

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1734 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

1302

STATE MEDICAL LICENSING BOARD

State of Alaska
Division of Occupational Licensing
Pouch D
Juneau, Alaska 99811

June 1, 1989

Representative Dave Donley
Chairman
House Labor & Commerce Committee
Capitol Building, Room 13
Pouch V
Juneau, Alaska 99811

Dear Representative Donley:

The State Medical Licensing Board, after reviewing the proposed CS for House Bill 146(L&C), would like to make some comments on the proposal and requests that they be added to the bill file for consideration during the second session of the Sixteenth Legislature.

Please find enclosed a proposal for legislation drafted by the board in February 1989 with a memorandum explaining its provisions. As can be seen the proposed legislation incorporates the provisions of HB 146 in its original form and adds several additional sections. These additions deal with extension of protection from civil liability for volunteers in the Impaired Physicians Program who act as agents of the board in confronting substance abuse, close several loopholes in the law, make some administrative changes that will improve board efficiency, create categories for licensure of retired physicians and those accompanying sports teams (such as Olympic teams), and tightens up on the prescribing of amphetamines. Finally the proposal would limit stays on board sanctions to prevent individuals whose licenses have been revoked, suspended or limited from practicing during a frequently prolonged appeals process.

In regard to this final point the board would be happy to consider other means to accomplish the same end. We have surveyed laws in the fifty states in this regard and have discovered that some jurisdictions solve the problem by limiting the granting of stays to situations where the respondent can demonstrate that he/she is not a danger to the public health or safety and is likely to prevail on the merits of the case during the appeals process.

In its discussions during its regular meeting of 22-23 May the board additionally decided to request revision of AS 08.64.380(7)(B) to read: to use or publicly display a title in connection with a person's name including "doctor of medicine," "physician," "M.D.," or "doctor of osteopathic medicine" or "DO" or a specialist designation including "surgeon," "dermatologist," or a similar title, in such manner as to show that the person is willing or qualified to diagnose or treat the sick or injured;

The change is requested as the board finds itself spending inordinate amounts of time and state legal funds pursuing individuals who have earned the academic title M.D., but who are not licensed and who "display" the title in other settings than in seeking patients (i.e., teaching, journal articles, legal consulting, out of personal pride, etc.). The proposed change would permit us to ignore such trivial matters while still empowering the board to pursue those using the title M.D. to dupe the public into believing they can legally diagnose and treat the sick and injured.

In regard to the provisions of the proposed CS for HB 146(L&C) the board enthusiastically supports Section 1, the amendment to AS 08.02.030, and would go one step further in revising AS 08.64.101(6) and AS 08.64.336(e), as presented above and in the accompanying documents. As to Section 3, the amendment to AS 08.64.190 we are pleased to inform you that the board has adopted these measures as policy--having it in law strengthens our position. Likewise the added sections under AS 08.64.200 place in law present board policy with the only difference being that the board requires, as does PL 99-660, submission of a list of malpractice judgements or settlements both at the time of initial licensure and biennial re-registration. To place such policy in law would be consonant with present board practice and in conformity with PL99-660. Requiring the submission of a list of malpractice claims filed does not meet with board approval as it would be time consuming and costly to investigate them, add little or no useful information to an application file and raises troubling constitutional questions. This will be discussed further below.

The State Medical Board, for reasons to be discussed below, does not support, indeed vigorously opposes Section 2 (amendments to AS 08.64.130) Section 14 (new 08.64.345) and Section 15 (required report to the Legislature).

It is the board's experience, as it is the experience of boards throughout the country, that civil liability litigation commonly referred to as malpractice litigation and impaired, incompetent, or illegal practice have little relationship to each other. Required by PL-660 and our own policies to inquire into liability judgments at the 1988 re-registration of licensees we received such reports on 40 re-registrants for the period 1984-88. Just how many claims, as opposed to judgments or settlements, this distillation represents we have no way of knowing but is likely a substantially larger number.

So far, and needless to say at substantial investigative expense to the state, we have investigated and cleared 35 of that number and the information on the remaining 5, slightly less than completely investigated, indicate we should be closing them out in August. All cases so far have been closed as without merit from a licensing standpoint on the recommendation of the State of Alaska. [Investigations are conducted by the Division of Occupational Licensing and presented to the board for action or closure.]

Contact with other state boards around the country confirms similar experiences. Lee Buckler, M.D., former president of the Delaware Board, informs me they have investigated settlements and judgments for the last 8 years, averaging 10 per month or 960 over the last 8 years [a small and rather more rural than typical enclave on the eastern seaboard, Delaware, with 2100 licensees, has only three times as many physicians as Alaska's approximately 700. However, the medical liability explosion has tended to move east to west so they have had a much larger experience to date in a proportional sense]. In only one of those cases has information derived from investigation led to licensure proceedings and even in this one case an independent complaint arriving two months after the case opened would have triggered investigation.

As far as I can determine the only jurisdiction investigating claims made is Maryland. This is still in its first year but according to board counsel who I spoke with in Chicago in April, it is consuming vast amounts of time with no appreciable results. The board is presently discussing the advisability of presenting a statistical review of the process, after two years experience, in an effort to shed itself of what it regards as a meaningless but onerous requirement.

None of this should be in the least surprising to anyone who has followed the growth of liability actions in this country. Analysis of the phenomenon especially in relationship to licensure and discipline lead to a number of inescapable conclusions.

