

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1733 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990, 1301

Alaska State Medical Board

FY-89 Annual Report

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Board or Commission	Appointed	Term
STATE MEDICAL BOARD		
AS 08.54 - 7 members; 4 year term, serves until new member is appointed and qualified.		
Raymond Bailey (Public Member) 1726 Chena Pump Road Fairbanks, Alaska 99709 (work) 479-0690 (home) 479-0134	January 12, 1989	August 13, 1992
T.L. Conley, M.D., (Chairperson) Ketchikan Medical Clinic, Inc. 3612 Tongass Ketchikan, AK 99901 (work) 225-5146 (home) 225-4483	July 15, 1982	April 21, 1990
Abigale Ryan Hensley (Public Member) (Secretary) P.O. Box 710 Kotzebue, AK 99752 (work & home) 442-3669	Feb 10, 1986	January 9, 1983
Joan G. Jelinek, M.D. 2111 Cowles, Suite 1 Fairbanks, Alaska 99701 (work) 452-7522	January 12, 1989	November 6, 1992
Michael H. Newman, M.D. 4048 Laurel St., #106 Anchorage, AK 99508 (work) 563-8141 (home) 243-5269	July 18, 1988	July 8, 1992
Patrick Nolan, D.O. 3300 Providence Drive, # 206 Anchorage, AK 99508 (work) 561-6100 (home) 345-1796	April 22, 1988	April 21, 1992
James W. Thompson, M.D. 3260 Hospital Drive Juneau, AK 99801 (work) 586-8447 (home) 789-7491	Feb 26, 1987	January 12, 1992
Kym Walker, Licensing Examiner Division of Occupational Licensing P.O. Box D-LIC Juneau, AK 99811-0800 (work) 465-2541		
Pam Ventgen, CMA, Executive Secretary State Medical Board 3601 "C" Street, Suite 722 Anchorage, AK 99503 (work) 561-2878 (home) 349-9301		

NARRATIVE SUMMARY

The purpose of the State Medical Board is to serve and protect the public health. The functions of the State Medical Board can be viewed as falling into three broad areas:

1. The issuance, after scrutinizing qualifications, of licenses to physicians, osteopaths and podiatrists, and permits to paramedics and physician assistants.
2. The investigation of infractions of rules and statutes, particularly as they relate to incompetence, negligence and impairment which may endanger the public, by any members, new applicants or those already licensed or permitted, of the regulated groups. On findings of deficiencies, the board is enjoined and empowered to take corrective action up to and including revocation of licenses and permits.
3. The review of existing regulations and the proposal and adoption of new regulations designed to ensure that quality medical care be readily and efficiently available to the population. The board is also expected to advise the Legislature on necessary changes in statutes to ensure the same end.

The board feels that it has made significant progress in all three areas over the last fiscal year and is optimistic that the board can fulfill its responsibilities even more effectively in FY-90.

Issuance of Licenses

In this area, the board has continued to very carefully scrutinize applications to ensure that applicants are qualified for practice in the State of Alaska. The process has become more complex and time consuming in order to assure continued high quality and competence. The board now requires that all applications be accompanied by disciplinary data bank information from the Federation of State Medical Boards in regard to disciplinary sanctions imposed by other jurisdictions. Additionally, as part of the application process, the board is requiring information from all hospitals where physician applicants have previously had staff privileges. It is widely accepted that this is the one most effective tool in assessing competence. Deficiencies in practice are generally more likely to come to the attention of hospital staffs earlier than they do to other review boards and having access to this data spotlights those applicants who we need to investigate more closely. This does create more work for the board and occasionally results in some slow down in licensure but it is felt that this is a small price to pay for assuring that those licensed in the State of Alaska will meet high standards. Additionally, during FY-89, the board instituted the use of a biographical data sheet for use during the interview process and began requesting independent verification of physician applicants' medical school and first year of post graduate training.

Meetings

During FY-89 the board had funding and staff support to hold four meetings as required by statute. All four of these meetings were held in Anchorage in

order to accomplish business at minimum expense. This meeting schedule allowed the board to function effectively without undue delays in licensure and disciplinary matters.

Investigations

The concerns of the board in prior years about lack of funding and personnel to adequately address investigative matters have been considerably improved with the services of a full-time dedicated investigator. The number of investigations in FY-89 was significantly higher than in prior years and investigations were delayed in some cases. It appears that the services of the executive secretary and investigator have increased public awareness of the of the board's function and existence, resulting in an increase in the number of complaints from the public and the medical community.

Federation of State Medical Boards

The board was able to send a board member and the executive secretary to the annual meeting of the Federation of State Medical Boards in April 1989. This was a very worthwhile undertaking and one that the board hopes to continue on an annual basis. Input from other medical boards was helpful in assessing our programs, getting advice on model legislation, and learning about innovative ways of handling common problems. As noted, information coming to the board from the disciplinary data bank of the Federation of State Medical Boards has been very beneficial in the area of licensure. Improvements in the rapidity with which this data can be accessed were presented at the annual meeting and the State Medical Board is looking into ways of making use of these new on-line data systems. Additionally, close cooperation with the Federation of State Medical Boards insures access to training for board members and staff.

National Practitioner Data Bank

The board was also able to obtain current information on the National Practitioner Data Bank due to be in operation at the federal level in the fall of 1989. This data bank is one portion of the Health Care Quality Improvement Act of 1986 (PL 99-660) and requires hospitals and malpractice insurance carriers to report disciplinary actions through state medical boards to the data bank. This will require increased staff time to accommodate the additional reporting requirements of PL 99-660 and the anticipated increase in investigatory cases.

Impaired Physician Program

The executive secretary position was created and funded in FY-87. Having a full-time executive officer for the board has been a welcome addition and has increased the effectiveness of the board. One of the primary goals of the executive secretary this year was the implementation of an impaired physician program. Such a program was authorized by legislation that passed FY-87 which instructed the board to coordinate with private professional organizations to establish an impaired physician program. Actual provision of services will be with the state medical association. This program was a cooperative effort between the State Medical Board and the Alaska State Medical Association and was approved by the board, the association and the Division of Occupational Licensing in June 1988. In general, the program requires the impaired

practitioner to receive rehabilitative treatment and participate in a monitored recovery program and chemical monitoring during a five-year period of probationary licensure. Experience around the country indicates that such programs are highly effective and can salvage otherwise competent practitioners while at the same time effectively protecting the public.

Regulations

In regard to regulatory projects, there are several that were completed within FY-89 and several that are in progress at the moment. Regulations covering Physician Assistants were revised in FY-88 and 89 and became effective in FY-89. They included provisions for locum tenens PA's and clarification of the registration and authorization to practice procedures. The regulations revisions also included a number of housekeeping changes. Regulatory projects still in progress include paramedic internship, short term physician licensure as well as housekeeping changes to the physician locum tenens permit coverage. Statutory changes sought this year did not make it through the legislature this term and will be attempted again in FY-90.

New Board Members

The board acquired two new Fairbanks members this year. Joan Jelinek, M.D. replaced Jeffrey Partnow, M.D., and Raymond Bailey replaced Bonnie Coghlan in a public member position.

Applicant Interviews

Since most applicants travel to or through Anchorage, the Anchorage board members continue to shoulder the burden of interviewing the vast majority of physician applicants. In FY-88, the executive secretary was delegated the authority to interview physician assistants and issue temporary permits. This has provided more timely service to licensees and at the same time, eased some of the load on the board members.

Recognition and Appreciation

The State Medical Board appreciates the assistance of Division of Occupational Licensing staff including:

Pam Ventgen, CMA, Executive Secretary
Ryn Walker, Licensing Examiner
Curtin Matthews, Investigator
Ervin Henderson, Regulations Specialist

The board also recognizes and appreciates the assistance of the Hearing Officers and Assistant Attorneys General.

Summary

Finally, the board would like to comment that cooperation between the board and the Division of Occupational Licensing in Fiscal Year 1989 has been excellent. We all seem to have been moving toward common goals in the last year and the spirit of cooperation has resulted in significant

accomplishments. Regulation of professional licensure is a very complex and demanding task and one that the public is demanding be carried out consistently and with competence. Great strides have been made in this process in the last year and the board feels that the state has been well served.

FY 89 STATISTICAL INFORMATION
(Please Type)

Date: June 30, 1989

Method: Check the appropriate method in which licenses are issued (not including Examination), and cite the specific statutory authority.

<u> </u> Credentials	AS 08. <u>64.250</u>
<u> </u> Reciprocity	AS 08. <u>N/A</u>
<u> </u> Comity	AS 08. <u>N/A</u>
<u> </u> Endorsement	AS 08. <u>N/A</u>

New Licenses: List each category and the number of licenses issued within each category for the first time in FY 89

CATEGORY:

NUMBER OF LICENSES:

(1) <u>Allopathic Physicians (M.D.'s)</u>	<u>86</u>
(2) <u>Osteopathic Physicians (D.O.'s)</u>	<u>12</u>
(3) <u>Podiatrists</u>	<u>1</u>
(4) <u>Physician Assistants</u>	<u>25</u>
(5) <u>Mobile Intensive Care Paramedics</u>	<u>21</u>
Total:	<u>145</u>

	Physician	Total:	Physician Assistant	Paramedic
Number of CURRENT licensees:	<u>925</u>		<u>138</u>	<u>100</u>
Number of LAPSED licensees:	<u>744</u>		<u>70</u>	<u>42</u>
Number of INACTIVE licensees:	<u>255</u>		<u>--</u>	<u>--</u>

Expiration Date: If the expiration date is different for each category, indicate the category after each date.

Expire: 12-31-90

Examination: List each examination separately indicating the licensure category (such as RN, LPN, Dentist, Dental Hygienist), the total number of examinees, number passed and failed.

Exam Statute Authority: AS 08.64.210

(1) Category:	Total Candidates	#Passed	#Failed
<u>M.D. FLEX</u>	<u>None in FY 89</u>	_____	_____
Date and City: _____			
(2) Category:	Total Candidates	#Passed	#Failed
_____	_____	_____	_____
Date and City: _____			
(3) Category:	Total Candidates	#Passed	#Failed
_____	_____	_____	_____
Date and City: _____			
(4) Category:	Total Candidates	#Passed	#Failed
_____	_____	_____	_____
Date and City: _____			

MEETINGS: List Date(s) and Location(s)

1. 10/13,15,16/88 - Anchorage
2. 01/09-10/89 - Anchorage
3. 03/20-21/89 - Anchorage
4. 05/22-23/89 - Anchorage

TELECONFERENCES: List Date(s) and Site(s)

1. 12/31/88

REGULATION HEARINGS: List Date(s) and Site(s)

No hearings held.

Although no hearings were held, work was done on paramedic regulations.

INVESTIGATIONS: (Attach Case Summary)

See attached

STATE MEDICAL BOARD
ENFORCEMENT STATISTICS

FY-89

Investigations

Cases Pending Start of FY-89	17
New Cases Opened	94
Cases Closed	68
Cases Pending End of FY-89	43

Litigation

Cases Pending Start of FY-89	7
New Cases Opened	3
Cases Closed	2
Cases Pending End of FY-89	8

Enforcement Activity

Accusations	1
Statement of Issues	0
Cease and Desist Orders	0
Hearings	1

Disciplinary Actions

Cases Dismissed	0
Licenses Denied	0
Licenses Suspended	1
Probation	4
Licenses Revoked	0
Stipulations/Settlements	3
Letters of Reprimand	0

BOARD/COMMISSION TRAVEL REQUEST

A. In-State Regular Board Meetings: FY 90 FY 91

Number of board meetings authorized
by statute: 4

Number of board meetings requested: 4 4

Location(s):	Anchorage	Anchorage
	Anchorage	Anchorage
	Juneau	Anchorage
	Anchorage	Anchorage

B. Out-of-State Travel

<u>Name of Event</u>	<u>Location</u>	<u>Dates</u>	<u>Who expected to Attend</u>	<u>Alternate</u>
Western Region Meeting AIMS (Medical Board Administrators)	Sacramento, CA	Oct. 89	Pam Ventgen	—
Site Visit Evaluate residential chemical dependency treatment facilities	Portland, OR Atlanta, GA	Jan-Feb 90	J. Thompson, MD	—
Federation of State Medical Boards Annual Meeting	Birmingham, AL	April 90	J. Thompson, MD	A. Hensley
AMA Conference on Impaired Health Practitioners	Orlando, FL	June 90	Pam Ventgen	—

SUNSET PERFORMANCE AUDIT RECOMMENDATIONS

The last sunset audit of the medical board was completed in January 1987. Although there were no recommendations included in the report, several issues were identified in the analysis of public need. A response to the sunset audit was prepared by then-Commissioner J. Anthony Smith to address these specific issues.

