ALASKA LEGISLATURE COMMITTEE BILL FILES - 1987 - 1988 8879

HB 70 cont., CSHB 70 229

1 investigation under this chapter, the board may issue a subpoena to,
2 administer or cause to be administered an oath to, and examine or
3 cause to have examined the parts of the books, papers, and records of
4 a person to whom the board has issued a license or permit or to a
5 person the board reasonably believes has information relevant to the
6 investigation. The superior court, on application of the board, shall
7 enforce the attendance and testimony of witnesses and the production
8 and examination of books, papers, and records.
9 Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes
10 of an investigation under this chapter, the board may order a person
11 to whom it has issued a license or permit to submit to a medical or
12 psychiatric examination by a physician or other practitioner of the
13 healing arts appointed by the board. An examination shall be at the
14 board's expense. An examination may include the required submission
15 of biological specimens requested by the examining physician or prac-
16 titioner.
17 * Sec. 10. Rule 504(d) of the Alaska Rules of Evidence is amended to
18 read:
19 (d) EXCEPTIONS. There is no privilege under this rule:
20 (1) Condition and Element of Claim or Defense. As to
21 communications relevant to the physical, mental or emotional condition
22 of the patient in any proceeding in which the condition of the patient
23 is an element of the claim or defense of the patient, of any party
24 claiming through or under the patient, of any person raising the
25 patient's condition as an element of his own case, or of any person
26 claiming as a beneficiary of the patient through a contract to which
27 the patient is or was a party; or after the patient's death, in any
28 proceeding in which any party puts the condition in issue.
29 (2) Crime or Fraud. If the services of the physician or

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

1 (7) Criminal Proceeding. For physician-patient communica-
2 tions in a criminal proceeding. This exception does not apply to the
3 psychotherapist-patient privilege.
4 * Sec. 11. AS 08.64.260(b), (c), and (d) are repealed.

CSHB

70

SENATE COMMITTEE REPORT

FURTHER:

5/7/87

DATE TURNED INTO OFFICE 5/16/87

Mr. President:

FINANCE Committee considered CSHB 70(Fin)am

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

and recommended:

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

[✓] attached amendment(s)

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to ________

[ ] letter of intent adopted ________

Committee [✓] attached or [ ] adopted fiscal note(s)
[ ] new [ ] updated or [✓] previous
[ ] zero [✓] fiscal impact

MEMBERS SIGNING DO PASS	OTHER RECOMMENDATIONS

DO PASS
Chairman signature and recommendation

[ ] Committee Backup Attached

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

No. 2

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

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0	88.4	88.4	88.4	88.4	88.4
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	1.4	1.4	1.4	1.4	1.4
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
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)

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:

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

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

5-0291Pa
Hein
Lip Sund
5/16/87

AMENDMENT

Offered in the SENATE

TO: SCS CSHB 70 (Judiciary)

Page 1, lines 11 - 26:

Delete all material

Page 1, line 27:

Delete "Sec. 2"

Insert "Section 1"

Renumber following bill sections accordingly.

Page 2, after line 24:

Insert a new bill section to read:

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

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

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

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

based on complaints filed with the department or with the board; and

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

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

Insert "AS 08.01.050(c);"

Page 10, lines 18 - 19:

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

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

Page 10, line 26:

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

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

Offered: 5/7/87
Referred: Finance

5-0291P

Original sponsors: Sund, Koponen,
Taylor and Zawacki

1 IN THE HOUSE BY THE JUDICIARY COMMITTEE

2 SENATE CS FOR CS FOR HOUSE BILL NO. 70 (Judiciary)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

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

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

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

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

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

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

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

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

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

1 for which the fee is charged. <u>The actual or anticipated costs to the</u>
2 <u>department of services provided to or on behalf of a board must re-</u>
3 <u>flect, to the extent possible, the amount of fees the department</u>
4 <u>collects from persons in occupations regulated by the board.</u>
5 * Sec. 3. AS 08.03.010(c)(11) is amended to read:
6 (11) State Medical Board (AS 08.64.010) -- <u>June 30, 1991</u>
7 [JUNE 30, 1987].
8 * Sec. 4. AS 08.64.101 is amended to read:
9 Sec. 08.64.101. DUTIES. The board shall
10 (1) examine and issue licenses to applicants;
11 (2) develop written guidelines to insure that licensing
12 requirements are not unreasonably burdensome and the issuance of
13 licenses is not unreasonably withheld or delayed;
14 (3) submit an annual report of its proceedings to the
15 governor, including a statement of money received and disbursed;
16 (4) after a hearing, impose disciplinary sanctions on
17 persons who violate this chapter, or the regulations or orders of the
18 board;
19 (5) adopt regulations insuring that renewal of licenses is
20 contingent upon proof of continued competency on the part of the
21 licensee<u>; and</u>
22 <u>(6) coordinate with private professional organizations to</u>
23 <u>establish an impaired medical professionals program to treat persons</u>
24 <u>licensed under this chapter who abuse addictive substances</u>.
25 * Sec. 5. AS 08.64.200 is amended by adding a new subsection to read:
26 (b) The board shall determine whether each physician applicant
27 has any disciplinary or other actions recorded in the nationwide
28 disciplinary data bank of the Federation of State Medical Boards.
29 * Sec. 6. AS 08.64.210(b) is repealed and reenacted to read:

1 (b) The deadline for submitting an exam application to the board
2 shall be established by regulation.
3 * Sec. 7. AS 08.64.220(a) is repealed and reenacted to read:
4 (a) The board shall offer a written examination sufficient to
5 test the applicant's fitness to practice medicine or osteopathy.
6 * Sec. 8. AS 08.64.255 is amended to read:
7 Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licen-
8 sure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in
9 person by at least one member of the board before a license will be
10 issued. The interview must [SHALL] be recorded. If [, AND, IF] the
11 application is denied on the basis of the interview, the denial must
12 [SHALL] be stated in writing, with the reasons for it, and the record
13 must [SHALL] be preserved.
14 * Sec. 9. AS 08.64.270 is amended to read:
15 Sec. 08.64.270. TEMPORARY PERMITS. (a) The board may issue a
16 temporary permit to a physician applicant, osteopath applicant, or
17 podiatry [AN] applicant who meets the requirements of AS 08.64.200,
18 08.64.205, or 08.64.209 and pays the required fee.
19 (b) A temporary permit issued under this section is valid for
20 eight months or until the board meets to consider the application,
21 whichever occurs first.
22 (c) A temporary permit issued under this section may be renewed
23 at the board's discretion one time only.
24 * Sec. 10. AS 08.64.272 is repealed and reenacted to read:
25 Sec. 08.64.272. RESIDENCY AND INTERNSHIP PERMITS. (a) A person
26 may not serve as a resident or intern without a permit issued under
27 this section.
28 (b) For the limited purpose of residency or internship, the
29 board may issue a permit to an applicant without examination if the

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

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

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

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

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

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

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

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

20 (1) permanently revoke a license to practice;
21 (2) suspend a license for a determinate period of time;
22 (3) censure a licensee;
23 (4) issue a letter of reprimand;
24 (5) place a licensee on probationary status and require the
25 licensee to

26 (A) report regularly to the board on matters involving
27 the basis of probation;
28 (B) limit practice to those areas prescribed;
29 (C) continue professional education until a

1 satisfactory degree of skill has been attained in those areas
2 determined by the board to need improvement;
3 (6) impose limitations or conditions on the practice of a
4 licensee; [OR]
5 (7) impose a civil fine of not more than $10,000; or
6 (8) impose one or more of the sanctions set out in (1) -
7 (7) [(1) - (6)] of this subsection.
8 * Sec. 14. AS 08.64.332 is repealed and reenacted to read:
9 Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR
10 INSANITY. Notwithstanding AS 44.62, if a person holding a license to
11 practice medicine or osteopathy under this chapter is adjudged mental-
12 ly incompetent or insane by a final order or adjudication of a court
13 of competent jurisdiction or by voluntary commitment to an institution
14 for the treatment of mental illness, the person's license shall be
15 suspended by the board. The suspension shall continue in effect until
16 the court finds or adjudges that the person has been restored to
17 reason or until a licensed psychiatrist approved by the board deter-
18 mines that the person has been restored to reason.
19 * Sec. 15. AS 08.64 is amended by adding a new section to read:
20 Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUS-
21 PENSION OR SURRENDER. The board shall promptly report to the Federa-
22 tion of State Medical Boards for inclusion in the nationwide disci-
23 plinary data bank license refusals under AS 08.64.240, actions taken
24 by the board under AS 08.64.331, and license suspensions or surrenders
25 under AS 08.64.332 or 08.64.334.
26 * Sec. 16. AS 08.64.336 is repealed and reenacted to read:
27 Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (a)
28 A physician who professionally treats a person licensed to practice
29 medicine or osteopathy in this state for alcoholism or drug addiction,

1 or for mental, emotional, or personality disorders, shall report it to
2 the board if there is probable cause that the person may constitute a
3 danger to the health and welfare of that person's patients or the
4 public if that person continues in practice. The report shall state
5 the name and address of the person and the condition found.
6 (b) A hospital that revokes, suspends, conditions, restricts,
7 or refuses to grant hospital privileges to, or imposes a consultation
8 requirement on, a person licensed to practice medicine or osteopathy
9 in the state shall report to the board the name and address of the
10 person and the reasons for the action within seven working days after
11 the action is taken. A hospital shall also report to the board the
12 name and address of a person licensed to practice medicine or osteo-
13 pathy in the state if the person resigns hospital staff privileges
14 while under investigation by the hospital or a committee of the hospi-
15 tal and the investigation could result in the revocation, suspension,
16 conditioning, or restricting of, or the refusal to grant, hospital
17 privileges, or in the imposition of a consultation requirement. A
18 report is required under this subsection regardless of whether the
19 person voluntarily agrees to the action taken by the hospital. A
20 report is not required if the sole reason for the action is the per-
21 son's failure to complete hospital records in a timely manner or to
22 attend staff or committee meetings. In this subsection "consultation
23 requirement" means a restriction placed on a person's existing hospi-
24 tal privileges requiring consultation with a designated physician or
25 group of physicians in order to continue to exercise the hospital
26 privileges.
27 (c) Upon receipt of a report under (a) or (b) of this section,
28 the board shall investigate the matter and, upon a finding that there
29 is reasonable cause to believe that the person who is the subject of