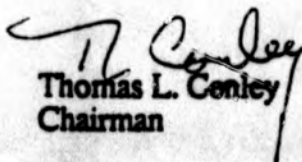
1. The growth of liability actions reflects a change in the ethos of society and in no way reflects a change in the level of competence or ethics of those being sued. As a society we have bought into the idea that no matter what goes awry there must be some human agency responsible who can be held to account at least in a monetary sense. Such an idea will of course eventually lead to societal chaos and clearly reflects an amazing hubris about human capabilities.
2. It is precisely the most competent active and innovative practitioners who stand the greatest chance of being sued for they are the ones seeing the difficult cases and practicing on the cutting edge of medicine where the likelihood of untoward results are greatest. Simultaneously it is the least competent, the sulkers who never seek hospital privileges or who engage in outpatient quackery, who run the lowest risk of malpractice litigation for they take no chances and engage in the provision of Dr. Feelgood services.
3. Two stratagems prove the most effective in detecting and pursuing malefactors. The first is to require that those loosing hospital privileges or having them limited be reported to the board -- this identifies those "falling from grace." The second consists of computerized tracking of excessive and questionable prescription writing through the PADS program presently being introduced to Alaska with active board support.
4. Most malpractice claims arise in two circumstances. The first is anger and frustration over the reality of the disease process and a need to find some individual or agency to blame. The second is anger at the perceived callousness and arrogance of care providers. Anyone who is around medicine for any length of time cannot fail to notice that a disproportionate number of physicians are arrogant and seemingly unfeeling individuals. It seems to go with the territory. Though it certainly doesn't equate to malpractice, indeed intellectually is in no way related, it nonetheless gives rise to a large number of suits that would otherwise not occur. Indeed one could defend the proposition that the maladroitness of physicians in the social realm is the greatest of boons to the malpractice lawyer or as one of my legal friends puts it, "if they didn't exist they should be invented and encouraged to practice medicine."
5. With the above in mind, tracking malpractice settlements, most of which are settled for fairly minimal amounts as these things go, is unlikely to yield useful information in the majority of cases. PL 99-660 requires this tracking as does a sense of rational public relations. Clearly however, tracking of claims made is a fools errand likely to yield little substantial information at enormous cost in terms of time and investigative expense.
6. It was strongly suggested by all those familiar with the situation, even the Inspector General of DHEW, Richard Kussorouth, that PL 99-660 set a dollar figure for reporting liability settlements. It was felt that suits settled for under \$25,000 were invariably nuisance suits that were settled to avoid the cost and irritation of going to court and invariably had no substance to them. Setting a dollar figure was felt to spare boards the requirement of investigating these matters since it was a foregone conclusion that the investigations, while expensive, would have no yield. Congress unfortunately did not see fit to set a figure though it was debated. The argument holds even more strongly for claims made then abandoned.
7. Investigating claims made rather than settlements or judgments and particularly using claims made as a rational for taking licensing action as suggested by CS-HB 146(L&C) is extremely disturbing in a constitutional sense. To proceed in this fashion would be to elevate accusation to the level of proof of malfeasance and encourage the board and the State of Alaska to totally ignore the due process provisions of the constitution.

Representative Dave Donley
June 1, 1989
Page 4

8. The board assumes the good intentions of the drafter of the committee substitute but is seriously disturbed by his/her unfamiliarity with the realities of the present civil liability situation and apparent unfamiliarity with constitutional guarantees about the presumption of innocence in advance of the playing out of due process.

The board stands ready to help in redrafting the legislation as preparations proceed for the opening of the second session of the Sixteenth Legislature.

Sincerely,


Thomas L. Conley
Chairman

TLC:bjh

Enclosure

cc: Board/Randall Burns/Pam Ventgen
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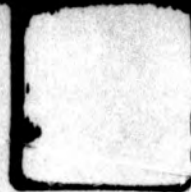
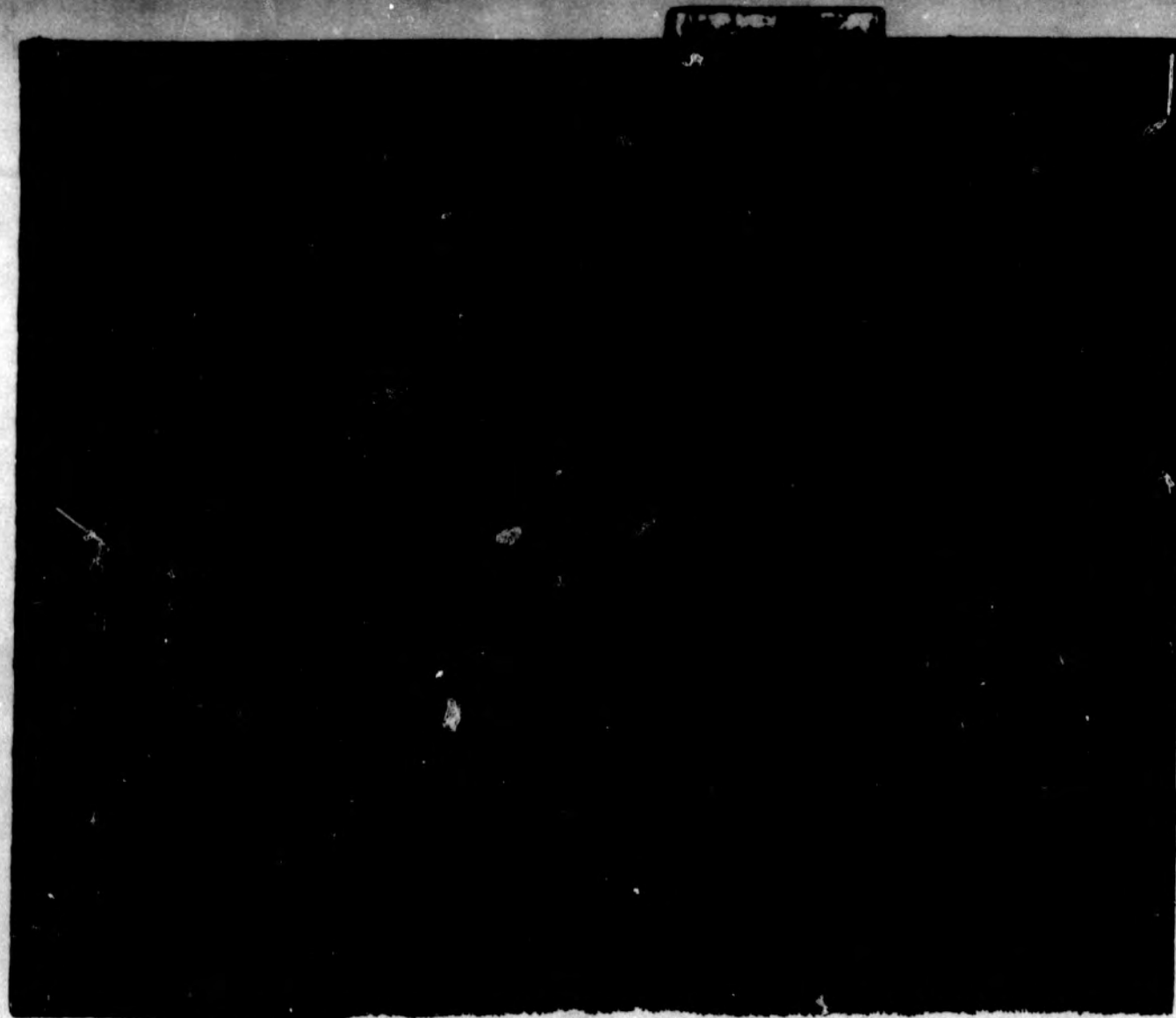


TABLE 2 REVENUE DISCIPLINARY FUNCTION - MANDATORY REPORTING OF VIOLATIONS, WHO MUST REPORT, PENALTY FOR FAILURE TO REPORT, CIVIL PENALTIES (FINES) FOR FAILURE TO REPORT.