There has been a renewed commitment to hold four face-to-face meetings each year. The board has done so in FY-88 and FY-89 and plans to hold four face-to-face meetings in FY-90.

As indicated in the commissioner's 1987 letter, the division is now able to allocate direct and indirect costs as well as actual revenues to the medical board. This allows for more accurate setting of fees to match the expenses of operating and supporting the board.

Lastly, the board has established regulations (12 AAC 40.055) to govern the interview requirement. The board continues to revise and improve its handling of interviews, primarily with the scheduling of all interviews through staff and the delegation to the executive secretary of physician assistant, paramedic, locum tenens and resident-in-training permit interviews.

REVIEW OF PRIOR YEAR OBJECTIVES

Goal I - Meet the requirements of Alaska Medical Statutes AS 08.64.

A. To enforce statutes and regulations in issues of discipline and quality assurance.

1. To investigate and take action on complaints within three months of the complaint: The board, through the Division of Occupational Licensing, continues striving to improve in this area.
2. To work cooperatively with the Attorney General's Office in the timely enforcement of disciplinary actions: The innovative use of hearing officers within the division has resulted in a more rapid clearing of cases. Additionally, cases, especially in the area of impairment, are handled through mutually arrived at consent decrees rather than taking them through the lengthy litigation process. Delays due to work load in the Anchorage Attorney General's office continue to plague the process.
3. The number of cases is up considerably over prior years, in part due to the ability to work all cases that come to the board's attention. The full-time investigator dedicated to the medical board continues to gain expertise in the medical arena and is increasingly effective. Complaints are responded to promptly, investigations are handled thoroughly and brought to the board in a timely manner.

B. To review applications of medical practitioners on a timely and impartial basis.

1. To review within three months all completed applications for licensure to practice in the State of Alaska of allopathic physicians (M.D.'s), osteopathic physicians (D.O.'s), podiatrists, physician assistants, and mobile intensive care paramedics: With the opportunity to meet four times in this fiscal year, we have fulfilled this goal in most cases. In those cases where there has been delay, it has almost invariably been caused by failure of the applicant to submit the needed data or the uncovering of information that led to further investigation. In those areas where all the data was complete and there was no adverse information presented, licensure was completed within the time frame indicated.
2. To evaluate, on an ongoing basis, ways to improve the application and licensing process: The board has continued to review its function in this area. With the employment of the executive secretary, the board has made further improvements. The executive secretary has streamlined the setting of applicant appointments for interviews and has increased the assurance that license files were complete prior to interview. Additionally, the executive secretary's handling of temporary permits to

physician assistants has provided more efficient service to PA applicants and the public they serve. The executive secretary continues to revise and update the license application forms and procedures to accommodate regulation revisions and policy changes. Lastly, the executive secretary is able to assist applicants with the licensing process, and is especially adept when out of the ordinary situations arise.

C. To have four (4) face-to-face meetings every year. This has been accomplished in FY-89.

1. To advertise board meetings well in advance and widely in various media: We continue to try and do this with mixed success, primarily due to cost of advertising.
2. To inform the public of board activities through a periodic newsletter: A newsletter is still financially prohibitive; however, the board has been more successful in publishing the results of its deliberations both in the general press and through State Medical Association publications.
3. Increase public awareness of the medical board's function: The board would like to assist the division in development of a generic brochure educating the public on how to file a complaint with the division.

D. To provide the Federation Licensing Examinations (FLEX).

To hold two FLEX examinations yearly (June and December): These continue to be offered.

Goal II - Improve the performance of the board and ensure that existing statutes and regulations are relevant.

A. To evaluate the relevance of existing medical practice statutes and regulations.

1. To examine, rewrite, and put into effect policies and regulations that will rectify inconsistencies and conflicts in present regulations and policies: We have continued to do this. The Physician Assistant regulatory project was completed in FY-89. These new regulations allow for locum tenens physician assistants and clarify the distinction between registration and the physician assistant's authorization to practice.
2. To recommend, when appropriate, statutory changes to the present Alaska Medical Statutes, AS 08.64:

The board sought statutory changes this year to:

- a. establish a "retired" status medical license to allow retired

physicians no longer practicing to maintain their licenses with no continuing medical education (CME) requirements.

b. establish a "courtesy status" license to accommodate physicians accompanying interstate and international sporting teams.

c. provide for short-term licensure with full credentialing requirements and reduced fee for short-term work assignments.

d. restrict locum tenens permits to those physicians specifically substituting for another Alaska licensed physician.

e. extend peer review immunity to the impaired physician committee of the Alaska State Medical Association.

f. provide for the executive secretary to conduct locum tenens and resident-in-training permit interviews.

g. restrict the use of amphetamines to currently appropriate medical uses.

h. preserve the sanctions imposed by the board during the sometimes lengthy appeals process.

B. To improve administrative functioning.

1. To effectively utilize the services of the executive secretary in administrative areas, supervision of probationary licensure, setting up an impaired physicians program, etc.: The executive secretary is enhancing the functioning of the board by providing ongoing support for board meetings and carrying out the board's functions on a day-to-day basis, providing orientation to new board members, providing supervision of licensees under probation and working with the Alaska State Medical Association in implementing a formal impaired physician program.

C. To improve the board's knowledge and effectiveness in ensuring safe health care for the citizens of the State of Alaska.

1. To send one board member and the executive secretary to the annual meeting of the Federation of State Medical Boards: This was done this year with what the board considers significant benefit to its functioning.
2. To cooperate with the Nursing and Pharmacy Boards to ensure coordinated regulations relating to health care: The State Medical Board has continued to have contact with the Nursing and Pharmacy Boards. Present cooperation between the various boards is considered smooth and harmonious by all involved. The medical, nursing and pharmacy boards met jointly this year to address common issues of interest to these boards. Additionally,

the boards and the division sponsored a pain management continuing education seminar in October 89 to address concerns relating to appropriate prescribing of narcotic drugs.

3. To develop an effective impaired physician program: The Impaired Physician Treatment Program was developed in conjunction with the Alaska State Medical Association and based on Oregon's notably effective program. The program includes a residential treatment component, AA and peer support aftercare and random chemical screening for alcohol and drugs of abuse. The program was formally adopted by the medical board, medical association and the division in June 1988 and is being fully implemented.
4. The board participated in the Prescription Abuse Data Synthesis (PADS) project. The PADS project was developed and is funded by the American Medical Association (AMA) and was brought to Alaska at the request of the Alaska State Medical Association and the State Medical Board to assess the extent of any prescription drug abuse problems in Alaska. After analysis of the data and investigation into prescriptive practices in Alaska, it was determined that there is not a significant prescription drug abuse problem in Alaska although there are some areas where additional education would be appropriate. Recommendations were made by the PADS policy group and submitted to the Governor. The report is attached as addendum A.

NEW GOALS AND OBJECTIVES

Goal I - Meet the requirements of Alaska Medical Statutes AS 08.64.

A. To enforce statutes and regulations in issues of discipline and quality assurance.

1. To investigate and take action on complaints within three months of the complaint.
2. To work cooperatively with the Attorney General's Office and the Division Hearing Officers in the timely enforcement of disciplinary actions and to have the Assistant Attorney General present during a portion of each board meeting for advice and counsel.
3. To effectively utilize the services of the full-time medical investigator.

B. To review applications of medical practitioners on a timely and impartial basis.

1. To review within three months all completed applications for licensure to practice in the State of Alaska of:

Allopathic Physicians (M.D.s)
Osteopathic Physicians (D.O.s)
Podiatrists (D.P.M.s)
Physician Assistants (P.A.s)
Mobile Intensive Care Paramedics (M.I.C.P.s)

2. To evaluate, on an ongoing basis, ways to improve the application and licensing process.

C. To have four (4) face-to-face meetings every year.

1. To advertise board meetings widely and well in advance.
2. To inform medical providers and the public of board actions on a regular basis.

D. To offer FLEX examinations.

To offer two FLEX examinations yearly (June and December).

Goal II - Improve the performances of the board to ensure that existing statutes and regulations are relevant.

A. To evaluate the relevance of existing medical practice statutes and regulations.

1. To examine, rewrite and put into effect policies and regulations that will rectify inconsistencies and conflicts in present regulations and policies.
2. To recommend, when appropriate, statutory changes to the present Alaska Medical Statutes, AS 08.64.

B. To improve administrative functioning.

1. To effectively utilize the services of the executive secretary in administrative areas, supervising of probationary licensure, continued implementation of the impaired physician program and other projects as necessary.

C. To improve the board's knowledge and action in ensuring safe health care for the citizens of the State of Alaska.

1. To send one board member and the executive secretary to the Annual meeting of the Federation of State Medical Boards.
2. To send the executive secretary to the Administrators in Medicine Society (AIMS is a subgroup of the Federation of State Medical Boards consisting of executive officers of all the state medical boards) regional and semi-annual meetings.
3. To cooperate with the Nursing and Pharmacy Boards to ensure coordinated regulations relating to health care.
4. To continue working with the Alaska State Medical Association to fully implement the recently adopted Impaired Physician Treatment Program.
5. To develop and distribute a brochure explaining the purpose and function of the medical board and the complaint and investigation process so that the public has better access to the services of the board.
6. To develop and implement the recommendations resulting from the PADS project.

BUDGET RECOMMENDATIONS

In considering the budget for the State Medical Board in FY-90, the board requests funding be allocated for four (4) face-to-face meetings. Inevitably, there will be at least one teleconference during the year for unexpected matters. A board member and the executive secretary are expected to attend the Federation of State Medical Boards meeting in April 1990 in Birmingham, Alabama. Funding will also be required to send the executive secretary to the Administrators in Medicine Society (AIMS) Western Region meeting in Sacramento in October 1989. The AIMS regional meeting will be particularly important this year as it will deal largely with training and implementation of the National Practitioner Data Bank. Funding is required for the executive secretary to attend AMA's conference on Impaired Health Professionals in Orlando, Florida in June 1990. The executive secretary is also expected to represent the medical board at the annual meeting of the Alaska State Medical Association in Fairbanks in June 1990. Lastly, funding will be needed for a half-time position to provide data reporting services to the National Practitioner Data Bank, which was created under PL 99-660, the Health Care Quality Improvement Act of 1986. The data bank is scheduled to begin operation September 1, 1989.

LEGISLATIVE RECOMMENDATIONS

The board is considering legislation to increase post-graduate training requirements. AS 08.64.200(3) requires one year post-graduate level training. Other states are increasing their requirements to two and in some states three years of post-graduate level training. The board feels that the complexity of medicine now makes two years post-graduate training a reasonable requirement. In addition, the State of Alaska would not want to have lower standards than other states and thereby attract applicants who could not obtain licensure elsewhere.

The board is also considering legislation to provide for requiring the Special Purpose Examination (SPEX) for physician applicants who are some years (e.g., 10 years) beyond initial license examination. Without these requirements the board must rely on outdated examination results, letters of reference and recommendation, and other limited means. As other states begin to require this additional examination Alaska should assess the need to follow suit.

The board will be considering legislation to accommodate the single examination pathway to licensure. This new examination will replace both of the currently recognized examinations: The Federation Licensing Examination (FLEX) and the National Board of Medical Examiners (NBME) examinations. The single examination pathway to licensure was recently adopted by the Federation of State Medical Boards at its annual meeting in April 1989. It is expected that the single examination will be phased in over the next several years.

Additionally, the board intends to pursue legislation introduced in early 1989 relative to: interview requirements, retired status licensure, immunity extended to the impaired physician committee of the Alaska State Medical Association, credentialing for courtesy licenses, short-term full licenses, restricting the use of amphetamines, preserving sanctions of the board and amendments to the definitions in AS 08.64.380(7)(B).

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

Section 1. AS 08.64.101(6) is amended to read:

Sec. AS 08.64.101(6) coordinate with private professional organizations to establish an impaired medical professionals program to identify, confront and treat persons licensed under this chapter who abuse addictive substances.