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

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

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

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

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

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

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

1 Sec. 08.64.338. MEDICAL AND PSYCHIATRIC EXAMS. For the purposes
2 of an investigation under this chapter, the board may order a person
3 to whom it has issued a license or permit to submit to a medical or
4 psychiatric examination by a physician or other practitioner of the
5 healing arts appointed by the board. An examination shall be at the
6 board's expense. An examination may include the required submission
7 of biological specimens requested by the examining physician or prac-
8 titioner.
9 * Sec. 18. AS 18.20.050 is amended to read:
10 Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE.
11 The department may deny, suspend, or revoke a license in a case in
12 which it finds that there has been a substantial failure to comply
13 with the requirements established under <u>AS 08.64.336 or</u> AS 18.20.060 -
14 18.20.080.
15 * Sec. 19. AS 18.23.030 is amended by adding a new subsection to read:
16 (d) Notwithstanding the provisions of (b) and (c) of this sec-
17 tion, information contained in a report submitted to the State Medical
18 Board, and information gathered by the board during an investigation,
19 under AS 08.64.336 is not subject to subpoena or discovery unless and
20 until the board takes action to suspend, revoke, limit, or condition a
21 license of the person who is the subject of the report or investiga-
22 tion.
23 * Sec. 20. Rule 504(d) of the Alaska Rules of Evidence is amended to
24 read:
25 (d) EXCEPTIONS. There is no privilege under this rule:
26 (1) Condition and Element of Claim or Defense. As to
27 communications relevant to the physical, mental or emotional condition
28 of the patient in any proceeding in which the condition of the patient
29 is an element of the claim or defense of the patient, of any party

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

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

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

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

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

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

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. 21. AS 08.64.260(b), 08.64.260(c), 08.64.260(d), 08.64.370(4), and AS 18.20.076 are repealed.

* Sec. 22. 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. 23. Section 22 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.

JOHN SUND, REPRESENTATIVE
2504 2nd Avenue
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(907) 225-5552

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

M E M O R A N D U M

TO: Senate Judiciary Committee members

FROM: Rep. John Sund

DATE: May 7, 1987

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

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

1) Sec. 9; Page 3, Line 15: Rewriting of AS 08.64.270 was added to the bill in order to clarify temporary permits. This change was made to accomodate the clarification of resident and intern permits as described below.

2) Sec. 10; Page 3, Line 25: Present statute was inconsistent regarding resident and intern permits. One statute, AS 08.64.374 (4), exempted residents and interns from licensing under the State Medical Board while AS 08.64.272 stated that the Board may issue temporary permits to residents and interns.

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

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

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

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

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

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

Senate CS For CS For HB 70 (Judiciary)

SECTIONAL ANALYSIS
Revised May 8, 1987

Prepared by Rep. John Sund's office.

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

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

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

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

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

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

Section 8 (Page 3, Line 6) requires that all license applicants be personally interviewed by at least one medical board member. Present statute seems to leave this open to choice.

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

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

Section 11 (Page 4, Line 8) quires that licenses be renewed at least every two years instead of the present four years. The department shall establish the renewal date. This permits the department to continue its policy of renewing all licenses at the same time.

Section 12 (Page 4, Line 12) rewrites the statute relating to inactive medical licenses. Current law requires that a licensee must reside outside the state in order to obtain an inactive license. As rewritten, a licensee's residence would be irrelevant. The cnly criterion would be whether the licensee practices in the state. If the licensee does practice in the state, no matter how infrequently, the licensee must hold an active license.

Section 13 (Page 4, Line 17) amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a).

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

Section 15 (Page 5, Line 19) requires the Board to report to the Federation of State Medical Boards data bank any license refusals, restrictions, suspensions, surrenders, etc. as described in AS 08.64.240, 08.64.331, 08.64.332 and 08.64.334.

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

Specifically, this section adds to current law a requirement that a hospital that revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to

the board within seven working days and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.
The hospital must also report the name and address of a physician if that physician resigned while under an investigation that could have lead to a restriction, suspension, condition, etc.
This section also clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a practitioner is a danger to the health or welfare of the public or the practitioner's patients." This section also specifically authorizes the board to suspend the licensee's license before appointing the committee or before receiving the committee's report.
Finally, this section adds two new subsections to the reporting law. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is AS 18.23.030, which is the statute that makes review organization reports confidential. Also not grounds for refusing to report is that the matter that is required to be reported was the subject of a meeting exempt from the public meeting law.

Section 17 (Page 7, Line 29) adds a new statute. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board expense, and may include tests requested by the examining physician.

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

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

Section 20 (Page 8, Line 23) amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that unless the identity of a patient would be revealed, a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings. The amendment includes, however, that the court may decide it necessary to reveal the identity of a patient in order to serve justice.

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

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

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

POSITION PAPER

Department of Commerce & Economic Development

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

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

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

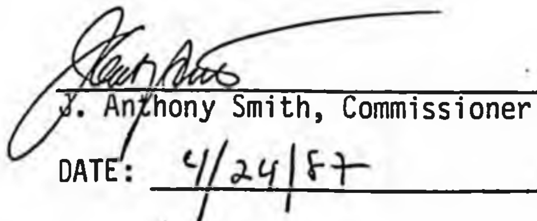
The executive secretary will enable the board to more effectively enforce disciplinary actions taken against physicians and will coordinate a treatment program for physicians who have substance abuse problems.