	AL	CL	CRT	HSP	ONE	LIAB	LMS	LPS	OSA	SLE	SMS	SPS	PMD	PTP	OP	FA	CIV. PEN. Y-N
AL	X			X										X			
AL	X	X	X	X	X			X	X					X			
AZ-N	X		X	X	X	X	X	X		X	X	X		X			No
AZ-O	X			X		X	X	X			X	X					
AL	X			X													
CA-N			X	X	X	X											
CA-O	X	X	X	X	X	X	X		X	X	X						
CO	X	X		X		X											
CT-N	X			X		X					X						
DE	X	X		X	X	X	X	X		X	X	X	X	X			
DE				X													
FL-N	X			X		X	X	X	X		X	X	X		X		
FL-O	X	X		X		X	X	X			X	X					
GA				X		X											
GA-N	X	X	X					X	X								
HI-N	X	X	X	X	X	X	X	X			X	X					
ID	X			X													
IL			X	X	X	X		X	X	X							
IN			X					X									
IA	X	X		X		X											Yes (licensees only)
IS	X	X		X	X	X	X	X			X	X					
IT	X		X	X		X	X	X	X		X	X					
LA					X												
ME-N	X			X	X	X	X	X			X	X					
MD		X	X	X		X	X	X			X						Yes (HSP only)
MA		X	X	X	X	X	X	X	X	X	X	X			X		
ME-N			X	X		X											
ME-O			X	X		X											
MS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
MS			X			X	X				X	X					
ND			X	X	X												No
NE	X																

*Key: AL = All licensees; CL = Licensee committing a violation; CRT = Courts; HSP = Hospitals (staff/adminis); ONE = Other health care provider entities (eg, HMOs, IPPs, unaffil. clinics); LIAB = Lib. ins. carrier(s); LMS = Local med/osteo societies; LPS = Local prof. societies; OSA = Other state agencies; SLE = State/local law enforce. agencies; SMS = State med/osteo societies; SPS = State prof. societies; PMD = Prof. review organizations; PTP = Physicians treating physicians for spec. disorders; OP = Other health care professionals; FA = Federal agencies

	AL	CL	CRT	HSP	ONE	LIAB	LMS	LPS	OSA	SLE	SMS	SPS	PMD	PTP	OP	FA	CIV. PEN. Y-N
NE																	
NY-N	X	X	X	X	X	X	X	X			X	X			X		No
NY-O				X			X										
OH	X	X	X	X	X	X	X	X		X	X	X					
OK				X		X											
OR-N				X		X											
OR-O																	
PA	X	X	X	X	X	X	X	X			X	X			X		
NC				X		X											No
ND	X	X															
OH	X	X	X	X		X	X	X			X	X		X		X	
OK-N				X	X	X	X	X			X	X	X				
(All bold marks are pursuant to PL 99-500)																	
OK-O						X											
OR	X			X		X	X	X			X	X	X	X	X		Yes
PA-N	X	X	X	X				X									No
PA-O	X	X															
PR						X											
RI		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	No
SC				X	X												
SD				X													
TX-N					X												
TX-O					X												
TX	X	X	X	X	X	X	X	X			X	X			X		No
UT-N	X	X		X	X	X	X				X						
VT-N				X													
VA	X		X		X	X	X	X			X	X		X			
VI																	
WA-N	X		X	X	X	X	X		X	X	X		X			X	
WA-O	X	X				X											
WV-N	X	X	X	X	X	X	X	X	X		X	X	X				
WV-O	X	X		X					X	X	X						
WI				X		X			X								
WY	X	X		X	X	X	X	X			X	X					
Totals	36	26	22	51	27	39	30	24	17	12	30	23	8	9	8	3	Y = 3 / N = 7

#1178

PUBLIC CITIZEN

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EMBARGOED UNTIL:
PM'S SEPTEMBER 27

For Further Information:
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PUBLIC CITIZEN HEALTH RESEARCH GROUP

State Medical Licensing Board Doctor Disciplinary Actions in 1987
(Latest Data Available)

SEPTEMBER 1989

**PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT:
STATE MEDICAL BOARD DOCTOR DISCIPLINARY ACTIONS: 1987**

Prompted by a spate of adverse publicity and state and federal legislation, state medical boards boosted the number of serious disciplinary actions they levied against physicians for the fourth year in a row.

The number of medical license revocations, suspensions and probations rose by 17 percent in 1987, to 1,495¹, the equivalent of 2.78 disciplinary actions for every 1,000 U.S. doctors.

Public Citizen believes those figures still aren't high enough. A physician could still operate drunk, commit a gross act of negligence or sexually assault a patient and receive a mere slap on the wrist from his or her state's medical board in most states.

We estimate that well over 100,000 Americans are injured or killed each year as a result of doctors' negligence. The absence in most states of the maximum effort to discipline these doctors is one of the most serious threats to the health of American patients.

American patients would be much more protected if every state would discipline as many doctors as West Virginia, the top state in our rankings for 1987, which had a rate of revoking the licenses, suspension or probation of 8.58 per 1,000 physicians, 19 times more doctor discipline than Kansas with only .45 actions per 1000 physicians. If all states had a rate of serious doctor disciplinary action equalling West Virginia's, the total number of M.D.'s with serious disciplinary actions in 1987 would have been 4,616, three times the number actually subject to those actions. This would mean that an additional 3,121 physicians would have been subjected to serious disciplinary action in 1987, significantly increasing the amount of protection of patients against incompetent or otherwise poorly-practicing physicians.

One bright note: During 1987 and 1988, 44 state legislatures, including those in Florida, Maryland and Illinois, enacted legislation to strengthen state oversight of physician behavior. It remains to be seen whether those laws will provide a further push to state medical boards to take incompetent doctors' licenses and other means of practice away.