2. Public/Industry/Profession benefit:

To protect the public by facilitating the effective operation of the Impaired Physician Program.

3. State the problem or purpose prompting this request:

Sections 1 & 13 are to be read together.

The volunteers who staff the effort have been concerned that though they are protected from civil liability in terms of arranging treatment that their very necessary activity in terms of identification and confrontation of those in need of help is not so protected. The provisions of Section 1 & 13 extend the protection of immunity from civil and criminal liability for these necessary activities. This seems logical, appropriate and consonant with protection of the public's health.

4. Briefly state the history of this problem or proposal:

Under the provisions of HB 70 of the 15th Legislature the board was empowered to contract with a private professional agency to run an impaired professionals program. Such a contract was signed June 1988 between the Board and the Division of Occupational Licensing and the Alaska State Medical Association (ASMA). Members of the ASMA's Impaired Physician Committee (all unpaid volunteers) seek out individuals in trouble, confront them and get them into treatment. The program is working very well at this point and is a marvelous boon to the community in shortstopping problems before they go on to threaten the public health.

5. Identify the alternatives to this legislation (if any):

- a. One alternative is to provide no immunity, which would effectively chill the willingness of physician volunteers to risk the liability exposure of confronting impaired colleagues.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 2. AS 08.64.225 is amended to read:

Sec. AS 08.64.225. FOREIGN MEDICAL GRADUATES. Applicants who are graduates of medical colleges not accredited by the American Medical Association or one of its agencies must [SHALL] meet the requirements of AS 08.64.200(a)(3),(4),(5), and AS 098.64.255 and must have passed an examination and be certified by the Education Council on Foreign Medical Graduates, or be licensed by examination in another state or territory of the United States or province of Canada.

2. Public/Industry/Profession benefit:

To clarify the interview requirement and to make the statutes more consistent with present policy.

3. State the problem or purpose prompting this request:

Sections 2,3,6,7 & 10 are to be read together.

Present statute requires that all licensees and permittees be interviewed by at least one board member. Present policy requires that should the interviewer feel unsure about granting the license after the interview that an interview by the whole board and appropriate investigation by the division be carried out before licensure.

Interviews are carried out by both physician and non-physician members of the board without distinction. There is no attempt to use the interview as a test of knowledge both for practical and statutory reasons.

The interviewing of permanent and temporary licenses (most of the latter are expected to go on to permanent license status) should appropriately remain with board members exclusively. It is being found however that interviewing resident-in-training and locum tenens candidates is placing a severe burden on board members' time, especially in Anchorage and Fairbanks, and leading to delays and resentment on the part of both candidates and volunteer board members. It seems appropriate then that our executive secretary should take on part of that task. That individual is trained in statute and regulation and is familiar with training and testing cycles and the methods of acceptable identification.

4. Briefly state the history of this problem or proposal:

The interview requirement is one that was set by the legislature many years ago. What the legislative intent was is unclear to the board and

research through older versions of the statutes back to 1948 doesn't clarify the issue. Our practical experience is that it has some utility in determining that the applicant is indeed who he says he is (documents and pictures match, etc.), seems to be sober and not flagrantly psychotic, and seems to present a logical sequence of training. It also allows for verification of immigration and naturalization documents which cannot, by law, be photocopied.

The board recognizes that the interview is of significantly less importance than careful review of notarized training, residency, hospital privilege, specialty board, testing and licensure (in other jurisdictions) documentation plus clearance by the DEA and National Federation of State Medical Boards.

5. Identify the alternatives to this legislation (if any):

Eliminate interview requirement for resident-in-training and for locum tenens applicants.

6. Which alternative mentioned would be most acceptable?

Proposed changes.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 3. AS 08.64.230 is amended to read:

Section AS 08.64.230. LICENSE GRANTED. (a) If the physician applicant passes the examination and meets the requirements of AS 08.64.200 and AS 08.64.255, the board shall grant a license to the applicant to practice medicine in the state.

(b) If the osteopath applicant passes the examination and meets the requirements of AS 08.64.205 and AS 08.64.255, the board shall grant a license to the applicant to practice osteopath in that state.

(c) Each license shall be signed by the secretary and president of the board, and have the seal of the board affixed to it.

2. Public/Industry/Profession benefit:

To make statutory requirements more consistent between sections.

3. State the problem or purpose prompting this request:

See Section 2.

4. Briefly state the history of this problem or proposal:

See Section 2.

5. Identify the alternatives to this legislation (if any):

Eliminate interview requirement.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 4. AS 08.64.240(a) is amended to read:

Section AS 08.64.240. LICENSE REFUSED. (a) The board may not grant or license if

(4) The applicant has surrendered a license in another jurisdiction while under investigation and the license has not been reinstated in that jurisdiction.

2. Public/Industry/Profession benefit:

To protect the public from incompetent practitioners.

3. State the problem or purpose prompting this request:

This section closes a loophole. At present, persons who have surrendered a license in another jurisdiction while under investigation are free to apply in Alaska (if they have had the license revoked they are not so permitted). It seems sensible to require that they clear up their problem one way or another in the prior jurisdiction before applying in Alaska.

4. Briefly state the history of this problem or proposal:

See above.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 5. AS 08.64.270 is repealed and readopted to read:

Sec. AS 08.64.270. TEMPORARY PERMIT. (a) The board may issue a temporary permit to a physician applicant, osteopath applicant, or podiatry applicant who meets the requirements of AS 08.64.205, AS 08.64.209 or AS 08.64.225 and pays the required fee.

(b) A temporary permit issued under this section is valid for six months and must be approved by the board at the next regularly scheduled meeting of the board after it is issued.

(c) A temporary permit issued under this section may not be renewed. The fee for the permit shall be one quarter of the biennial licensing fee (plus the appropriate application fee). At the discretion of the licensee and with board approval the temporary license may be converted to a biennial license (permanent license) upon payment of the remainder of the fee due for such a license.

2. Public/Industry/Profession benefit:

To make the statutes and regulations consistent with desired policy.

3. State the problem or purpose prompting this request:

Sections 5 & 7 should be read together:

In the past, a temporary license was granted to an individual who had completed all the requirements for a permanent license including an interview and was waiting for the board to meet to confirm the material and grant permanent licensure.

The ~~locum~~ tenens permit, though statutorially designed to be used only by those substituting for another physician, developed an expanded, and to the board, uncomfortable meaning. It was used as intended for substitute physicians but was also used to cover individuals who came to Alaska to work in seasonal jobs, emergency rooms, etc., and those coming up briefly to see if they wanted to relocate to Alaska. Often they were not actually substituting for an Alaskan physician but there seemed no other reasonable category in which to place them without requiring permanent licensure. Some individuals also seemed to acquire such permits on a regular basis, and as it were, acquire sort of a permanent license at a cut rate.

By coordinating AS 08.64.270 and AS 08.275 the board hopes to create two categories.

A. Temporary Permit - good for 6 months and requiring all the documentation required for a permanent license plus interview by a board member to be used

- 1) While waiting formal board action at the next regular meeting at which point it is converted to a permanent license.
- 2) By those filling a temporary slot in an emergency room, seasonal clinic, etc., but not substituting for an Alaskan physician.
- 3) By those moving to the state who have not yet decided if they wish to stay permanently.
- 4) Individuals in category 2 & 3 (or for that matter, those who wish to get frequent locum tenens permits) can then move on to permanent licensure by paying the remnant 75% of the permanent licensure fee any time up to 6 months after getting the temporary as they will have complied with all the requirements. The board would still have the discretion of putting a hold on this if the individual had gotten into trouble during the 6-month temporary period.

B. Locum Tenens Permit - good for 60 days with one renewal and a limit of 240 days in any two years between new permits and renewals. It would require somewhat less documentation than a temporary (but demand a currently valid license in another jurisdiction and clearance by National Federation of State Medical Boards) plus an interview by either a board member or the board's executive secretary. It could be used only by one substituting for an Alaskan physician who would have to be specifically designated. An individual who chose to function repeatedly in the role (i.e., beyond 240 days in two years) would be expected to get a permanent license (either directly or through the temporary license route) in his own right, not as a substitute.

4. Briefly state the history of this problem or proposal:

See above.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 6. AS 08.64.272(b) is amended to read:

(b) For the limited purpose of residency or internship, the board may issue a permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(a)(2) and applicable regulations of the board, meets the requirements of AS 08.64.278. pays the required fee, and has been accepted by an eligible institution in the state for the purpose of residency or internship.

2. Public/Industry/Profession benefit:

To make statutory requirements more consistent between the sections.

3. State the problem or purpose of prompting this request:

See Section 2.

4. Briefly state the history of this problem or proposal:

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR
PROPOSED LEGISLATION

1. Proposed language:

Section 7. AS 08.64.275 is amended to read:

Sec. AS 08.64.275 TEMPORARY PERMIT FOR LOCUM TENENS PRACTICE. (a) A member of the board may grant a temporary permit to a physician or osteopath for the purpose of substituting for another physician or osteopath licensed in this state. The permit is valid for [120] 60 consecutive days. If circumstances warrant, an extension of the permit may be granted by the board.

(b) A physician applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.200 and of AS 08.64.278. In addition, the physician shall submit evidence of holding a license to practice medicine in a state or territory of the United States or in a province of Canada.

(c) An osteopath applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.205 and of AS 08.64.278. In addition, the osteopath shall submit evidence of holding a license to practice in a state or territory of the United States or in a province of Canada.

(d) Within 10 days after the permit has been granted, the board member shall forward to the department a report of the issuance of the permit.

(e) A limit of four such permits and/or extensions (limit of 240 days) may be granted to a single individual during a two year period.

2. Public/Industry/Profession benefit:

To make requirements consistent.

3. State the problem or purpose prompting this request:

See Section 2.

4. Briefly state the history of this problem or proposal:

5. Identify the alternatives to this legislation (if any):

Eliminate interview requirement for locum tenens practice.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 8. AS 08.64 is amended by adding a new section to read:

Sec. AS 08.64.276. RETIRED STATUS (a) on reaching the age of 65, and on payment of an appropriate one time fee, a licensee in good standing with the board may apply for the conversion of an active or inactive license to retired status.

(b) A retired license is issued for the remnant span of the licensee's life and does not require renewal.

(c) Individuals holding retired licenses are exempt from the provisions of AS 08.64.312.

(d) Individuals holding a retired license are prohibited from practicing medicine, osteopathy or podiatry, as the case may be, in the State of Alaska.

(e) Retired licensees may reapply for active licensure but are required to meet any reasonable criteria set by the board in the individual case including but not limited to demonstration of adequate CME credits, retaking of national examinations such as the FLEX exam, physical and psychiatric examination, interview with the board as a whole, and clearance by the National Data Bank of the National Federation of State Medical Boards.

2. Public/Industry/Profession benefit:

These provisions would allow a physician retired from active practice to continue to use the honorific "M.D." and maintain a medical license without the continuing education requirements or the ability to practice medicine.

3. State the problem or purpose prompting this request:

It is felt that a permanent retired license status will serve the retired physicians' purposes and protect the public health. Retired status should also appeal to those who are effectively retired and presently faced with CME requirements they cannot meet because of age or infirmity. The CME statutes at present make no provision for people in this status.

The proposed statute, while not precluding reactivation of retired licenses, would empower the board to make very certain that the individual was competent to resume such practice.

4. Briefly state the history of this problem or proposal:

It is recognized that there are a number of physicians who retain licensure beyond the time it is reasonable for them to practice out of the sense of pride licensing brings them and because of an oddity in statute that prohibits them from using the "M.D." after their name if not licensed. (The statute, AS 08.02.010, is designed to prevent the unlicensed from deluding the public as to their qualifications).

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR
PROPOSED LEGISLATION

1. Proposed language:

Section 9. AS 08.64 is amended by adding a new section to read:

Sec. AS 08.64.277. COURTESY LICENSE. The State Medical Board may by regulation set criteria for issuing temporary courtesy licenses to medical and osteopathic physicians and podiatrists accompanying interstate and international sporting teams and international contingents participating in activities in Alaska. Such licenses shall be limited in time to that length of time the contingent or sporting team is present in Alaska and in any case no longer than 45 days. Such licensees will be limited to practicing on team or contingent members, their dependents and foreign nationals accompanying international groups.

