined
14 by the board to need improvement;
15 (6) impose limitations or conditions on the practice of a
16 licensee; [OR]
17 (7) impose a civil fine of not more than $10,000; or
18 (8) impose one or more of the sanctions set out in (1) -
19 (7) [(1) - (6)] of this subsection.
20 * Sec. 6. AS 08.64.336(b) is amended to read:
21 (b) A hospital that places a consultation requirement on,
22 revokes, suspends, conditions, restricts, or refuses to grant hospital
23 privileges to a person licensed to practice medicine and surgery or
24 osteopathy in this state [BECAUSE THAT PERSON POSES A DANGER TO THE
25 PUBLIC] shall report to the board the name and address of the person
26 and the reasons for placing a consultation requirement on, revoking,
27 suspending, conditioning, restricting, or refusing to grant hospital
28 privileges. A report is required under this subsection regardless of
29 whether the licensee voluntarily agrees to the action taken by the

1 hospital. A report is not required if the sole reason for the action
2 is the licensee's failure to complete hospital records in a timely
3 manner or to attend staff or committee meetings.
4 * Sec. 7. AS 08.64.336(c) is amended to read:
5 (c) Upon receipt of a report under (a) or (b) of this section,
6 the board shall investigate the matter and, upon a finding that there
7 is [OF] reasonable cause to believe that a practitioner is a danger to
8 the health or welfare of the public or the practitioner's patients,
9 the board [,] may appoint a committee of three qualified physicians to
10 examine the licensee and report their findings to the board. Notwith-
11 standing the provisions of this subsection, the board may summarily
12 suspend a license under AS 08.64.331(c) before appointing an examining
13 committee or before the committee makes or reports their findings.
14 * Sec. 8. AS 08.64.336 is amended by adding new subsections to read:
15 (e) A physician, hospital, or hospital committee that in good
16 faith submits a report under this section or participates in an inves-
17 tigation or judicial proceeding related to a report submitted under
18 this section is immune from civil or criminal liability for the sub-
19 mission or participation.
20 (f) A physician or hospital may not refuse to submit a report
21 under this section or withhold from the board or its investigators
22 evidence related to an investigation under this section on the grounds
23 that the report or evidence concerns a matter that was disclosed in
24 the course of a confidential physician-patient or psychotherapist-
25 patient relationship or during a meeting of a hospital medical staff,
26 governing body, or committee that was exempt from the public meeting
27 requirements of AS 44.62.310.
28 * Sec. 9. AS 08.64 is amended by adding new sections to read:
29 Sec. 08.64.337. SUBPOENA POWER. For the purposes of an