OVERALL U.S. TRENDS

For the fourth time in the last five years, Public Citizen Health Research Group has analyzed the most recent (1987) data which state medical licensing boards forward to their national organization, the Federation of State Medical Boards. The three

types of serious disciplinary actions which we use as the basis for ranking the states are revocation of license, suspension of license and probation. A fourth category of disciplinary actions, which includes reprimands, voluntary surrender of license and a variety of other actions is not included because the Federation does not release the details as to what proportion are really serious and how many are not.

As can be seen in Table 1, in 1987, state licensing boards took 1,495 serious disciplinary actions against U.S. physicians (M.D.'s). This represented an increase of 218 such actions over the previous year or an increase of 17 percent. That rate of increase is the same seen between 1985 and 1986.

It is much smaller, however, than the improvement between 1984 and 1985, when the number of serious actions increased 344, from 745 to 1089, an increase of 46 percent.

With a total of 538,008 non-federal M.D.'s in the U.S. as of December 31, 1986, (the latest available figure)³ the average rate of doctor discipline for the country is only 2.78 serious disciplinary actions (revocation, suspension, or probation) per 1000 M.D.'s.

STATE BY STATE RANKING

The number and rate per 1000 M.D.'s of serious disciplinary actions for each state and the District of Columbia in 1987, compared to 1986, can be seen in Table 2. These rates are calculated by dividing the number of serious disciplinary actions (revocations, suspensions or probations) -- reported by each state to the Federation of State Medical Boards -- by the number of non-Federal M.D.'s in each state.

Better News

Six of the top 20 states in 1987 were not in the top 20 in 1986. These include Mississippi, South Dakota, Nevada, Delaware, North Dakota and Massachusetts.

Massachusetts continued a rapid rise in the rankings, from 39th in 1985 that came after the state passed legislation to strengthen doctor discipline in mid-1986. By 1986, the state had risen to 21st and, as of 1987, to 20th.

Other states with sizable increases in the number of serious disciplinary actions from 1986 to 1987 were West Virginia, Kentucky, Hawaii, Wisconsin, Louisiana, Washington, Michigan and Maryland.

Laudable progress has also been made in New York, the state with the largest number of disciplinary actions (though only the

15th highest rate). New York's 259 serious disciplinary actions represent a more than four-fold increase from 1985, when there were 60 serious disciplinary actions. New York's ranking went from 40th in 1985 to 16th in 1986 and, in 1987, to 15th.

New York City Council President Andrew Stein and Gov. Mario Cuomo deserve credit for focusing public attention and government resources on the discipline issue.

It should also be noted that Kentucky, Iowa, Georgia and Oklahoma have been in the top 10 states for doctor disciplinary rates for three straight years.

Worse News

At the other end of the scale, Kansas, which ranked 33rd among the states in 1986, fell to the bottom of the rankings in 1987, as the number of serious disciplinary actions it levied fell from 7 to 2. In addition, North Carolina, California, and Maine, which were not among the bottom 20 states in 1986 fell to the bottom 20 in 1987.

It is particularly sad that California, whose Board of Medical Quality Assurance was a model of doctor discipline in the late 1970's, now is apparently not putting a priority on patient safety. A recent University of California, San Diego study called physician discipline in that state "a code blue emergency," adding, "The system cannot and does not protect Californians from incompetent medical practice."⁴

Other declines were seen in Utah and Oregon -- though both remained in the top 20 -- Virginia, Ohio and particularly Indiana, where the number of serious disciplinary actions was nearly halved from 57 in 1986 to 30 in 1987.

Maintaining their abysmal rates of discipline in the bottom 10 states were Connecticut, Tennessee, and Pennsylvania.

IMPLICATIONS

Our estimate that at least 100,000 Americans are injured or killed each year by doctor negligence is based on three published studies.

The Joint Malpractice Commission estimated that 3.6 percent of all patients entering hospitals are injured and that 14.5 percent of the injuries were due to negligence.⁵ That estimate would indicate 203,000 injuries from doctor negligence in 1983.

A study of 5,612 surgical admissions at a Boston hospital showed 36 patients suffered adverse outcomes "due to error during care."⁶ Applied to all 1983 surgical admissions, that malpractice

rate would result in 136,000 injuries.

A California study found that 24,000 out of the 3 million admitted to hospitals there in one year appeared to be victims of malpractice.⁷ Applied to the entire U.S. in 1983, that would have resulted in 310,400 deaths or injuries.

Even though the 1987 total of 1,495 serious doctor disciplinary actions is better than in any previous year, it falls very short of catching most of the incompetent doctors in this country. In most states, the majority of disciplinary actions are for drug and alcohol problems, only a fraction being for incompetence.

Since there is no evidence that doctors settle in certain states depending on how competent they are, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors. The disparity between states with higher rates of doctor discipline and states with only a fraction of these higher rates is cause for alarm by the residents of the low-discipline states. People in these states are much more likely than people in high-rate doctor discipline states to be injured or killed by doctors still on the loose because they haven't been "caught." What might be unacceptable medical practice in one state just goes by the state licensing boards in another.

A further indication that the rate of doctor discipline by most state medical boards is too low comes from a recent Tufts University study.⁸ Those researchers found that physician-owned insurance companies terminated coverage of 6.6 out of every 1,000 policyholders in 1985 because of negligence-prone behavior, and restricted the practice or imposed other medical sanctions on an additional 7 of every 1,000 policyholders, whose performance was viewed as substandard. Thus, if the combined rates of malpractice insurance termination and other sanctions by physicians-owned insurance companies (13.6 per thousand physicians) were applied to all physicians in the U.S., this would be a rate which is almost 5 times higher than the actual rate of serious doctor disciplinary actions by state licensing boards.

DOCTOR DISCIPLINE AND MEDICAL MALPRACTICE

We continue to believe that until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice. At the heart of the so-called medical malpractice crisis, other than the manipulative efforts of the insurance industry, is actual malpractice, patients being injured or killed by negligent physician behavior.

WHY IS WEST VIRGINIA NUMBER ONE IN DOCTOR DISCIPLINE?

Ronald Walton, Executive Director of the West Virginia Board of Medicine, attributes his state's success to several factors:

- 1) A new, dedicated group of board members have joined the board in the last four years. Their presence has greatly increased the visibility of the board, particularly after the State Supreme Court ruled four years ago that the Board must make all of its disciplinary actions public. The West Virginia Board of Medicine now sends press releases to local newspapers every time it disciplines a doctor. As a result, according to Mr. Walton, the board has received a much larger number of consumer complaints about questionable physicians.
- 2) The Board hired a full-time legal counsel in 1987 which enabled it to largely clean up its backlog of complaints and move forward to resolve most cases within a matter of months. Walton said, "We get a hell of a lot more done."
- 3) In addition, the Board's lone investigator noses out bad physicians by making the rounds of pharmacies throughout the state. "Pharmacists in small communities know pretty much what is going on. They know who the drug addicts are," he said.