2. Public/Industry/Profession benefit:

This would permit the board to grant courtesy licensure, under appropriate restrictions, to medical practitioners accompanying sports teams, such as Olympic teams (if Anchorage had been selected as the site), interstate and international sporting contingents.

3. State the problem or purpose prompting this request:

There is currently no provision for credentialing the courtesy physicians.

4. Briefly state the history of this problem or proposal:

Difficulties occasionally arise when visiting participants under the care of their own physicians require services or supplies from the local health care system.

5. Identify the alternatives to this legislation (if any):

No action.

6. Which alternative mentioned would be most acceptable?

Prefer proposed legislation.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR
PROPOSED LEGISLATION

1. Proposed language:

Section 10. AS 08.64 is amended by add a new section to read:

Sec. AS 08.64.278. INTERVIEW REQUIRED FOR PERMITS. An applicant for an intern permit, a resident permit, or a temporary permit for locum tenens practice must be interviewed in person by at least one member of the board or by the executive secretary of the board.

2. Public/Industry/Profession benefit:

Allowing the executive secretary of the board to conduct resident-in-training and locum tenens interviews will make the licensing process less burdensome on applicants and board members.

3. State the problem or purpose prompting this request:

See Section 2.

4. Briefly state the history of this problem or proposal:

See Section 2.

5. Identify the alternatives to this legislation (if any):

Eliminate interview requirement.

6. Which alternative mentioned would be most acceptable?

Proposed legislation.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 11. AS 08.64 is amended by adding a new subsection to AS 08.64.326 numbered AS 08.64.326(a) (14) to read:

Sec. AS 08.64.326 GROUNDS FOR IMPOSITION OF DISCIPLINARY SANCTIONS.
(a) (14) Has prescribed, ordered, dispensed, administered, supplied, sold, or given any amphetamine, sympathomimetic amine drug or compound identified as a Schedule II controlled substance under AS 11.71.150 to or for any person except for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

2. Public/Industry/Profession benefit:

Protect the public from inappropriate prescribing of amphetamines.

3. State the problem or purpose prompting this request:

It is clear that 99+% of all amphetamines prescribed are for weight reduction. It is clear that while they may be beneficial for 2-3 weeks that after that they serve no purpose in that regard and lead to significant habituation. Amphetamine prescription in "weight reduction clinics" is the single most significant diversion point of these medications onto the illicit market.

The proposed legislation, adapted from Wisconsin statutes, recognizes the seven (7) valid uses of the medication (accounting for less than 1% of prescriptions) and makes other use subject to disciplinary sanction.

It will help in showing down diversion and will also help the ethical physician when importuned by individuals seeking such medications if he/she can inform those individuals that such prescribing is illegal.

Such provisions have proved quite useful in other states.

It is suggested that statutory language of a similar nature be inserted into the pharmacy statutes to further control amphetamine use. The division, along with the boards of pharmacy, nursing and medicine, the DEA, the ASMA and State Troopers are presently engaged in a cooperative effort known as PADS (prescription abuse data system) to try to reduce diversion. The present statute will help in that effort.

4. Briefly state the history of this problem or proposal:

See item 3 above.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

N/A.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR
PROPOSED LEGISLATION

1. Proposed language:

Section 12. AS 08.64.335 is amended to read:

Sec. AS 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license or permit refusals under AS 08.64.240, actions taken by the board under AS 08.64.331, and license or permit suspensions or surrenders under AS 08.64.332 or AS 08.64.334.

2. Public/Industry/Profession benefit:

To protect the public from incompetent practitioners by reporting adverse board actions to the nationwide disciplinary data bank.

3. State the problem or purpose prompting this request:

When this section was crafted for HB 70 in 1986-87 we neglected to insert the word "permit". Since certain of our licenses (temporary, locum tenens) and our physician assistant authority are referred to as permits it could be argued we are prevented from reporting disciplinary and other actions concerning these licenses and permits. We have considered that such reports fall under the legislative intent of the statute so have proceeded to submit reports when appropriate but feel it would be best to clean up the language.

4. Briefly state the history of this problem or proposal:

See above.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:

Section 13. AS 08.64.336(e) is amended to read:

Sec. AS 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (e) A physician, hospital, hospital committee, or private professional organization designated under AS 08.64.101(6) to identify, confront and treat individuals licensed under this chapter who abuse addictive substances, that in good faith submit a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil or criminal liability for the submission or participation.

To be read with Section 1 - to provide immunity for the Impaired Physician Program volunteers and staff.

2. Public/Industry/Profession benefit:

To protect the public by facilitating the effective operation of the Impaired Physician Program.

3. State the problem or purpose prompting this request:

Sections 1 & 13 are to be read together.

The volunteers who staff the effort have been concerned that though they are protected from civil liability in terms of arranging treatment that their very necessary activity in terms of identification and confrontation of those in need of help is not so protected. The provisions of Section 1 and 13 extend the protection of immunity from civil and criminal liability for these necessary activities. This seems logical, appropriate and consonant with protection of the public's health.

4. Briefly state the history of this problem or proposal:

Under the provisions of HB 70 of the 15th Legislature the board was empowered to contract with a private professional agency to run an impaired professionals program. Such a contract was signed June 1988 between the Board and the Division of Occupational Licensing and the Alaska State Medical Association (ASMA). Members of the ASMA's Impaired Physician Committee (all unpaid volunteers) seek out individuals in trouble, confront them and get them into treatment. The program is working very well at this point and is a marvelous boon to the community in shortstopping problems before they go on to threaten the public health.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

N/A.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR
PROPOSED LEGISLATION

1. Proposed Language:

Section 14. AS 08.64 is amended by adding a new section to read:

Sec. AS 08.64.369. PRESERVING SANCTIONS OF THE BOARD. A refusal of or a sanction of a license or permit issued under this chapter may not be temporarily enjoined nor an action of the board in refusing or sanctioning a license stayed pending appeal to a court of competent jurisdiction or temporarily enjoined or stayed pending appeal to superior appellate review unless the court granting such an injunction or stay does so on demonstration of reasonable cause to presume the board's refusal to grant a license or permit or sanction a license or permit may have been based on discrimination on the basis of race, creed, color, sex, national origin, or handicapping condition that does not impair safe practice, on conspiracy in restraint of trade, or malicious intent to injure the applicant or licensee or permittee.

2. Public/Industry/Profession benefit:

To protect the public from incompetent practitioners who have been sanctioned by the board and are pursuing appeals processing.

3. State the problem or purpose prompting this request:

The division, the board, and the National Federation of State Medical Boards regard medical licensure as a privilege granted to individuals by the state for the convenience and health of its citizens. It is not an inherent right of individuals any more than is a drivers license. Thus when there is good and sufficient reason for the board to believe an individual is not practicing safely and is endangering the public health, it seems reasonable to permit sanctions imposed to stand unless and until a court of competent jurisdiction overrules the board on appeal. It must be remembered the board acts cautiously and in full compliance with the Administrative Procedure Act, assuring rights to a complete hearing, before acting on a license sanction. To then have a court stay the action for long periods of time while an appeal is heard seems to be significantly detrimental to the public's health and safety. In one particularly notorious case within the board's experience an incompetent practitioner who had caused a number of deaths was permitted to practice for seven years after the board revoked his license while he slowly pursued appeals all the way to the U.S. Supreme Court. The board's action was upheld at each level but the practitioner was permitted to endanger the public for an additional seven years after original revocation.

The present statute, with language which protects the licensee against arbitrary action by the board, seeks to correct this most unfortunate state of affairs.

4. Briefly state the history of this problem or proposal:

See above.

5. Identify the alternatives to this legislation (if any):

None.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this legislative request?

Yes.

8. In the event questions should be raised during review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

1. Proposed language:
Section 15. This Act takes effect immediately under AS 01.10.070(c).
2. Public/Industry/Profession benefit:
Immediate effectiveness of the statutory changes.
3. State the problem or purpose prompting this request:
Request elimination of any delay in implementation.
5. Identify the alternatives to this legislation (if any):
None.
6. Which alternative mentioned would be most acceptable?
N/A.
7. Does the entire board/commission agree with this legislative request?
Yes.
8. In the event questions should be raised during review of this request, please indicate below which board member we should contact.

Board/Commission Member: Thomas L. Conley, M.D.

Day Phone: 225-4483

REGULATION RECOMMENDATIONS

The regulations project addressing paramedic internship and licensing has been addressed in detail this year and is working its way through the approval process. The physician assistant regulations are in need of revision to include requirements for alternate collaborative physician. Provisions for the alternate were inadvertently dropped when the last revisions were completed. The board will also seek regulations revisions following adoption of the statutory changes currently before the legislature.

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED REGULATIONS

The Division of Occupational Licensing requests that each board or commission proposing regulation requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

12 AAC 40.410

A plan of collaboration includes identification of at least one physician, licensed in Alaska, to serve as alternate collaborating physician. The alternate may serve at the request of or in the absence of the primary collaborating physician.

2. Public/Profession/Industry benefit:

Protection of the public through provision of a physician to provide supervision/consultation when the primary collaborating physician is unavailable.

3. State the problem or purpose prompting this request:

The board has always required designation of an alternate collaborating physician. This requirement used to be found in 12 AAC 40.400(b)(s) and was inadvertently dropped during the regulations revisions. The board has maintained the policy and asks that the requirement be put back in the regulations.

4. Briefly state the history of this problem or proposal:

See above.

5. Identify the alternatives to this regulation (if any):

None.

6. Which alternative mentioned would be most acceptable?

Proposed language.

7. Does the entire board/commission agree with this regulation request?

Yes.

8. In the event questions should be raised during the review of this request, please indicate below which board member we should contact.

Pam Ventgen, Executive Secretary, State Medical Board - 561-2878 or

Board/Commission Member: James W. Thompson, M.D., Chair

Phone: 586-2605

FEDERAL LEGISLATION IMPACTING THE STATE MEDICAL BOARD

The Health Care Quality Improvement Act was enacted on November 14, 1986 as Title IV of Public Law 99-660. This act places the Federal Government in a new role regarding health care practitioner credentialing. Its purpose is to identify incompetent and unethical physicians and dentists through collection and dissemination of data regarding adverse actions taken against health care practitioners. The following entities will be required to report to the data bank: state medical boards, hospitals, malpractice insurance carriers, self-insured physicians, HMO's and group medical practices with a formal professional review process, and professional societies with formal peer review. According to the March 21, 1988 Federal Register, the act provides for these reporting entities to report to the state medical boards, and the boards in turn, report to the national data bank. The Act also requires the boards to monitor the compliance of health care entities in reporting to the board under these regulations.

Although enacted in 1986, the original implementation date was November 14, 1987. Implementation was postponed due to lack of funding and is now scheduled for September 1, 1989.

The Health Care Quality Improvement Act (PL 99-660) will have considerable impact on the State Medical Board by significantly increasing demands on staff to accomplish the required reporting of medical board actions and actions reported to the board by other entities. There is also potential for increased investigative activity as more information comes to the board's attention. The board requests support from the Division of Occupational Licensing to establish a half-time position to enable the board to meet these upcoming Federal requirements.

0523M

ADDENDUM A

PADS PROJECT REPORT

PRESCRIPTION ABUSE DATA SYNTHESIS (PADS)

THE ALASKA PADS REPORT

SUBMITTED TO GOVERNOR COWPER

JUNE 1989

EXECUTIVE SUMMARY

THE ALASKA PADS REPORT

For almost a year, more than a dozen Alaskan health care organizations have been working on a project to reduce the abuse and diversion of prescription drugs. The PADS Project (Prescription Abuse Data Synthesis) was developed by the American Medical Association in 1983. Twenty-eight other states have implemented this project, with technical assistance provided free-of-charge to states by the AMA. In Alaska, this public-private sector effort was sponsored by the Alaska State Medical Association with the Division of Occupational Licensing, Department of Commerce and Economic Development being the lead state agency.

The PADS model involves a technical component which defines the nature and extent of the potential abuse and diversion of prescription drugs. Diversion is the process by which these drugs, intended for legitimate medical use, become abused for illicit purposes.