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

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

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

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



J. Anthony Smith, Commissioner

DATE: 4/24/87

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Back-up CSHB 70 Fin

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

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

M E M O R A N D U M

TO: Senator Johne Binkley

FROM: Rep. John Sund

DATE: May 5, 1987

RE: HB 70
"An Act relating to the State Medical Board . . ."

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

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

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

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

Thanks in advance for your time on this bill.

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

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

M E M O R A N D U M

TO: Senator Tim Kelly

FROM: Rep. John Sund

DATE: April 7, 1987

RE: HB 70
"An Act relating to the State Medical Board . . ."

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

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

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

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

Thanks in advance for your time on this bill.

CS For HB 70 (Finance) am

SECTIONAL ANALYSIS
Revised April 7, 1987

Prepared by Rep. John Sund's office.

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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)

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:

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

ANALYSIS: (Attach a separate page if necessary)

Prepared by:
Phone:
Division:
Date:

Approved by Commissioner:
Date:
Agency:

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

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

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

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

34,419	Salary
9,873	Benefits
44,292	Total

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

34,243	Salary
9,838	Benefits
44,081	Total

Subtotal - Personal Services: $ 88,373.00

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

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

Subtotal - Examinations: $ 1,350.00

TOTAL: $89,723.00

Surcharge Calculation:

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

Note: currently doctors pay $150 per year

ALASKA STATE MEDICAL BOARD

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

November 3, 1986

Dear Alaska Physician:

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

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

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

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

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

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

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

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

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

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

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

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

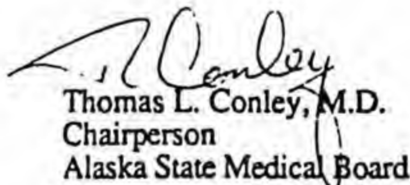
Practitioners should also be aware of board plans to institute a monitored treatment program in conjunction with the Alaska State Medical Association. This would be directed at physicians impaired by drug and alcohol use. Good studies show that up to 90% of at least alcohol impaired physicians can achieve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

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

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

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

Sincerely,



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

TLC:ts

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REVISED 1985

A Guide To The Essentials of a Modern Medical Practice Act

THE FEDERATION OF STATE MEDICAL BOARDS

OF THE UNITED STATES

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

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INTRODUCTION

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

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

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

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

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

A GUIDE TO THE ESSENTIALS

OF A

MODERN MEDICAL PRACTICE ACT

PREAMBLE

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

SECTION I:

STATEMENT OF PURPOSE

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

A. The practice of medicine is a privilege granted by the people acting through their elected representatives. It is not a natural right of individuals.

B. In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

C. The primary responsibility and obligation of the medical licensing board is to protect the public.

SECTION II:

DEFINITIONS

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

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

1. advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;

2. offering or undertaking to prescribe, give, or administer any drug or medicine for the use of any other person;

3. offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, devices, or instrumentalities any disease, illness, pain, wound, fracture, infirmity, deformity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;

4. offering or undertaking to perform any surgical operation upon any person;

5. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction.

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

1. students while engaged in training in a medical school approved by the medical licensing board or while engaged in graduate medical training under the supervision of the medical staff of a hospital or other health care facility approved by the medical licensing board for such training, except as stipulated in Section VIII (LIMITED LICENSE);

2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged, or received;

3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act;

4. those practicing optometry, psychology, podiatry, dentistry, nursing, or any other of the

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

5. those practicing the religious tenets of a church in ministering to the sick or suffering by mental or spiritual means, provided that no person should be exempt from the sanitary and quarantine laws of the jurisdiction or the federal government;

6. a person administering a lawful domestic or family remedy to a member of his or her own family.

SECTION III:

THE MEDICAL LICENSING BOARD

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

A. Whatever the professional regulatory structure established by the jurisdiction, physicians should bear the responsibility of licensing and regulating the medical profession with due safeguards to protect the public and individual physicians from the abuse of that responsibility.

B. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity.

C. Members of the Board should be subject to removal only when found guilty, through due process, of malfeasance, misfeasance, or nonfeasance.

D. All physician members of the Board should be licensed in the jurisdiction, should be persons of recognized professional ability and integrity, and should have practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

E. Whatever the make-up of the Board, physicians should constitute the majority of the membership.

F. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service.

G. Members of the Board should receive appropriate reimbursement for expenses and services.

H. The Board should be authorized to employ an executive secretary or director and other staff, including an adequate staff of investigators, to effectively fulfill its responsibilities under the act. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel.

SECTION IV:

EXAMINATIONS

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

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

1. No person should receive a license to practice medicine in the jurisdiction unless he or she passes or has passed an examination or examinations satisfactory to the Board.

2. The Board should approve the preparation and administration of an examination or examinations, in English, which it deems must be satisfactorily passed as part of its procedure for determining an applicant's qualification for the practice of medicine.

3. Examinations should be scored in a way to ensure the anonymity of applicants.

4. Examinations should be conducted at least semiannually, provided there is an applicant.

5. The Board should stipulate the score required for passing the examination(s). The required passing score should be set before the administration of the examination(s).

6. Applicants should be required to pass all examinations within a specific period of time after initial application in any jurisdiction. Specific requirements for the satisfactory completion of further medical education should be established by the Board for those applicants seeking to be examined after the specified passing period.