Mr Walton also said that the number of doctor disciplinary actions taken by the Board has continued to increase in 1988 and 1989.

RECOMMENDATIONS FOR STATES

1. Increase doctor license fees to \$500 per year: all money going to finance doctor disciplinary actions. State medical boards now are chronically understaffed and underfunded; many have huge backlogs of complaints.
2. Require periodic recertification of doctors based on written exams and audits of doctor performance such as medical record review.
3. Grant subpoena power to state licensing boards to go after evidence necessary to evaluate doctors.
4. Grant state boards emergency powers to suspend a doctor's license to practice, pending investigation, when continued practice is considered to constitute a hazard to public safety.

5. Require all hospitals in your state to have a risk management program designed to prevent injury to patients. According to the American Hospital Association, only 60 percent of hospitals have such programs and only half of these are excellent programs.

6. Require all insurance companies to experience-rate doctors within subspecialties, whereby doctors with the best records pay the lowest premiums, and multiple malpractice loser doctors pay the most.

7. Require insurance companies to immediately publicly disclose and forward to the state licensing board the filing of malpractice claims, as well as the results of all malpractice settlements and adjudications.

8. Require hospitals or other institutions taking disciplinary actions against doctors to publicly disclose and forward to the state licensing board the details of such actions.

9. Provide immunity and confidentiality to all those reporting doctor malpractice, incompetence, substance abuse or fraud to state medical boards.

10. Provide strong consumer representation on state medical boards. Do not allow the state medical society to control membership on the boards.

11. Officials should make strong, public statements indicating a commitment to strong doctor discipline and protection of patients' safety.

TABLE 1
SERIOUS DISCIPLINARY ACTIONS
AGAINST U.S. PHYSICIANS (M.D.s)
1984-1987

YEAR	1984	1985	1986	1987
SERIOUS ACTIONS	745	1089	1277	1495
CHANGE FROM PREVIOUS YEAR	--	+345	+188	+218
PERCENT	--	+46%	+17%	+17%

1. Galusha, Bryant L. and Breaden, Dale G. Official 1987 Federation Summary of Reported Disciplinary Actions. Federation Bulletin, Sept. 1989, 275-280.

2. Intergovernmental Health Policy Project, State Oversight and Regulation of Physicians, George Washington University, Sept. 1988.

3. Physician Characteristics and Distribution in the U.S., 1987. Chicago, Ill., American Medical Association, 1987.

4. Fellmeth, Robert C., Physician Discipline in California: A Code Blue Emergency, Center for Public Interest Law, University of San Diego School of Law, April 5, 1989.

5. J. Legal Medicine, Feb. 1976.

6. New England J. Med. 1981, 304, 634-7.

7. Medical World News, July 22, 1985.

8. Schwartz, William B., and Mendelson, Daniel N., The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence., JAMA, 1989; 260, 10:1342-1346.

TABLE 2
SERIOUS DISCIPLINARY ACTIONS AGAINST M.D.S (REVOCATIONS, SUSPENSIONS
AND PROBATIONS) BY STATE LICENSING BOARD 1987

RANK 1987	RANK 1986	STATE	SERIOUS ACTIONS PER 1000 M.D.S	SERIOUS ACTIONS 1987	ACTIONS 1986	NUMBER C DOCTORS
1	4	WEST VIRGINIA	8.58	29	19	3,381
2	19	ALASKA	6.91	5	2	724
3	9	KENTUCKY	6.63	41	22	6,188
4	26	MISSISSIPPI	6.15	21	8	3,416
5	11	HAWAII	5.99	15	8	2,506
6	44	SOUTH DAKOTA	5.98	6	1	1,004
7	3	IOWA	5.93	26	26	4,384
8	1	GEORGIA	5.70	60	73	10,524
9	24	NEVADA	5.37	9	4	1,676
10	7	OKLAHOMA	5.21	26	21	4,994
11	8	MISSOURI	4.90	49	38	9,996
12	18	WISCONSIN	4.87	45	26	9,234
13	34	DELAWARE	4.65	6	2	1,290
14	20	FLORIDA	4.60	128	75	27,851
15	16	NEW YORK	4.48	259	167	57,779
16	5	UTAH	4.16	13	17	3,128
17	6	OREGON	3.91	23	28	5,877
18	10	COLORADO	3.56	25	24	7,028
19	29	NORTH DAKOTA	3.52	4	2	1,136
20	28	MASSACHUSETTS	3.49	69	42	19,766
21	15	SOUTH CAROLINA	3.44	19	16	5,522
21	2	INDIANA	3.44	30	57	8,731
23	23	NEW JERSEY	3.12	59	49	18,883
24	13	MINNESOTA	2.94	28	30	9,535
25	17	ILLINOIS	2.62	67	73	25,537
26	35	LOUISIANA	2.48	21	13	8,453
27	25	D.C.	2.36	9	9	3,819
27	12	VIRGINIA	2.36	29	39	12,311
29	42	WASHINGTON	2.28	23	11	10,079
30	14	IDAHO	2.24	3	4	1,341
31	49	VERMONT	2.04	3	1	1,469
32	27	NORTH CAROLINA	1.95	23	26	11,783
33	47	MICHIGAN	1.94	34	14	17,549
34	50	NEW HAMPSHIRE	1.86	4	1	2,149
35	21	OHIO	1.79	39	58	21,744
36	48	MARYLAND	1.73	26	11	15,000
37	41	RHODE ISLAND	1.61	4	3	2,489
38	39	TEXAS	1.47	43	41	29,207
39	37	NEW MEXICO	1.46	4	4	2,735
40	38	NEBRASKA	1.45	4	4	2,762
41	51	WYOMING	1.42	1	0	706
42	30	CALIFORNIA	1.32	94	121	71,349
43	22	MAINE	1.30	3	6	2,306
44	40	ALABAMA	1.27	8	8	6,323
45	31	ARIZONA	1.23	9	12	7,303
46	45	PENNSYLVANIA	0.98	28	27	28,476
47	43	TENNESSEE	0.86	8	10	9,285
48	31	ARKANSAS	0.82	3	6	3,664
49	36	MONTANA	0.76	1	2	1,323
50	46	CONNECTICUT	0.71	7	9	9,833
51	33	KANSAS	0.45	2	7	4,460
			2.78	1495	1377	558008