Although drugs are diverted at numerous points in the production and distribution chain, 80% to 90% of such diversion occurs at the hospital, practitioner and pharmacy level, according to the American Medical Association. Practitioner diverters have been identified in PADS by four major categories:

- The dishonest - who knowingly prescribe or dispense drugs for abuse purposes, usually for profit.
- The disabled - whose professional competence has been impaired by alcohol and/or other drug abuse.
- The duped - who unwittingly contribute to the problem by acquiescing to patients' ruses or insistent demands for drugs, or by being lax in the security of prescription pads and office procedures.
- The dated - who have not kept pace with developments in pharmacology, drug therapy or the abuse of drugs.

The PADS Project in Alaska involved the efforts of four working groups. The Technical Group conducted the most comprehensive study of prescription drug abuse ever conducted in the state, using information on the supply of these medications, as well as their abuse demand. The Technical Group Report revealed that while cocaine and marijuana are responsible for a vast majority of the drug abuse treatment admissions and arrests, prescription drug abuse remains a problem. The Regulatory/Enforcement Group conducted thirty-one investigations of potential sources of diversion. Nine cases were found to have violations of laws or regulations.

The Professional Associations Group focused its attention on the need for voluntary, early-intervention, impaired practice programs for all health care practitioners who prescribe, dispense, or administer controlled prescription drugs.

The Policy Group made eight recommendations that resulted from the implementation of the PADS Project and from the activities needed to be conducted to reduce the abuse and diversion of prescription drugs in Alaska.

The Recommendations are:

1. The Division of Medical Assistance, Department of Health and Social Services should produce computerized reports employing the Drug Utilization Review System (DURS). These reports should be produced as frequently as is cost effective, ideally on a quarterly basis. Based on the experience with PADS, the cost of producing these reports would be covered by the savings in public funds that would otherwise be spent on reimbursement for inappropriate prescriptions. The state should provide the funds for the production of these reports if the operating budget of the Division of Medical Assistance cannot cover the expense of generating the DURS report from out of the current budget.
2. There should be a central clearinghouse for identifying persons who attempt to obtain prescription drugs under false pretenses, and to disseminate this information to prescribers, pharmacists and hospital emergency rooms. The Attorney General's Office should render an opinion as to how this may be accomplished without violating patient confidentiality. If statutory language is required then the state should seek the necessary legislation.
3. The Division of Occupational Licensing should seek legislative approval to enter into agreements with private professional associations to establish impaired practitioner programs.
4. The Division of Occupational Licensing should establish a Task Force on Impaired Practice, with representation from each of the health care professional associations and regulatory boards whose members or licensees prescribe, dispense or administer controlled prescription drugs. The Task Force should develop common guidelines and funding requirements for the establishment of impaired practice

programs, reporting to the Division Director no later than December 31, 1989.

5. The Code Revision Commission, which has begun work on revisions to the occupational licensing acts, should prioritize the completion of this work.

6. As part of the existing mandatory continuing education program, all practitioners who can prescribe or dispense, should be mandated to take six core hours of controlled prescription drug curriculum material in a two year period. Thereafter, two hours of update should be required in a two year period. The two year periods would coincide with license renewals.

7. Professional associations should utilize the various educational opportunities available to them (for example, newsletters, meetings, etc.) to inform their members of the PADS Report and related materials.

8. The PADS Policy Group should meet to review the status of these recommendations, no later than November 15, 1989.

PRESCRIPTION ABUSE DATA SYNTHESIS (PADS)

THE ALASKA PADS REPORT

I. INTRODUCTION

At the invitation of the Alaska State Medical Association and the Alaska State Medical Board, Bonnie Wilford of the American Medical Association provided information on the PADS Project to state agencies and professional associations in a July 7, 1988 meeting in Anchorage. The organizations represented decided to implement the PADS Project. The Division of Occupational Licensing agreed to co-sponsor the project with the Alaska State Medical Association, and became the lead state agency.

In October of 1988, the first of four implementation site visits was conducted by Barry Rhodes, the PADS Technical Consultant. Mr. Rhodes is an independent consultant who is retained by the American Medical Association which provides his services free-of-charge to states implementing the PADS Project. The four site visits, culminating on May 16 and 17, 1989, are the basis of this report on the results of the implementation of the PADS Project in Alaska.

II. THE PADS MODEL

The PADS model was developed by the American Medical Association to create a public-private mechanism to address prescription drug diversion. Diversion is the process whereby prescription drugs are being rechanneled from appropriate medical use through legal distribution routes to "street" drug abusers through a variety of licit and illicit routes. The PADS model utilizes existing information to identify the nature, extent and complexity of the problem. It inventories the policies, procedures and resources which address diversion control, and identifies the problem areas within the diversion control system. Action is taken during the implementation of the model, by the agencies and organizations involved, to resolve those problems that can be fixed with existing resources, laws and regulations. Those problems for which the solutions require further action are reported to the governor at the conclusion of the implementation phase of the project.

Although drugs are diverted at numerous points in the production and distribution chain, 80% to 90% of such diversion occurs at the hospital, practitioner and pharmacy level, according to the American Medical Association.

Diversifiers have been identified in PADS by four major categories:

Dishonest --or "script"-- health care professionals who willfully and knowingly prescribe and/or dispense drugs for purposes of abuse, and usually for profit, and pharmacists who willingly and knowingly dispense drugs pursuant to false or forged prescriptions or dispense drugs of abuse without a prescription.

Disabled --or impaired-- health care professionals whose professional competence has been impaired by drug abuse, alcoholism, or other physical or mental disorders.

Duped practitioners and pharmacists who unwittingly contribute to the problem by acquiescing to some patients' ruses or insistent demands for drugs of abuse or pharmacists who dispense drugs of abuse pursuant to forged or false prescriptions.

Dated health care professionals who have not kept pace with developments in pharmacology, drug therapy or the abuse of drugs.

These categories illustrate both the broad scope and the complexity of the drug diversion problem. No single solution is appropriate for all diversion cases. Intervention strategies must be responsive to the precise nature of the diversion problem.

The PADS model was designed for use at the state level because the nature of prescription drug abuse varies dramatically from state to state, and because problem identification and resolution mechanisms (enforcement, regulatory and licensing authorities, treatment agencies and professional associations) are concentrated at the

state level.

In Alaska, four groups were established to perform the work necessary to implement the PADS model: The Technical Group, The Regulatory/Enforcement Group, The Professional Associations Group, and The Policy Group.

The Technical Group performed a study of the nature and extent of the prescription drug abuse problem in Alaska by examining data on both the supply of drugs and the abuse demand. The organizations serving on the Technical Group included:

Division of Occupational Licensing
Department of Commerce and Economic Development

Division of Medical Assistance
Department of Health and Social Services

Alaska State Troopers
Department of Public Safety

State Office of Alcoholism and Drug Abuse
Department of Health and Social Services

Alaska State Medical Association

United States Drug Enforcement Administration

The Regulatory/Enforcement Group coordinated the targeting of specific cases developed from computerized data. Joint investigations were conducted to verify the PADS targeting methodology. As a result of these investigations, approximately nine practitioner diversion cases were developed for regulatory board action.

The agencies participating in the Regulatory/Enforcement Group were:

Division of Occupational Licensing
Department of Commerce and Economic Development

Division of Medical Assistance
Department of Health and Social Services

State Office of Alcoholism and Drug Abuse
Department of Health and Social Services

Alaska State Troopers
Department of Public Safety

United States Drug Enforcement Administration

The Professional Associations Group conducted an inventory of policies, resources, and procedures pertaining to identification, intervention, and rehabilitation of impaired health care professionals. In addition, this group developed strategies for education of health care professionals about the problem of

prescription drug misuse, abuse and diversion. The organizations that participated in the Professional Associations Group were:

Alaska State Medical Association
Alaska Academy of Physician Assistants
Alaska Pharmaceutical Association
Alaska Nurses Association
Alaska Nurse Practitioner Association
Alaska Veterinarian Association
Alaska Dental Society

The Policy Group served as the coordinating body for the PADS Project and was the ultimate forum which formulated the final project recommendations by consensus. One of the chief benefits of having this group address solutions to problems in the diversion control system is the diversity of experience and perspective brought to bear. The membership of this Group included all of the agencies and organizations listed for the three groups mentioned above, plus:

Governor Cowper's Office
Alaska State Medical Board
Alaska Board of Nursing

III. SUMMARY OF PADS ACTIVITIES TO DATE

The Technical Group

The Technical Group Report to the Policy Group (Appendix A) on the nature and extent of the prescription drug abuse problem in Alaska is the most comprehensive study of the problem ever conducted. Abuse demand data was submitted by two state agencies. The Alaska Scientific Crime Detection Laboratory presented information on drugs analyzed. The State Office of Alcoholism and Drug Abuse provided data on treatment admissions to drug abuse programs.

Drug supply data was provided by one federal agency and one state agency. The U.S. Drug Enforcement Administration provided information from ARCOS (Automation of Reports and Consolidated Orders System) on the purchases of drugs that exceeded national, state, regional norms. The purchases of the following ARCOS drugs were analyzed: Meperidine, Dronabinol, Cocaine, Pentobarbital, Alfentanil, and Methamphetamine. The Division of Medical Assistance provided data from MMIS (Medicaid Management Information System.) The MMIS data was used to identify abnormally high prescribers of the following drugs: Valium, Tylox, Percodan/Percocet, Xanax, Darvon and Demerol. The information needed to analyze drug supply patterns by physician and hospital bed distribution came from the Alaska State Medical Association.

The MMIS data required a considerable amount of manual data compilation and analysis. The Division of Medical Assistance requested, from their contractor, reports on the prescribing and dispensing of selected controlled prescription drugs. These reports were then analyzed by the PADS Technical Consultant for more than two days to select targets for further investigation. The Medical Consultant to the Division then spent nearly five days retrieving and analyzing the additional information needed by the Regulatory/Enforcement Group. The Policy Group, in Section IV of this report, recommends making the use of the MMIS data more efficient as a diversion detection tool.

The Regulatory/Enforcement Group

The Technical Group Report was used to identify targets for investigation developed from the analysis of the ARCOS and MMIS data. In all, thirty-one targets were selected for further investigation by the Division of Occupational Licensing and the U.S. Drug Enforcement Administration. This effort by the PADS Enforcement Group was the largest comprehensive investigation of prescription drug diversion in Alaska's history. The PADS Enforcement Group Report to the Policy Group (Appendix B) contains the background, results and preliminary conclusions, as well as a case by case synopsis.

The Professional Associations Group

The Professional Associations Group conducted a study of its member organizations to determine which disciplines had impaired practice intervention programs. It was determined that only the Medical Association and the Dental Society had such programs. Each professional association wanted to enhance its ability to focus on early identification of and intervention with impaired practitioners. Since these programs require considerable resources and expertise, the members of the Professional Associations Group decided to work towards an interdisciplinary set of standards and procedures, as well as a sharing of resources where appropriate.

An important aspect of professional association impaired practice programs is that they supplement and not replace the activities of the regulatory licensing boards. Therefore, the Professional Associations Group sought to develop written agreements, such as the one already in place between the Medical Association, the Medical Board, and the Division of Occupational Licensing. It was determined that the legislature would need to amend the practice acts of the professions other than medicine in order for the other state licensing boards to enter into such agreements with their associated private professional associations. The Policy Group, in Section IV of this report, recommends that the legislature take such action.

The Policy Group

The specialized expertise offered to the PADS Project by each of the three working groups was brought together in the Policy Group. In this setting, issues were discussed and policy decisions were made. It was an opportunity for an exchange of ideas between the regulators and the regulated. The different perspectives of those in the public and private sectors were shared and formed the basis for consensus decision-making. The Policy Group brainstormed a list of problem statements that were the basis for the recommendations from the Policy Group in Section IV of this report.

IV. RECOMMENDED ACTIONS FOR THE REDUCTION OF PRESCRIPTION DRUG ABUSE IN ALASKA

PROBLEM STATEMENT #1: There is no central source of data about the prescribing or dispensing of controlled prescription drugs.

RECOMMENDATION #1

The Division of Medical Assistance (DMA) should produce computerized reports employing the Drug Utilization Review System (DURS). These reports should be produced as frequently as is cost effective, ideally on a quarterly basis. Based on the experience with PADS, the cost of producing these reports would be covered by the savings in public funds that would otherwise be spent on reimbursement for inappropriate prescriptions. The state should provide the funds for the production of these reports if the operating budget of DMA cannot cover the expense of generating the DURS report from out of the current budget.