7. The Board should be authorized to limit the number of times an examination may be taken before the satisfactory completion of further medical education is required of an applicant.

8. Fees for any examination should be paid by an applicant before the examination is given and no later than a date set by the Board.

B. **Examination Application:**

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

1. his or her full name and all aliases or other names ever used, current address, social security number, and date and place of birth;

2. a recent signed photograph and a set of fingerprints of the applicant;

3. notarized photocopies of all documents and credentials required by the Board;

4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has applied for licensure to practice medicine or is authorized or has applied for authorization to practice medicine;

5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or has voluntarily surrendered such licensure or authorization;

6. a list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, which would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;

7. a detailed educational history, including places, institutions, dates, and program descriptions, of all his or her education beginning with secondary schooling and including all college, pre-professional, professional, and professional graduate education;

8. a detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign);

9. any other information or documentation the Board determines is necessary.

C. Examination Security:

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

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

   a. conduct which violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; and/or

   b. conduct which violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination distributed; and/or

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

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

SECTION V:

REQUIREMENTS FOR FULL LICENSURE

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

A. The applicant should possess the degree of Doctor of Medicine or Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada which was approved by the Board or by a private non-profit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school which was not so approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement/reciprocity.

B. The applicant should have satisfactorily completed at least twelve (12) months of graduate medical training approved by the Board or by a private non-profit accrediting body approved by the Board in an institution in the United States, its territories or possessions, or Canada approved by the Board or by a private non-profit accrediting body approved by the Board.

C. The applicant should have passed medical licensure examination(s) satisfactory to the Board.

D. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, or professional competency examination if deemed necessary by the Board.

E. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct which would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board, at its discretion, should be authorized to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

F. The applicant should make a personal appearance before the Board or a representative thereof for interview, examination, or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

G. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board should be directed to establish regulations governing the review and verification of medical education credentials.

H. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board.

SECTION VI:

GRADUATES OF FOREIGN MEDICAL SCHOOLS

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

A. Such applicants should possess the degree of Doctor of Medicine or Osteopathy, Bachelor of Medicine or Osteopathy, or the equivalent from a medical college or school whose full training program and curriculum are available to and approved by the Board on the basis of criteria approved by the Board. Necessary information regarding such schools should be gathered by the Board or by a qualified private non-profit body approved by the Board with which the Board has entered into a written agreement for such a purpose. The information gathering process should be permitted to include a site-visit to the institution if deemed necessary by the Board, though the cost of such a visit should not be borne by the licensing jurisdiction.

B. Such applicants should be eligible by virtue of education and training for unrestricted licensure or authorization to practice medicine in the country in which they received the medical degree.

C. Such applicants should have passed a screening examination in basic medical knowledge acceptable to the Board (e.g., the Foreign Medical Graduates Examination in the Medical Sciences).

D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or by its Board approved successor(s).

E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.

F. The Board should be authorized to establish regulations requiring all such applicants to satisfactorily complete more than twelve (12) months and up to thirty-six (36) months of Board approved graduate medical training if it determines such a requirement is necessary for the protection of the public health and welfare.

G. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by notarized English translations acceptable to the Board

H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

SECTION VII:

LICENSURE WITHOUT EXAMINATION AND TEMPORARY LICENSURE

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

A. **Endorsement/Reciprocity:** The Board should be authorized, at its discretion, to issue a license by endorsement/reciprocity to an applicant who:

1. has complied with all current medical licensure requirements save that for examination; and

2. has passed a medical licensure examination given in English in another state, the District of Columbia, a territory or possession of the United States, or Canada, provided the Board determines that examination was equivalent to its own current examination; and

3. has a valid current medical license in another state, the District of Columbia, a territory or possession of the United States, or Canada.

B. **Certifying Agencies:** The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensure requirements save that for examination; and

2. has passed the examination of and been certified by a certifying agency recognized by the Board (e.g., the National Board of Medical Examiners or the National Board of Examiners for Osteopathic Physicians and Surgeons), provided the Board determines that examination was equivalent to its own current examination and was not a specialty board examination.

C. **Endorsement/Reciprocity Examination:** Notwithstanding any other provision of the act, the Board should be authorized to require applicants for full and unrestricted medical licensure without examination who have not been formally tested by a United States or Canadian medical licensing jurisdiction, a Board approved medical certifying agency, or a Board approved medical specialty board within a specific period of time before application (e.g., eight or ten years) to pass a written and/or oral medical examination approved by the Board. Such an examination could be all or part of the Board's current licensure examination.

D. **Temporary Licensure:** The Board should be authorized to establish regulations for the issuance of temporary medical licenses for the intervals between Board meetings in order to meet specific needs. If a temporary medical license is issued, it should:

1. be issued only to an applicant who is qualified for full and unrestricted medical licensure

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

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

SECTION VIII:

LIMITED LICENSURE FOR PHYSICIANS IN GRADUATE TRAINING

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

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except graduate education and/or licensure examination.

B. The application for limited licensure should be made through the Board approved institution which is to supervise the applicant's graduate training and that institution should be required to verify the applicant's fulfillment of the requirements for limited licensure. The demonstrated failure of an approved supervising institution to properly and effectively verify an applicant's fulfillment of the requirements for limited licensure should be grounds for the Board, at its discretion, to withdraw or limit its approval of that institution for graduate training until such time as the institution can demonstrate to the Board's satisfaction the implementation of an acceptable verification process. Proof of an institution's failure to properly and effectively verify the requirements for limited licensure should be established by the presence in graduate training of an individual whose medical or other required documents or credentials are shown to be fraudulent or to have been obtained through fraud, deception, or dishonesty, or by the identification of such an individual after the completion of his or her graduate training.