**Defining,
Measuring,
Assuring**

Quality of Care

A Summary of AMA Policy

*Alaska State Medical Association
4107 Laurel Street
Anchorage, Alaska 99508
(907)562-2662 or FAX (907)561-2063*

A WORD OF INTRODUCTION

As government, business and other payors search for ways to lower their health care costs, and as competition increases in the health sector, efforts to preserve the quality of health care have become increasingly important. Pressure will grow for changes in delivery and financing system which may tend to reduce the quality of care provided. Public debate will increasingly focus on how to define and measure quality, as health professionals, payors and patients address such issues as:

- * ensuring quality care in contracting with provider groups;
- * deceptiveness of advertisements stating that certain providers give "the highest quality of health care available";
- * the feasibility of incorporating a measure of quality in reimbursing hospitals or any other health care providers; and
- * evaluating the effectiveness of various treatment modalities and delivery systems.

The American Medical Association's Council on Medical Service sees the challenge posed by this evolving health care environment as three-fold:

- * To develop guidelines regarding appropriate methods for assessing or measuring the quality of care.
- * To encourage wide and systematic use of quality assessment findings to improve the care delivered, and thus increase overall access to care of high quality.
- * To foster a broader public understanding of what is meant by the term "high quality medical care," and of the current mechanisms used to assess and assure quality.

This booklet brings together and summarizes some of the reports and recommendations developed by the AMA in its effort to respond to that challenge.

WHAT IS "HIGH QUALITY?"

Care of high quality can be conceptually defined in terms of its results, or patient outcomes. In 1984, the AMA characterized care of high quality as that "which consistently contributes to the maintenance or improvement of health and well being.

The definition recognizes that, when other variables which could affect outcome—such as patient age, sex, living environment, attitude toward illness, health history, severity of illness, and natural history of the disease—are adequately measured and accounted for, patient outcome reflects the degree of effectiveness with which health professionals combine their own skill and compassion with the use of technology for the patient's benefit. It encompasses both the effects of care on the patient, and the proficiency with which such care is provided. Also implicit in the definition is the need to develop more meaningful criteria as to what constitutes a "favorable" outcome.

There are other essential elements which characterize care of high quality. Such care should:

- * Emphasize health promotion, disease and disability prevention, and early detection and treatment.**
- * Be provided in a timely manner, without inappropriate delay, interruption, premature termination or prolongation of treatment.**
- * Seek the patient's cooperation and participation in the decisions and process of his/her treatment.**
- * Be based on accepted principles of medical science, and the skillful and appropriate use of other health professionals and technology.**
- * Be provided with sensitivity to the stress and anxiety that illness can cause, and with concern for the patient's and family's overall welfare.**
- * Use technology and other resources efficiently to achieve the treatment goal.**
- * Be sufficiently documented in the patient's medical record to allow continuity of care and peer evaluation.**

HOW CAN PATIENTS IDENTIFY HIGH QUALITY?

Some of the essential elements listed above can be very meaningful to the patient as indicators of quality-sensitivity and compassion, emphasis on prevention and health promotion and involvement in treatment decisions. Other meaningful indicators can include the caregiver's accessibility, and willingness to listen, explain and answer questions about treatment or charges, help find other needed services, or arrange for consultation when asked or needed. The degree to which the physician is sensitive to and attempts to respond to legitimate patient goals which may be different from those of the physician can also be important.

The physician's technical competence, as well as medical outcomes, have been the traditional indicators of quality. Recently, however, patient satisfaction has also gained credibility as a possible criterion by which quality of care can be identified. Patient satisfaction not only reflects the personal aspects of care, but there is some evidence that patients can adequately evaluate the technical aspects of care when such care is of a fairly routine nature.

HOW SHOULD QUALITY BE MEASURED?

The heart of any program to measure or assess the quality of medical care is peer review by practicing physicians of the quality of services ordered or performed by other practicing physicians. To facilitate the process of peer review, screening criteria may be developed and applied to identify those care episodes which should be subjected to indepth quality assessment by professional peers. However, such criteria should never be used as per se indicators of the quality of care provided.

Quality assessment programs should be conducted in accord with the following guidelines:

- * Criteria for assessing quality of care should be developed and agreed upon by the professionals whose performance will be reviewed.
- * Criteria can be based on the structure-the setting in which care occurs, and the process-the content of care, as well as on the outcome-or the effect of care on the patient. However, only those elements of structure and process that have a demonstrated and consistent relationship to favorable patient outcomes should be evaluated, to the extent they can be identified.
- * To better distinguish between the effects of care provided and other factors, outcome should be assessed prospectively as well as retrospectively. The identification of "expected" outcome prior to care and comparison with actual results allows such a distinction.
- * The evaluation of "intermediate" rather than "final" outcomes is acceptable. It is often more feasible to use immediate treatment results as indicators of quality rather than long-term morbidity and mortality data, particularly since the direct effects of care received are progressively obscured over time.
- * Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis using "indicators" or "markets" of potential problem areas, a sampling basis, or a combination of both, depending on goals of the review process.
- * Both explicit and implicit criteria are useful in assessing the quality of care. Explicit criteria are highly structured, specific and written guidelines, and are needed to maintain consistency and objectivity in the assessment process. Implicit criteria are the less structured and individual expectations and judgment of an expert practitioner acting as an evaluator. They are needed to accommodate legitimate professional differences regarding optimal treatment for individual cases.
- * Traditional consultation with another physician prior to treatment, as well as concurrent and retrospective peer review are all valid aspects of quality assessment as long as their prime objective is to maintain and improve quality of care.
- * Quality assessment results should be used to improve practitioners' performance and thus improve quality of care. Practitioners reviewed should systematically receive the results of that review and should be assisted in improving their knowledge and in modifying their practice patterns where indicated.
- * The quality assessment process itself should be subject to continued evaluation and modification as needed.

HOW SHOULD PROBLEMS WITH QUALITY BE RESOLVED?

The integral complement to any program of quality measurement or assessment is a system for quality assurance, or physician-directed activity to help

professionals in modifying practice behavior found deficient by quality assessment, and to protect the public against incompetent practitioners.