As is explained in Section III of this report, considerable manual effort was used to test the efficacy of using the DMA's new Medicaid Management Information System (MMIS) for detecting the diversion and abuse of prescription drugs. The DURS software provides excellent automated reports that would give program managers from the Division of Medical Assistance and investigators from the Division of Occupational Licensing the information they need to open diversion cases.

RECOMMENDATION #2

There should be a central clearinghouse for identifying persons who attempt to obtain prescription drugs under false pretenses, and to disseminate this information to prescribers, pharmacists and hospital emergency rooms. The Attorney General's Office should render an opinion as to how this may be accomplished without violating patient confidentiality. If statutory language is required then the state should seek the necessary legislation.

Drug abusers use various ruses, such as feigning particular medical conditions that require medication, or presenting forged or falsified prescriptions to obtain controlled prescription drugs. These "professional patients" or "doctor shoppers" often victimize many physicians, dentists, hospital emergency rooms and pharmacies. If health care providers are alerted to the identity of a person who is engaged in these fraudulent activities, a significant amount of diversion and abuse could be thwarted. Several states have systems that alert health care providers, while some states have ruled that such a system violates the rights of the perpetrator. Should the Attorney General's Office rule that such a system could be used in Alaska, whether under existing statute or on passage of legislation authorizing such shared information, the Division of Occupational Licensing would pursue the development of such a clearinghouse.

PROBLEM STATEMENT #2: The current practice acts are unclear and vague.

RECOMMENDATION #3

The Division of Occupational Licensing should seek legislative approval to enter into agreements with private professional associations to establish impaired practitioner programs.

The only practice act that currently allows such an agreement is the medical practice act. A memorandum of understanding exists with the Division of Occupational Licensing, the Alaska State Medical Association and the Alaska State Medical Board. The legislature should grant approval of such action by amending Title 8, Chapter 1, "Centralized Licensing," to provide for such programs wherever a professional organization is willing and able to seek such an agreement with the state.

RECOMMENDATION #4

The Division of Occupational Licensing (DOL) should establish a Task Force on Impaired Practice, with representation from each of the health care professional associations and regulatory boards whose members or licensees are authorized to prescribe, dispense or administer controlled prescription drugs. The Task Force should develop common guidelines and funding requirements for the establishment of impaired practice programs, reporting to the Division Director of DOL no later than December 31, 1989.

Impaired practice programs should function within the same guidelines, regardless of profession. Medicine and dentistry are the only professional associations that currently have programs. Other professions either lack the membership base or the financial resources to implement a successful effort. If programs operate under the same guidelines, some program components can be conducted jointly, by the professional organizations. A significant increase in professional self-policing would actually act to improve the health and safety of the public serviced by these professions.

RECOMMENDATION #5

The Code Revision Commission, which has begun work on revisions to the occupational licensing practice acts, should prioritize the completion of this work.

PROBLEM STATEMENT #3: The lack of knowledge about prescribing leads to inappropriate prescribing.

RECOMMENDATION #6

As part of the existing mandatory continuing education program, all practitioners who can prescribe or dispense should be mandated to take six core hours of controlled prescription drug curriculum material in a two year period. Thereafter, two hours of update should be required in a two year period. The two year periods would coincide with license renewals.

The PADS Policy Group wanted to be certain that the curriculum materials necessary for obtaining the mandated credits were readily accessible in Alaska. The licensing boards are responsible for the certification of courses, and the Division of Occupational Licensing should facilitate this activity with the appropriate boards.

RECOMMENDATION #7

Professional associations should utilize the various educational opportunities available to them (for example, newsletters, meetings, etc.) to inform their members of the PADS Report and related materials.

RECOMMENDATION #8

The PADS Policy Group should meet to review the status of these recommendations, no later than November 15, 1989.

ADDENDUM B

REGULATIONS REVISIONS,
MOBILE INTENSIVE CARE PARAMEDICS

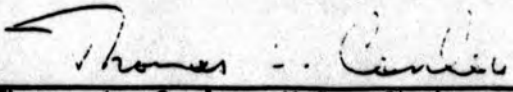
ORDER ADOPTING, AMENDING, AND REPEALING REGULATIONS OF THE
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
STATE MEDICAL BOARD

The attached _____ pages of regulations which constitute a major revision to mobile intensive care paramedics regulations and which address application requirements, curriculum, internships, continuing education, license renewal, scope of practice, and numerous housekeeping provisions are hereby certified to be correct copies of the regulations which the Department of Commerce and Economic Development, State Medical Board, after the May 22, 1989 vote of a quorum of the board, amends, repeals, and adopts under the authority of AS 08.64.100 and AS 08.64.107 and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and AS 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

This order takes effect on the 30th day after it has been filed by the Lieutenant Governor as provided in AS 44.62.180.

DATE: 22 May 1989
Anchorage, AK


Thomas L. Conley, M.D., Chairman
State Medical Board

FILING CERTIFICATION

I, Stephen McAlpine, Lieutenant Governor for the State of Alaska, certify that on _____, 198____, at _____ .m., I filed the attached regulations according to the provisions of AS 44.62.040 - AS 44.62.120.

Stephen McAlpine, Lieutenant Governor

Effective: _____)

Register: _____)

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PROPOSED REGULATIONS

STATE MEDICAL BOARD

CHAPTER 40

12 AAC 40.300(c) is amended to read:

(c) The application must be notarized [MADE UNDER OATH] before a person empowered by AS 09.63.010 [AS 09.65.010 TO ADMINISTER OATHS] and must be signed by the sponsoring physician. (Eff. 1/13/80, Reg. 73, am / / , Reg. ____)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.310 is repealed and readopted to read:

12 AAC 40.310 QUALIFICATION FOR INITIAL LICENSE. (a) An applicant for a mobile intensive care paramedic license shall:

- (1) be 19 years of age or older;
- (2) be a high school graduate;
- (3) provide a letter from the applicant's physician sponsor verifying that the applicant will, at all times, be under the supervision of a physician sponsor approved by the board, as required under 12 AAC 40.315;
- (4) have successfully completed an approved curriculum under 12 AAC 40.320;
- (5) following the successful completion of the didactic and clinical portions of the board-approved curriculum, have satisfactorily completed a 480 hour internship which meets the requirements of 12 AAC 40.325;
- (6) pass the written and practical examination for emergency medical technician-paramedic administered by the National Registry of Emergency Medical Technicians, and;
- (7) submit the fees established by 12 AAC 02.250.

(b) An applicant for licensure as a mobile intensive care paramedic, who is currently licensed in another state, shall fulfill the requirements outlined in (a) of this section and shall;

(1) not be currently under suspension or revocation as mobile intensive care paramedic, emergency medical technician-paramedic, or equivalent, and must not be the subject of an unresolved investigation, complaint review procedure, or disciplinary proceeding undertaken by a certifying or licensing agency in another state; and

(2) must submit written verification from the applicant's previous physician sponsor, on a form approved by the department, attesting that the applicant is capable of performing the activities listed in 12 AAC 40.370 (a) plus any other specific emergency procedures authorized by the physician sponsor.

(c) The board will, in its discretion, require an applicant to provide any additional documentation necessary to verify the applicant's education or experience. (Eff. 1/13/80, Reg. 73, am 5/11/85, Reg. 94, am 8/20/87, Reg. 103, am 4/10/88, Reg. 106; am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107
AS 08.64.240

12 AAC 40.320 is amended to read:

12 AAC 40.320 APPROVED CURRICULUM. (a) The approved curriculum for license as a mobile intensive care paramedic is the U.S. Department of Transportation National Training Course Emergency Medical Technician Paramedic, in effect at the time of training.

(b) The training program must be under the direction of a physician licensed in the state where the training takes place.

(c) A training program taught in Alaska must be approved, in advance, by the board and by the Alaska Department of Health and Social Services. (Eff. 1/13/80, Reg. 73, am 4/10/88, Reg. 106, am 8/20/87, am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40 is amended by adding a new section to read:

12 AAC. 40.322. PARAMEDIC TRAINING PROGRAM COURSE APPROVAL. (a) An individual or organization applying for approval of a mobile intensive care paramedic training program to be taught within Alaska shall show to the board that it:

(1) has a written agreement with a board approved physician who is familiar with training and direction of prehospital emergency care providers and who agrees to

(A) review all components of the paramedic training program to ensure that instructional accuracy is maintained;

(B) review the progress of each student to ensure that instructional goals are being met and that demonstration of competence is occurring before the student is put into a patient care setting; and

(C) act as liaison to hospitals and emergency medical services participating in the paramedic training program;

(2) has a written agreement with the institutions and agencies which are to provide clinical experience and which agree to

(A) provide access to patients who present common problems encountered in the delivery of advanced emergency care in sufficient numbers and in distribution by age and sex;

(B) assign students to clinical settings to include the operating room, recovery room, delivery room, intensive care unit, respiratory therapy, labor and delivery, pediatrics, and the emergency department; and

(C) ensure that the students are supervised by program instructors or hospital personnel, such as nurses and physicians.

(3) has a written agreement with an advanced life support emergency medical services system which has a call volume which will provide students with access to patients who present common problems in the delivery of advanced prehospital emergency care in sufficient numbers and in distribution by age and sex and which agrees to ensure that

(A) adequate personnel resources exist within the EMS system so that the assigned student is never a substitute for paid personnel or a required team member;

(B) the student is under the direct supervision of

a physician, physician assistant, registered nurse, or mobile intensive care paramedic, licensed or certified in the state where the internship takes place, who has been designated the responsibility of supervision by the course medical director;

(C) the student is assigned to a unit that has the capability of voice communications with on-line medical direction and is equipped with equipment and medications necessary for advanced life support;

(D) the student's performance is evaluated by his or her preceptor at the end of each shift; and

(E) records are kept concerning the type and number of emergency care procedures performed and whether each emergency care procedure was performed acceptably.

(4) uses the curriculum approved by the board.

(5) has a full time program director whose primary responsibility and full time commitment is to the educational program at all times when the program is functioning;

(6) has an advisory board charged with assisting program and institutional personnel in formulating appropriate goals and standards, monitoring needs and expectations, and ensuring program responsiveness to change. The advisory board shall include the program medical director, the program director, a mobile intensive care paramedic, a registered nurse involved with the student's supervision or training and a physician from the emergency department of a facility where clinical training is performed;

(7) has a plan to verify the student's achievement of objectives stated in the curriculum. Evaluation methods must include assessment of student competencies in patient care environments; and

(8) is affiliated with the university or community college system.

(b) An application for course approval must be submitted to the board at least 120 days before the first day of the course. The application must include prospective class and laboratory schedules, and requirements for clinical and field internship rotations.

(c) An individual or organization conducting approved courses shall ensure that students are clearly identified by name plate, uniform, or other apparent means to distinguish them from graduate emergency medical services personnel, other health professionals, workers, or students. (Eff. / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.325 is amended to read:

12 AAC 40.325 PARAMEDIC INTERNSHIP REQUIREMENTS. An internship for licensing as a mobile intensive care paramedic must meet the following requirements:

(1) all procedures performed by an intern must be under the direct supervision of a physician [SPONSOR OR ANOTHER PHYSICIAN], physician assistant, registered nurse, or mobile intensive care paramedic, licensed or certified in the state where the internship takes place, who has been designated the responsibility of supervision by the physician sponsor of the training program;

(2) the successful completion of the internship must be verified, on a form approved by the board, by the physician sponsor, attesting that the mobile intensive care paramedic intern is capable of performing the activities listed in 12 AAC 40.370(a) including any other emergency procedures authorized by the physician sponsor under 12 AAC 40.370(a)(7) [12 AAC 40.370(a)(8); and

(3) all internship sites in Alaska must be approved in advance by the board [VERIFICATION FROM THE SUPERVISING PHYSICIAN OF THE SUCCESSFUL COMPLETION OF 20 TWENTY FOUR HOUR SHIFTS, OR THE EQUIVALENT NUMBER OF HOURS, COMPLETED AT A LOCATION APPROVED BY THE BOARD]. (Eff. 5/11/85, Reg. 94; am / / , Reg. ____)

Authority AS 08.64.100
AS 08.64.107

12 AAC ~~40.330~~ is repealed:

12 AAC ~~40.330~~ PERSONS CURRENTLY PRACTICING AS MOBILE INTENSIVE CARE PARAMEDICS. (Repealed / / , Reg.)

12 AAC 40.350 is repealed and readopted to read:

12 AAC 40.350 RENEWAL OF LICENSE. (a) An applicant for renewal of a mobile intensive care paramedic license shall submit:

(1) a completed license renewal application provided by the board;

(2) satisfactory evidence of completion of continuing medical education consisting of not less than 60 classroom or clinical hours or any combination of hours for each complete 12 month period the applicant has held a mobile intensive care paramedic license during the concluding license period;

(3) evidence of current certification as an advanced cardiac life support provider or advanced cardiac life support instructor;

(4) evidence of certification in basic life support (adult, child and infant CPR and airway obstruction maneuvers) from the American Heart Association or American Red Cross;

(5) a written recommendation as to the applicant's fitness to practice as a mobile intensive care paramedic, made by the applicant's sponsor physician, which includes verification of skills performance in those skill areas required by the department; and

(6) the license renewal fee established by 12 AAC 02.250.