C. The Board should be directed to establish by regulation restrictions for the limited license to assure the holder will practice only under appropriate supervision acceptable to the Board.

D. The limited license should be renewable annually with the approval of the Board and upon the written recommendation of the supervising institution until such time as Board regulations require the achievement of full and unrestricted medical licensure.

E. The disciplinary provisions of the medical practice act should apply to the holders of the limited license as if they held full and unrestricted medical licensure.

F. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license will be issued at any future date.

SECTION IX:

DISCIPLINARY ACTION AGAINST LICENSEES

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

A. A range of disciplinary actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;
2. suspension of the medical license;
3. probation;
4. stipulations, limitations, and conditions relating to practice;
5. fines (including costs);
6. reprimands;
7. letters of censure; and
8. letters of concern.

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

B. The Board should be authorized to require a licensee to be examined on his or her medical knowledge and skills should the Board have reason to believe the licensee may be deficient in such knowledge and skills. It should also be authorized to require a licensee to be physically or mentally examined should it have reason to believe the licensee's physical or mental condition may adversely affect his or her practice of medicine.

C. The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic reregistration of a medical license;
2. cheating on or attempting to subvert the medical licensing examination(s);
3. the commission or conviction of a gross misdemeanor or a felony, whether or not related to the practice of medicine, or the entry of a guilty or nolo contendere plea to a gross misdemeanor or a felony charge;

4. conduct likely to deceive, defraud, or harm the public;

5. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;

6. representing to a patient that a manifestly incurable condition, sickness, disease, or injury can be cured;

7. willfully or negligently violating the confidentiality between physician and patient except as required by law;

8. gross negligence in the practice of medicine as determined by the Board;

9. being found mentally incompetent or insane by any court of competent jurisdiction;

10. a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

11. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

12. practicing medicine under a false or assumed name;

13. aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;

14. allowing another person or organization to use his or her license to practice medicine;

15. commission of any act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

16. being addicted or habituated to a drug or intoxicant;

17. prescribing, selling, administering, distributing, or giving any drug legally classified as a controlled substance or as an addictive or dangerous drug for other than medically accepted therapeutic purposes;

18. except as otherwise permitted by law, prescribing, selling, administering, distributing, or giving to a habitue or addict any drug legally classified as a controlled substance or as an addictive or dangerous drug;

19. prescribing, selling, administering, distributing, or giving a drug legally classified as a controlled substance or as an addictive or dangerous drug to a family member or to himself or herself;

20. violating any state or federal law or regulation relating to controlled substances;

21. obtaining any fee by fraud, deceit, or misrepresentation;

22. directly or indirectly giving or receiving any fee, commission, rebate, or other

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

23. disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine based upon acts or conduct by the licensee similar to acts or conduct which would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

24. sanctions or disciplinary actions taken by a peer review body, a hospital or other health care institution, or a medical or professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

25. failure to report to the Board any adverse action taken against him or her by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

26. surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

27. failure to report to the Board surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

28. any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

29. failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

30. failure to transfer medical records to another physician when requested to do so by the subject patient or by his or her legally designated representative;

31. failure to report to the Board the relocation of his or her office, in or out of the jurisdiction;

32. failure to furnish the Board, its investigators or representatives, information legally requested by the Board;

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

SECTION X:

PROCEDURES FOR ENFORCEMENT AND DISCIPLINARY ACTION

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

A. **Board Authority:** The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions.

B. **Separation of Functions:** In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary sanctions.

C. **Administrative Procedures:** The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for investigation of charges by the Board; notice of charges to the accused; an opportunity for a fair and impartial hearing for the accused before the Board or its examining committee; representation of the accused by counsel; the presentation of testimony, evidence, and argument; subpoena power and attendance of witnesses; a record of proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review.

D. **Informal Conference:** Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with an accused licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee as a result of such an informal conference and agreed to in writing by the Board and the accused licensee should be binding and a matter of public record. However, license revocation and suspension should be dealt with in open hearing. The holding of an informal conference should not preclude an open hearing if the Board determines such is necessary.

E. **Summary Suspension:** The Board should be authorized to summarily suspend a license prior to a formal hearing when it believes such action is required to protect the public health and safety. The Board should be permitted to summarily suspend a license by means of a vote conducted by telephone conference call if the Board president or executive believes such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time (e.g., fifteen to thirty days) of the date of the summary suspension.

F. **Injunctions:** The Board should be authorized to obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating the provisions

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

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

SECTION XI:

IMPAIRED PHYSICIANS

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

A. Impairment should be defined as the inability of a licensee to practice medicine with reasonable skill and safety by reason of:

   1. mental illness; or

   2. physical illness, including, but not limited to, physical deterioration which adversely affects cognitive, motor, or perceptive skills; or

   3. habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of other substances which impair ability.