Quality assurance activities should be consistent with the following guidelines:

- * The general policies and processes used in a quality assurance system should be developed and concurred with by the professionals whose performance will be monitored, and should be objectively and impartially administered.
- * Any attempt to improve the performance of an individual practitioner should be triggered by concern with that individual's overall practice patterns, rather than by deviation from specified criteria in a single case.
- * Before any remedial or corrective action is taken, the practitioner should have ample opportunity to explain observed deviations from accepted practice to professional peers.
- * The emphasis in quality assurance activities should be to help the practitioner correct deficiencies in knowledge or skills.
- * The quality assurance system should have the capability of offering or directing the practitioner to the appropriate educational resources needed to effect desired practice modifications.
- * Feedback mechanisms should be established to document needed changes in practice patterns, so as to evaluate the effectiveness of any remedial activities initiated.
- * Disciplinary action should be considered only for those professionals who do not respond to remedial activities. Such restriction or disciplinary actions should be imposed whenever the appropriate professional peers deem such action necessary to protect the public.
- * The imposition of restrictions or discipline should be timely, consistent with due process, and should be immediate when professional judgement perceives an imminent hazard to the health of patients.
- * Quality assurance systems should be structured so as to assure legal immunity for practitioners who are conducting such systems and are acting in good faith.
- * Quality assurance systems should attempt to recognize high quality care as well as to correct deficiencies in practice. Such systems should explore ways to identify and disseminate information on those treatment methodologies or protocols which consistently contribute to improved patient outcomes.

HOW CAN PHYSICIANS ENSURE ADHERENCE TO QUALITY MEASUREMENT AND ASSURANCE GUIDELINES?

When quality assurance and utilization review activities are conducted by other than physician-sponsored organizations-for example, by some PROs and by private third-party payors-there is a need to ensure physician involvement and influence in the conduct of such programs and in the development of criteria

used in the review process. Among the mechanisms which can help achieve such involvement are:

- * Interlocking or overlapping Boards in those states where PROs are medical society-sponsored.
- * Joint medical society-PRO liaison committees when the PRO is not medical society-sponsored, as well as individual member and staff contacts on an ongoing basis.
- * Medical society review and comment on PRO contract provisions affecting quality prior to their finalization. (Legislative or regulatory changes may be needed.)
- * Medical society sponsorship of quality review programs which could be offered to area employers and other private payors.
- * Medical society assistance and consultation to members in evaluating proposed contracts with private payors or managed care systems.
- * Medical society development of public information programs to alert health plan enrollees or beneficiaries of the existence of payor utilization controls which may affect their eligibility for benefits, and of enrollee rights under such programs.

IS QUALITY ASSESSMENT MOVING BEYOND THE HOSPITAL?

Over the past several years, a number of factors have combined to encourage the shifting of patient services from the inpatient to the outpatient setting. Chief among these have been changing practice patterns, technological advances, increased competition among health care providers, growing costs of capitalization, public demand for reduction in health care costs, and changes in third-party reimbursement requirements.

Accompanying this increased emphasis on ambulatory services has been a corresponding interest in assessing the quality of care provided in such settings. There has been an expansion of accreditation programs and recent attempts to assess more directly or review the quality of services provided in the ambulatory setting, by both the federally-mandated PRO program and in the private sector.

The AMA supports the conduct of voluntary, physician-directed review of services provided in all health care settings. Integral to conduct of accreditation or review programs for ambulatory care is an examination of the medical records of patients served, as well as the system for maintaining such records. Complete medical records will serve both as evidence of adherence to accepted practice patterns and as a criterion in themselves of high quality care. In general, an examination of records will seek to determine:

- (1) that appropriate information on the patient was obtained and recorded;
- (2) that appropriate care and services are provided based on the information obtained;

- (3) that information in the record is consistently organized; and
- (4) that an appropriate record system is in place.

Review of the types of requirements developed by various voluntary accreditation or review bodies, both for medical records and in other areas of practice, can be very informative to the practitioner who now or in the future, whether of his own volition or as required by law, may be involved in a review of the quality of care he or she provides in the ambulatory setting. An AMA report in June 1988 describes the requirements used by these different accreditation or review bodies.

HOW SHOULD REVIEW SYSTEMS BE ACCOUNTABLE TO THOSE REVIEWED? TO PATIENTS?

The guidelines for quality assessment and quality assurance activities summarized above address some elements of review system accountability, including due process requirements. With specific regard to accountability of physician reviewers, the AMA has urged that the PRO program be changed to require:

- * that all physicians reviewing a record and rendering a judgement on the care provided sign an attestation that a complete review was done, and that this attestation be made available to the physicians undergoing review; and
- * that in cases where a PRO denies benefits, a physician of the same specialty will review the case prior to a denial letter being sent.

With regard to payor accountability, the AMA has urged state medical societies to work for enactment of state legislation holding public and private payors liable for any patient harm resulting from unreasonable or negligent application of utilization review requirements.

ARE PHYSICIANS CONDUCTING QUALITY ASSESSMENT PROTECTED FROM LEGAL LIABILITY?

The recent Supreme Court opinion in *Patrick v. Burget* has caused concern about the legal liabilities associated with participating in peer review. Patrick affirmed a \$2.2 million antitrust verdict against physicians who allegedly misused the peer review process to eliminate a competitor. Physicians want to know whether they are at risk for similar verdicts when they participate in peer review. They also want to know what can be done to remove any unreasonable legal risks associated with participating in the peer review process.

An extensive report by the AMA in June, 1988 addresses the concerns raised by Patrick. It concludes that the risks of legal liability when a physician participates in peer review are minimal, provided that two conditions are met. First, the physician must be participating in peer review for the purpose of enhancing good quality medicine, and not for the purpose of damaging a competitor or some other bad faith motive. Second, proper procedures must be followed in the peer review to ensure fairness.

The AMA has also concluded that:

- * Physicians who have unfairly received an adverse peer review decision should have a means of redress should be in balance with the need to facilitate and encourage peer review.**
- * Accordingly, it is inappropriate to apply the triple damage antitrust law remedy to peer review, because of the chilling effect on the willingness of physicians to participate in the peer review process.**
- * Existing state and federal legislation which purports to immunize peer review from various legal liabilities is helpful, but inadequate to protect against antitrust lawsuits.**
- * Additional legislation could be passed by states to protect physicians from antitrust exposure by restoring the state action exemption under the guidelines furnished in the Patrick decision.**
- * Such legislation could provide alternatively for: review and reversal as appropriate by a state licensing board of any peer review decision on request of the aggrieved physician; peer review conducted by physicians or a committee of physicians designated by the licensing agency in any case where substantial loss of privileges is at risk or such external review is requested by one of the parties involved; or state agency review decisions. The AMA has provided more information on these legislative approaches to state medical societies, and at least one state-Oregon-has already enacted legislation of this type.**

Write Legibly

Careless writing of digits, decimal points, and test names can result in misinterpretation of results and are a liability in litigation. MIEC recommends that all lab test results be noted on a standard form, not written on loose slips of paper. Lab reports filed in one section of the chart, overlap style, are easier to find for review.