(b) If an applicant for renewal cannot meet the requirements for renewal under (a) of this section, the applicant shall apply and meet the requirements for initial licensure under 12 AAC 40.300-12 AAC 40.310.

(c) The board will, in its discretion, exempt a mobile intensive care paramedic from the requirements of (a)(2) of this section upon application giving evidence satisfactory to the board that he or she has been unable to comply with the requirements because of extenuating circumstances. No person will be exempted from more than 60 hours of continuing medical education in a four-year period. (Eff. 1/13/80, Reg. 73, am 8/20/87, Reg. 103; am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.352(a)(2) is amended to read:

(2) documentation that the continuing medical education requirements of 12 AAC 40.350(a)(2) [12 AAC 40.350(A)(1)] have been met for the entire period the license has been lapsed; (Eff. 8/20/87, Reg. 103; am / / , Reg.)

Authority AS 08.01.100(d)
AS 08.64.100
AS 08.64.107

12 AAC 40.355 is amended to read:

12 AAC 40.355 TEMPORARY PERMITS. (a) A member, or designee, of the board may issue a temporary mobile intensive care paramedic permit to an applicant who [(1)] meets the requirements of 12 AAC 40.310; [AND

(2) SUBMITS VERIFICATION OF SPONSORSHIP BY A PHYSICIAN SPONSOR.]

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

(c) The board will, in its discretion, renew a temporary permit for good cause, one time only.

(d) A temporary permit will be withdrawn by the board if the physician sponsorship [OF THE PHYSICIAN SPONSOR] is withdrawn.

(e) In this section, "temporary permit" means a permit issued by a member, or designee, of the board to an individual who has applied for licensure, has fulfilled the requirements set out in 12 AAC 40.310, and is awaiting the next meeting of the board for consideration of the application. (Eff. 5/11/85, Reg. 94; am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.356 is repealed and readopted to read:

12 AAC 40.356: PROVISIONAL LICENSE. (a) The board will, in its discretion, issue a provisional license to an applicant for initial licensure who has met all requirements of 12 AAC 40.310 except for passing the examination required in 12 AAC 40.310(6). The applicant shall submit written verification from the National Registry of Emergency Medical Technicians that he or she is awaiting examination results or is scheduled to take the next examination.

(b) A provisional license is not renewable and is valid until the first meeting of the board after the results of the examination for licensure have been issued, or until the physician sponsor withdraws sponsorship, or until the board is notified that the provisional licensee has failed the examination for licensure, whichever occurs first.

(c) A provisional license is not renewable. (Eff. 5/11/85, Reg. 94; am 8/2/86, Reg. 99, am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.360 is amended by adding a new paragraph to read:

(6) practice without physician sponsorship. (Eff. 1/13/80, Reg. 73; am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC 40.370 is amended to read:

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. (a) a licensed mobile intensive care paramedic, when under the supervision of a sponsoring physician, may perform the activities listed in this subsection. The direct supervision of these activities may be delegated when caring for a patient in a hospital under the direct supervision of a physician, or at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, on the order of the physician, or when under the specific written standing order of a physician. The authorized activities are:

(1) electrocardiographic monitoring [PERFORMING CARDIOPULMONARY RESUSCITATION] and defibrillation;

(2) initiating and maintaining intravenous routes using approved intravenous techniques and solutions;

(3) performing endotracheal intubation and pulmonary ventilation by approved methods;

(4) performing gastric suction by intubation;

(5) obtaining blood for laboratory analysis;

(6) [APPLYING ROTATING TORNIQUETS

(7)] administering parenterally, orally, or topically any approved agents or solutions;

(7) use of pneumatic anti-shock devices; and

(8) performing other emergency procedures authorized by a sponsoring physician.

(b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:

(1) the activities are required as part of the training program;

(2) the activities which take place in a hospital are supervised by a physician, physician assistant or nurse; and

(3) the activities which take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician medical sponsor's designee.

(c) A person who is completing the internship required by 12 AAC 40.310(5) [12 AAC 40.310(7)], in Alaska, may perform the activities in (a) of this section for no more than 480 hours, and for no more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.

(d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing non-emergency medications, performing physical examinations for non-emergency purposes, and treatment of non-emergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board. (Eff 1/13/80, Reg. 73, am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

12 AAC is repealed and readopted to read:

12 AAC IDENTIFICATION. (a) While performing the duties of a mobile intensive care paramedic, the licensee shall be clearly identified by name plate, uniform, or other apparent means to distinguish him, or her, from other health care professionals, workers, and students. (Eff 1/13/80, Reg. 73; am / / , Reg.)

Authority AS 08.64.100
AS 08.64.107

ADDENDUM C

MEDICAL BOARD FEE SCHEDULE

12 AAC 02.250. ALASKA ADMINISTRATIVE CODE 12 AAC 02.260

12 AAC 02.250. STATE MEDICAL BOARD. (a) The following fees are established for physicians, podiatrists and osteopaths:

- (1) application fee for initial license, \$50;
- (2) FLEX examination fee, \$500;
- (3) temporary permit fee, \$50;
- (4) locum tenens permit fee, \$100;
- (5) license fee for all or part of the initial biennial license period, \$400;
- (6) active biennial license renewal fee, \$400;
- (7) inactive biennial license renewal fee, \$200.

(b) The following fees are established for physician assistants:

- (1) application fee for initial registration, \$50;
- (2) temporary registration fee, \$50;
- (3) temporary authorization to practice fee, \$50;
- (4) locum tenens authorization to practice fee, \$50;
- (5) fee for establishing or changing a collaborative relationship, \$20;
- (6) registration fee for all or part of the initial biennial registration period, \$50;
- (7) biennial registration renewal fee, \$50.

(c) The following fees are established for mobile intensive care paramedics:

- (1) application fee for initial license, \$50;
- (2) temporary permit fee, \$50;
- (3) provisional license fee, \$50;
- (4) license fee for all or part of the initial biennial license period, \$50;
- (5) biennial license renewal fee, \$50. (Eff. 11/20/86, Register 100; am. 10/1/88, Register 107)

Authority: AS 08.01.065
AS 08.64.107
AS 08.64.315

12 AAC 02.260. MORTUARY SCIENCE. (a) A funeral director or embalmer license and a funeral establishment permit expires on December 31 of all even numbered years. The following fees are established for funeral directors, embalmers and funeral establishments:

- (1) application fee for initial license or permit, \$30;
- (2) license or permit fee for all or part of the initial license or permit period, \$60;
- (3) biennial license or permit renewal fee, \$60;
- (4) funeral director and embalmer examination fee, \$50.

(b) The following fees are established for funeral director or embalmer trainee permits:

ADDENDUM D

PROPOSED LEGISLATION - AS 08.64

MEMORANDUM

FROM: T.L. Conley, Chair, State Medical Licensing Board
TO : Legislature // Randall Burns, Director, Division of Licensure
DATE : February 8, 1989
RE : Proposed Legislation, explanation of provisions

The proposed legislation is designed to produce greater efficiency in interviewing candidates for licensure, afford liability protection to the impaired physician program volunteers, close some loopholes in present license provisions, effectively define the difference between temporary and locum tenens licenses, and create categories for retired licensees and for those accompanying sporting teams, especially those accompanying Olympic athletes. It also seeks to prevent diversion of amphetamines (speed) into illegitimate channels and prevent improper prescribing.

It is convenient to look at the bill by sections.

A. Sections 1 & 13 are to be read together. Under the provisions of HB 70 of the 15th Legislature the board was empowered to contract with a private professional agency to run an impaired professionals program. Such a contract was signed last June between the Board and The Division of Occupational Licensing and the Alaska State Medical Association. Members of the ASMA's Impaired Physician Committee (all unpaid volunteers) seek out individuals in trouble, confront them and get them into treatment. The program is working very well at this point and is a marvelous boon to the community in shortstopping problems before they go on to threaten the public health.

The volunteers who staff the effort have been concerned that though they are protected from civil liability in terms of arranging treatment that their very necessary activity in terms of identification and confrontation of those in need of help is not so protected. The provisions of Section 1 & 13 extend the protection of immunity from civil and criminal liability for these necessary activities. Such seems logical, appropriate and consonant with protection of the public's health.

B. Sections 2, 3, 6, 7 & 10 are to be read together.

Present statute requires that all licensees and permittees be interviewed by at least one board member. Present policy requires that should the interviewer feel unsure about granting the license after the interview that an interview by the whole board and appropriate investigation by the division be carried out before licensure.

The interview requirement is one that was set by the legislature many years ago. What the legislative intent was is unclear to the board and my research through older versions of the statutes back to 1948 doesn't clarify the issue. Our practical experience is that it has some utility in determining that the applicant is indeed who he says he is (documents & pictures match, etc), seems to be sober and not flagrantly psychotic, and seems to present a logical sequence of training. The board recognizes that the interview is of significantly less importance than careful review of notarized training, residency, hospital privilege, specialty board, testing and licensure (in other jurisdictions) documentation plus clearance by the DEA and National Federation of State Medical Boards.

Interviews are carried out by both physician and non-physician members of the board without distinction. There is no attempt to use the interview as a test of knowledge both for practical and statutory reasons.

The interviewing of permanent and temporary licensees (most of the latter are expected to go on to permanent license status) should appropriately remain with board members exclusively. It is being found however that interviewing residency and locum tenens candidates is placing a severe burden on board members' time especially in Anchorage and Fairbanks and leading to delays and resentment on the part of both candidates and volunteer board members. It seems appropriate then that our executive secretary should take on part of that task. That individual is trained in statute and regulation and is familiar with training and testing cycles and the methods of acceptable identification.

C. Section 4.

This section closes a loophole. At present, persons who have surrendered a license in another jurisdiction while under investigation are free to apply in Alaska (if they have had the license revoked they are not so permitted). It seems sensible to require that they clear up their problem one way or another in the prior jurisdiction before applying in Alaska.

D. Sections 5 & 7 should be read together:

In the past a temporary license was granted to an individual who had completed all the requirements for a permanent license including an interview and was waiting for the board to meet to confirm the material and grant permanent licensure.

The locum tenens license though statutorily designed to be used only by those substituting for another physician developed an expanded, and to the board uncomfortable, meaning. It was used as intended for substitute physicians but was also used to cover individuals who came to Alaska to work in seasonal jobs, emergency rooms, etc, and those coming up briefly to see if they wanted to relocate to Alaska. Often they were not actually substituting for an Alaskan physician but there seemed no other reasonable category in which to place them without requiring permanent licensure. Some individuals also seemed to acquire such permits on a regular basis and as it were acquire sort of a permanent license at a cut rate.

By coordinating AS 08.64.270 and AS 08.275 the board hopes to create two categories.

A. Temporary Permit - good for 6 months and requiring all the documentation required for a permanent license plus interview by a board member to be used

- 1) While waiting formal board action at the next regular meeting at which point it is converted to a permanent license.
- 2) By those filling a temporary slot in an emergency room, seasonal clinic, etc. but not substituting for an Alaskan physician.
- 3) By those moving to the state who have not yet decided if they wish to stay permanently.
- 4) Individuals in category 2 & 3 (or for that matter those who wish to get frequent locum tenens permits) can then move on to permanent licensure by paying the remnant 75% of the permanent licensure fee any time up to 6 months after getting the temporary as they will have complied with all the requirements. The

board would still have the discretion of putting a hold on this if the individual had gotten into trouble during the 6 month temporary period.