B. The Board should be authorized, upon probable cause, to require a licensee or applicant to submit to a mental or physical examination by physicians designated by the Board. The results of the examination should be admissible in any hearing before the Board, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination when properly directed to do so by the Board, unless failure was due to circumstances deemed to be beyond the licensee's control, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

C. If the Board finds, after examination and hearing, that a licensee is impaired, it should be authorized to take one or more of the following actions:

   1. direct the licensee to submit to care, counseling, or treatment acceptable to the Board;

   2. suspend, limit, or restrict the physician's medical license for the duration of the impairment;

   3. revoke the physician's medical license.

D. Any licensee or applicant who is prohibited from practicing medicine under this provision should, at reasonable intervals, be afforded an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. Licensure should not be reinstated, however, without the payment of all

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

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

SECTION XII:

COMPULSORY REPORTING AND INVESTIGATION

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

A. Any person should be permitted to report to the Board any information which appears to show that a medical licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine. The following should be required to promptly report such information to the Board:

   1. all physicians licensed under the act;

   2. the state medical association and its components;

   3. all health care institutions in the state;

   4. all state agencies;

   5. all law enforcement agencies in the state;

   6. all courts in the state.

B. A medical licensee's voluntary resignation from the staff of a health care institution or voluntary limitation of his or her staff privileges at such an institution should be promptly reported to the Board by the institution and the licensee if that action occurs while the licensee is under formal or informal investigation by the institution or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

C. Malpractice insurance carriers and affected licensees should be required to file with the Board a report of each final judgment, settlement, or award against insured licensees. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within thirty days).

D. Upon receiving reports concerning a licensee, or on its own motion, the Board should be permitted to investigate any evidence which appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

E. Any person, institution, agency, or organization required to report under this provision of the medical practice act who does so in good faith should not be subject to civil damages or criminal prosecution for so reporting.

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

SECTION XIII:

PROTECTED ACTION AND COMMUNICATION

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

A. No member of the Board, its committees, or its staff should bear liability or be subject to civil damages or criminal prosecution for any action undertaken or performed within the scope of the functions of the Board under the medical practice act and the rules and regulations of the Board when acting without malice and in the reasonable belief the action was warranted.

B. Every communication, oral or written, made by or on behalf of any person, institution, agency, or organization to the Board or to any person designated by the Board to investigate or otherwise hear matters relating to any disciplinary action, whether by way of report, complaint, or testimony, should be privileged. No action or proceeding, civil or criminal, should be permitted to lie against any such person, institution, agency, or organization by whom or on whose behalf such a communication was made, except upon proof that the communication was made with malice.

C. The protections afforded in these provisions should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law, or as prohibiting the respondent from normal access to the charges and evidence filed against him or her as a part of due process under the law.

SECTION XIV:

UNLAWFUL PRACTICE OF MEDICINE: VIOLATIONS/PENALTIES

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

A. It should be declared unlawful for any person, corporation, or association to do or perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board.

B. The Board should be authorized to obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.

C. A person, corporation, or association violating the provisions of the medical practice act, or causing or aiding and abetting such violation, should be deemed guilty of a crime.

SECTION XV:

PERIODIC REREGISTRATION

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

A. At the time of periodic reregistration, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The application form for license reregistration should be designed to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information.

1. Any action taken against the licensee by:

   a. any jurisdiction or authority (United States or foreign) which licenses or authorizes the practice of medicine;

   b. any peer review body;

   c. any health care institution;

   d. any professional medical society or association;

   e. any law enforcement agency;

   f. any court; or

   g. any governmental agency

   for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action.

2. Any adverse judgment, settlement, or award against the licensee arising from a professional liability claim.

3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.

4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.

5. The licensee's voluntary resignation from the medical staff of any health care institution

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

6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

7. Whether the licensee has ever been addicted to or treated for addiction to alcohol or any chemical substance.

8. Whether the licensee has had any physical injury or disease or mental illness within the registration period which could reasonably be expected to affect his or her practice of medicine.

9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the registration period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license reregistration and to require documentation of that education.

C. The licensee should be required to sign the application form for license reregistration and have it witnessed. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

D. The Board should be directed to establish an effective system for reviewing reregistration forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license reregistration.

SECTION XVI:

PHYSICIAN'S ASSISTANTS

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

A. **Definitions:** The following terms should have the meanings given them below:

1. "Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

2. "Physician's assistant" means a skilled person certified by the Board as being qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible, in a manner determined by the Board, for the performance of that person.

B. **Administration:** The Board should enforce and administer these provisions of the medical practice act.

C. **Certification and Registration as a Physician's Assistant:**

1. No person should perform or attempt to perform as a physician's assistant without first applying for and obtaining a certificate of qualification from the Board and having his or her employment registered in accordance with Board rules and regulations.

2. An applicant for a certificate of qualification as a physician's assistant should complete application forms prepared and furnished by the Board and pay a non-returnable fee. Upon being duly certified by the Board, the applicant should have his or her name and address and other pertinent information enrolled by the Board on a roster of physician's assistants.

3. Each certified physician's assistant should register his or her employment with the Board annually, stating his or her name and current address, the name and office address of both his or her employer and the supervising licensed physician, and submitting a copy of the current protocol governing his or her activities and such additional information as the Board deems necessary. Upon any change of employment as a physician's assistant, such registration should automatically be void. Each annual registration or reregistration of new employment should be accompanied by a fee set by the Board.