- B. Locum Tenens Permit - good for 60 days with one renewal and a limit of 240 days in any two years between new permits and renewals. It would require somewhat less documentation than a temporary (but demand a currently valid license in another jurisdiction and clearance by National Federation of State Medical Boards) plus an interview by either a board member or the board's executive secretary. It could be used only by one substituting for an Alaskan physician who would have to be specifically designated. An individual who chose to function repeatedly in the role (i.e. beyond 240 days in two years) would be expected to get a permanent license (either directly or through the temporary license route) in his own right, not as a substitute.

E. Section 8. Retired License.

This provision seeks to do a number of things. It is recognized that there are a number of physicians who retain licensure beyond the time it is reasonable for them to practice out of the sense of pride licensure brings them and because of an oddity in statute that prohibits them from using the "M.D." after their name if not licensed. (The statute, 08.02.010, is designed to prevent the unlicensed from deluding the public as to their qualifications).

It is felt that a permanent retired license status will serve their purposes and protect the public health. Retired status should also appeal to those who are effectively retired and presently faced with CME requirements they cannot meet because of age and infirmity. The CME statutes at present make no provision for people in this status.

The proposed statute while not precluding reactivation of retired licenses would empower the board to make very certain that the individual was competent to resume such practice.

F. Section 9. Courtesy License.

This would permit the board to grant courtesy licensure, under appropriate restrictions, to medical practitioners accompanying sports teams (such as the Olympic teams if Anchorage gets the nod for Winter Olympics).

G. Section 11. Amphetamines.

It is clear that 99+% of all amphetamines prescribed are for weight reduction. It is clear that while they may be beneficial for 2-3 weeks that after that they serve no purpose in that regard and lead to significant habituation. Amphetamine prescription in "weight reduction clinics" is the single most significant diversion point of these medications onto the illicit market.

The proposed legislation, adapted from Wisconsin statutes, recognizes the seven (7) valid uses of the medication (accounting for less than 1% of prescriptions) and makes other use subject to disciplinary sanction.

It will help us in slowing down diversion and will also help the ethical physician when importuned by individuals seeking such medications if he can inform those individuals that such prescribing is illegal.

Such provision have proved quite useful in other states. From the personal experience of 15 years of a general practice in Ketchikan I would remark that I have seen only two patients requiring amphetamines; one a patient with documented narcolepsy and one a patient with attention deficit

disorder (hyperactivity) who was intolerant of Ritalin (Methylphenidate), the drug usually used for that condition along with Cylert (Pemoline). (Though hyperactivity is clearly over-diagnosed it is a real condition and occasionally requires drug therapy).

It is our suggestion that statutory language of a similar nature be inserted into the pharmacy statutes to further control amphetamine use. The Division along with the boards of pharmacy, nursing and medicine, the DEA, the ASMA and State Troopers are presently engaged in a cooperative effort known as PADS (prescription abuse data system) to try to reduce diversion. The present statute will help in that effort.

The blank in the statute is to be filled in with a reference to statutory language defining Schedule II substances in Alaska law. I can't find the reference at present.

H. Section 12. Reports of Disciplinary Action or License Suspension or Surrender.

When this section was crafted for HB 70 in 1986-87 we neglected to insert the word permit. Since certain of our licenses (temporary, locum tenens) and our physician assistant authority are referred to as permits it could be argued we are prevented from reporting disciplinary and other actions concerning these licenses and permits. We have considered that such reports fall under the legislative intent of the statute so have proceeded to submit reports when appropriate but feel it would be best to clean up the language.

I. Section 14. Preserving Sanctions of the Board.

The division, the board, and the National Federation of State Medical Boards regard medical licensure as a privilege granted to individuals by the state for the convenience and health of its citizens. It is not an inherent right of individuals any more than is a drivers license. Thus when there is good and sufficient reason for the board to believe an individual is not practicing safely and endangering the public health, it seems reasonable to permit sanctions imposed to stand unless and until a court of competent jurisdiction overrules the board on appeal. It must be remembered the board acts cautiously and in full compliance with the administrative procedures act, assuring rights to a complete hearing, before acting on a license sanction. To then have a court stay the action for long periods of time while an appeal is heard seems to be significantly detrimental to the public's health and safety. In one particularly notorious case within the board's experience an incompetent practitioner who had caused a number of deaths was permitted to practice for seven years after the board revoked his license while he slowly pursued appeals all the way to the U.S. Supreme Court. The board's action was upheld at each level but the practitioner was permitted to endanger the public for an additional seven years after original revocation.

The present statute, with language which protects the licensee against arbitrary action by the board, seeks to correct this most unfortunate state of affairs.

The present proposal combines proposals from the board with proposals from the Governor's office relative to interviews so that there are not multiple bills concerning the medical board in the legislature simultaneously.

Any questions concerning the proposals can be directed to:

Juneau	Randall Burns, Director, Division of Occupational Licensing	465-2534
Anchorage	Pamela Ventgen, Executive Secretary, State Medical Board	561-2878
Ketchikan	Thomas L. Conley, Chairman, State Medical Board	225-5144
Kotzebue	Abigail Hensley, Secretary, State Medical Board	442-3669
Juneau	James Thompson, Member, State Medical Board	586-8447

Words underlined are new.

Words bracketed and capitalized are deleted.

BY THE _____ COMMITTEE
BY REQUEST OF THE GOVERNOR AND
THE STATE MEDICAL BOARD

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

FOR AN ACT ENTITLED: "An Act relating to medical licensure; and providing for an effective date."

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

Section 1. AS 08.64.101(6) is amended to read:

Sec. 08.64.101(6) coordinate with private professional organizations to establish an impaired medical professionals program to identify, confront and treat persons licensed under this chapter who abuse addictive substances.

Section 2. AS 08.64.225 is amended to read:

Sec. 08.64.225. FOREIGN MEDICAL GRADUATES. Applicants who are graduates of medical colleges not accredited by the American Medical Association or one of its agencies must [SHALL] meet the requirements of AS 08.64.200(a)(3), (4), and (5), and AS 098.64.255 and must have passed an examination and be certified by the Education Council on Foreign Medical Graduates, or be licensed by examination in another state or territory of the United States or province of Canada.

Section 3. 08.64.230 is amended to read:

Sec. 08.64.230. LICENSE GRANTED. (a) If the physician applicant passes the examination and meets the requirements of AS 08.64.200 and AS 08.64.255, the board shall grant a license to the applicant to practice medicine in the state.

(b) If the osteopath applicant passes the examination and meets the requirements of AS 08.64.205 and AS 08.64.255, the board shall grant a license to the applicant to practice osteopathy in the state.

(c) Each license shall be signed by the secretary and president of the board, and have the seal of the board affixed to it.

Section 4. 08.64.240(a) is amended to read:

Sec. 08.64.240. LICENSE REFUSED. (a) The board may ~~not~~ grant or license if

(4) The applicant has surrendered a license in another jurisdiction while under investigation and the license has not been re-instated in that jurisdiction.

Section 5. AS 08.64.270 is repealed and readopted to read:

Sec. 08.64.270. TEMPORARY PERMIT. (a) The board may issue a temporary permit to a physician applicant, osteopathic applicant, or podiatry applicant who meets the requirements of AS 08.64.200, 08.64.205, 08.64.209 or 08.64.225 and pays the required fee.

(b) A temporary permit issued under this section is valid for six months and must be approved by the board at the next regularly scheduled meeting of the board after it is issued.

(c) A temporary permit issued under this section may not be renewed. The fee for the permit shall be one quarter of the biennial licensing fee (plus the appropriate application fee). At the discretion of the licensee and with board approval the temporary license may be converted to a biennial license (permanent license) upon payment of the remainder of the fee due for such a license.

Section 6. AS 08.64.272(b) is amended to read:

(b) For the limited purpose of residency or internship, the board may issue a permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(a)(2) and applicable regulations of the board, meets the requirements of AS 08.64.278, pays the required fee, and has been accepted by an eligible institution in the state for the purpose of residency or internship.

Section 7. AS 08.64.275 is amended to read:

Sec. 08.64.275. TEMPORARY PERMIT FOR LOCUM TENENS PRACTICE. (a) A member of the board may grant a temporary permit to a physician or osteopath for the purpose of substituting for another physician or osteopath licensed in this state. The permit is valid for [120] 60 consecutive days. If circumstances warrant, an extension of the permit may be granted by the board.

(b) A physician applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.200 and of AS 08.64.278. In addition, the physician shall submit evidence of holding a license to practice medicine in a state or territory of the United States or in a province of Canada.

(c) An osteopath applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.205 and of AS 08.64.278. In addition, the osteopath shall submit evidence of holding a license to practice in a state or territory of the United States or in a province of Canada.

(d) Within 10 days after the permit has been granted, the board member shall forward to the department a report of the issuance of the permit.

(e) A limit of four such permits and/or extensions (limit of 240 days) may be granted to a single individual during a two year period.

Section 8. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.276. RETIRED LICENSE (a) on reaching the age of 65, and on payment of an appropriate one time fee, a licensee in good standing with the board may apply for the conversion of an active or inactive license to retired status.

(b) A retired license is issued for the remnant span of the licensee's life and does not require renewal.

(c) Individuals holding retired licenses are exempt from the provisions of 08.64.312.

(d) Individuals holding a retired license are prohibited from practicing medicine, osteopathy or podiatry, as the case may be, in the State of Alaska.

(e) Retired licensees may reapply for active licensure but are required to meet any reasonable criteria set by the board in the individual case including but not limited to demonstration of adequate CME credits, retaking of national examinations such as the FLEX exam, physical and psychiatric examination, interview with the board as a whole, and clearance by the National Data Bank of the National Federation of State Medical Boards.

Section 9. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.277. COURTESY LICENSE. The State Medical Board may by regulation set criteria for issuing temporary courtesy licenses to medical and osteopathic physicians and podiatrists accompanying interstate and international sporting teams and international contingents participating in activities in Alaska. Such licenses shall be limited in time to that length of time the contingent or sporting team is present in Alaska and in any case no longer than 45 days. Such licensees will be limited to practicing on team or contingent members, their dependents and foreign nationals accompanying international groups.

Section 10. AS 08.64 is amended by add a new section to read:

Sec. 08.64.278. INTERVIEW REQUIRED FOR PERMITS. An applicant for an intern permit, a resident permit, or a temporary permit for locum tenens practice must be interviewed in person by at least one member of the board or by the executive secretary of the board.

Section 11. AS 08.64 is amended by adding a new subsection to AS 08.64.326 numbered AS 08.64.326(a)(14) to read:

Sec. 08.64.326. GROUNDS FOR IMPOSITION OF DISCIPLINARY SANCTIONS. (a) (14) Has prescribed, ordered, dispensed, administered, supplied, sold, or given any amphetamine, sympathomimetic amine drug or compound identified as a schedule II controlled substance under _____ to or for any person except for the treatment of narcolepsy, or for the treatment of attention deficit disorder (hyperkinesis), or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

Section 12. AS 08.64.335 is amended to read:

Sec. 08.64.335. REPORTS OF DISCIPLINARY ACTION OR LICENSE SUSPENSION OR SURRENDER. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license or permit refusals under AS 08.64.240, actions taken by the board under AS 08.64.331, and license or permit suspensions or surrenders under AS 08.64.332 or 08.64.334.

Section 13. AS 08.64.336(e) is amended to read:

Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (e) A physician, hospital, hospital committee, or private professional organization designated under AS 08.64.101(6) to identify, confront and treat individuals licensed under this chapter who abuse addictive substances, that in good faith submit a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil or criminal liability for the submission or participation.

Section 14. AS 08.64 is amended by adding a new section to read:

Sec. 08.64.369. PRESERVING SANCTIONS OF THE BOARD. A refusal of or a sanction of a license or permit issued under this chapter may not be temporarily enjoined nor an action of the board in refusing or sanctioning a license stayed pending appeal to a court of competent jurisdiction or temporarily enjoined or stayed pending appeal to superior appellate review unless the court granting such an injunction or stay does so on demonstration of reasonable cause to presume the board's refusal to grant a license or permit or sanction a license or permit may have been based on discrimination on the basis of race, creed, color, sex, national origin, or handicapping condition that does not impair safe practice, on conspiracy in restraint of trade, or malicious intent to injure the applicant or licensee or permittee.

Section 15. This Act takes effect immediately under AS 01.10.070(c).