D. **Denial, Suspension or Revocation:** The Board should be empowered to deny or suspend any registration or to deny or revoke any certificate of qualification upon grounds similar to those for such disciplinary actions against licensed physicians.

E. **Rules and Regulations:** The Board should be empowered to adopt and enforce reasonable rules and regulations for:

1. setting qualifications of education, skill, and experience for certification of a person as a physician's assistant and providing forms and procedures for certificates of qualification and for annual registration of employment;

2. examining and evaluating applicants for certificates of qualification as physician's assistants as to their skill, knowledge, and experience in the field of medical care; and

3. establishing criteria for protocols governing the activities of physician's assistants.

F. **Duties of Physician's Assistants:** A physician's assistant should perform only those acts and duties approved by the Board for which the assistant has been trained and which have been assigned to the assistant by a supervising licensed physician who is fully qualified to perform and to supervise such acts and duties.

G. **Responsibility of Supervising Physician:** Every physician using, supervising, or employing a registered physician's assistant should be qualified in the medical areas in which the physician's assistant is to perform and should be individually responsible and liable for the performance and the acts and omissions of the physician's assistant. Nothing in these provisions, however, should be construed to relieve the physician's assistant of any responsibility and liability for any of his or her own acts and omissions. No physician should have under his or her supervision more than two currently registered physician's assistants.

SECTION XVII:

RULES AND REGULATIONS

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

A. The Board should be authorized to adopt and enforce rules and regulations to carry into effect the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

SECTION XVIII:

FUNDING AND FEES

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

A. All fees, charges, costs, and fines collected by the Board or on its behalf should be specifically designated for the use of the Board in fulfilling its duties under the medical practice act.

B. The Board should be authorized to set fees and charges for examination, licensure, certification, registration, reregistration, and other functions and services at levels adequate to support the Board's effective fulfillment of its duties under the medical practice act.

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)

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

POSITIONS:

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

ANALYSIS : (Attach a separate page if necessary)

Please see attached analysis.

Richard I. Peques

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

Richard I. Peques /For

Approved by Commissioner: Grace Berg Schaible, Atty. Gen.
Date : April 13, 1987
Agency : Department of Law

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

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 70 (Fin)

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

MEMO

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

The Problem:

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

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

3) The need for minor housekeeping changes.

Proposed Remedy:

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

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

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

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

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

M E M O R A N D U M February 24, 1987

SUBJECT: Amendments to CSHB 70 (L&C)

TO: Representative John Sund

FROM: Edward H. Hein *EH*
Legislative Counsel

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

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

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

EHH:mkr
m9/047

Enclosures

Department of Commerce & Economic Development / POSITION PAPER

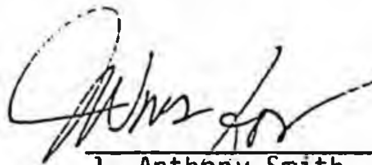
CSHB 70 (JUD): An Act relating to the State Medical Board; and amending Rule 504(d) of the Alaska Rules of Evidence.

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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An Overview of State Medical Discipline

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

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

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

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

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

LITTLE RISE IN BOARD RESOURCES

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

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

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

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

INSPECTOR GENERAL'S ROLE

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

From the scandals involving fraudu-

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

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

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

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

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

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

Organizational Changes

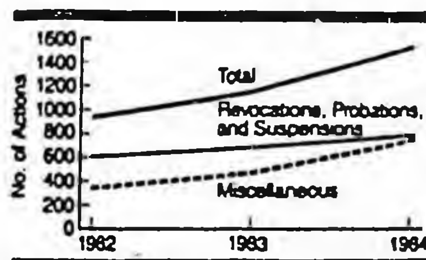
Boards have experienced other significant changes in recent years in addition to rising work loads greater than the resources to deal with them. Both the organizational structure and size of boards have changed. While in 1969, only 16 boards were housed under the aegis of a central agency, currently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

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

STATE BOARDS' RESPONSE

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

States' responses to overworked investigators and board members have focused mainly on ways of easing the burden on board members. Among the



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

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

Incidence of Disciplinary Actions

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

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

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

Types of Violations

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

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

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

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

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

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

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

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

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

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

Source of Disciplinary Actions

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

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

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

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

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

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

Information Sharing

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

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

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

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

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

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

CONCLUSION AND RECOMMENDATIONS

We have shown how boards have been confronted with increased work loads, inadequate financial support, and many conflicting pressures. Yet, their ability to act as necessary is predicated on their resource level. Accordingly, we believe physician license renewal fees should be set at a level sufficient to support expansion and improvement of the enforcement activities of the boards. (A recent report by the Public Citizen Health Research Group called for an increase in annual physician renewal fees to at least $500, "with all of the money going to identification and discipline of doctors who are incompetent or otherwise practicing bad medicine."[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.

References

1. *Medical Licensure and Discipline: An Overview.* US Dept of Health and Human Services, 1986.
2. *Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal.* US General Accounting Office, 1980.
3. *Federal, State, and Private Activities Pertaining to U.S. Graduates of Foreign Medical Schools.* US General Accounting Office, 1985.
4. Relman AS: Professional regulation and the state medical boards. *N Engl J Med* 1985;312:784-785.
5. Wolfe SM, Bergman H, Silver G: *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform.* Washington, DC, Public Citizen Health Research Group, 1985.