Correct Errors Properly

In court, written-over entries suggest that the record was deliberately altered. Do not write over an incorrect entry, which may obscure the correct entry. Instead, start a new slip; or cross out the error with a single line so that the error still is readable, write in the correct entry, and initial it.

Document and Report Incidents

Document unexpected incidents which occur in the course of drawing a specimen for lab tests, *even if there is no apparent injury*. If a patient falls or complains of an injury, a physician should examine the patient and document the findings. Documentation of incidents is helpful in defending a claim made long after the incident occurred. Any incident, such as a fall or a complaint expressed by a patient, should be reported to MIEC's Claims Department.

Maintain Equipment

Inspect and test laboratory equipment regularly. If equipment malfunctions, it should be checked by an appropriate technician or engineer before it is placed back in service. A preventive maintenance program prevents injury or error, and in litigation testifies to your care and caution. State and local regulations concerning the disposal of waste products must be followed. Contact your state's Health

Department for information about proper disposal.

Ensure the Safety of the Premises

Periodically inspect the lab premises to identify hazards. The test area should be furnished with sturdy, four-legged chairs. Do not permit patients to sit on chairs with wheels. Prescription pads, dangerous instruments and drugs should not be left in the test area. Avoid leaving patients alone in the area after drawing blood; some patients feel light-headed even after a minimal amount of blood is drawn. Assist elderly patients to their feet if they have been sitting or lying down for a long period of time.

Be Courteous

Some patients are fearful about any new medical procedure. Lab personnel can help to reduce a patient's fear and anxiety by being courteous and helpful. Never ridicule a patient who is anxious or upset. Instead, explain what you are doing and reassure the patient. Office staff are important for better patient relations.

If you have questions about MIEC's coverage of an in-office lab, if you want to report an incident, or need legal advice or assistance, please call MIEC at 415/428-9411; outside California, call toll free: 800/227-4527.

MIEC

Medical Insurance Exchange of California

6250 Claremont Avenue
Oakland, California 94618-1324

Avoiding Liabilities for In-Office Laboratories

RECOMMENDATIONS
FOR THE PHYSICIAN
AND MEDICAL OFFICE STAFFS

MIEC

Medical Insurance Exchange of California

This article is for physicians whose office staff performs laboratory tests on the premises or collects specimens for testing by an outside laboratory.

Liability Coverage for Office Laboratories

MIEC's professional liability policy includes coverage for a physician's incidental office laboratory. No premium is charged for this coverage, but to ensure that the coverage is extended, the policyholder must request it by writing or calling the Underwriting Department. If laboratory technicians are employed, MIEC must be advised to extend coverage to those individuals. *The coverage for an incidental laboratory does not extend liability protection to the policyholder if tests are performed for physicians other than the named policyholder(s).* Separate coverage is available from MIEC for laboratories owned by physician partnerships or corporations, including those operated in a physician's office.

Preventing Malpractice Claims

Ensure Adequate Orientation and Training of Staff

All staff who perform laboratory tests should be instructed in office laboratory policies. Policies should be written. New personnel should work under supervision of an experienced aide or physician until they demonstrate competence.

Identify the Patient

Misidentification of patients and of specimens can result in injuries and law suits. Identification errors occur when patients do not hear or misunderstand an aide and mistakenly answer, "Yes," when asked (for example), "Are you Mr. Jones?" Before drawing blood or accepting other specimens from a patient, aides should verify the patient's identity by saying, "Please tell me your name." Include the patient's full name on specimens and test result forms. If your office has more than one patient with the same name, flag requisitions and each patient's chart with a colored sticker or other code.

Communicate With the Patient

Some patients do not understand medical procedures and are fearful of lab tests, even though the drawing of blood involves little risk. Aides who draw blood can help the patient relax by explaining what is being done.

Don't Practice Medicine

Aides should not offer medical advice or interpret results of laboratory tests. Test interpretation should be provided only by a physician. If the patient has questions, inform the physician so that he or she can respond.

Protect the Patient's Privacy

All aspects of a patient's medical care are protected by confidentiality laws. Unauthorized release of medical information, including disclosure that laboratory tests have been performed or the results of such tests, expose the physician and his staff to a breach of privacy lawsuit if the patient is harmed by the disclosure. Such lawsuits are difficult to defend.

Office aides who draw blood for AIDS-related HIV tests should be familiar with the special laws protecting the con-

identiality of the tests and their results. [Ask for MIEC's *Claims Alert #11* on the liability associated with AIDS testing.]

Disclose Results to Patients

Make sure the person you are talking to is the patient. Ask patients at the time the tests are run to indicate when and where they can be called. If the patient calls the office for the results, an aide may ask the patient to cite a confidential lab slip number as a means of identification. Test results should be disclosed only to the patient, unless the patient has authorized disclosure to others. If the patient cannot be reached by telephone, messages for the patient to return the call should not inadvertently breach his or her privacy. Do not say, for example, "Please have her call Dr. Smith's office for the results of her pregnancy test."

Document Actions

Document the fact that laboratory results were reported to the patient. One way to ensure consistent documentation is a rubber stamp template (see below) which can be imprinted on each report and completed by an aide. The template also can be used to indicate the physician has reviewed the results before the slips are filed, to prevent inadvertent filing of lab slips before the physician has seen them.

Report reviewed by: _____
Report to patient? ☐ Yes ☐ No
Phoned to: _____
Comments: _____
Date/Time: _____
By: _____

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Avoiding Medical Record Deficiencies

RECOMMENDATIONS
FOR THE MEDICAL OFFICE STAFF

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d. Do not discuss a potential claim with other physicians. If you must discuss ongoing patient care with co-treating physicians, do not discuss the medical-legal aspects of the case. In litigation, such discussions are discoverable by the opposing attorney.

e. Do not cancel charges because of a threat of litigation. Obtain advice about further billing from an MIEC claims representative.

f. Do NOT release original records or x-rays until you have obtained advice from a claims representative or defense attorney.

MIEC's Claims Department welcomes your calls for advice or assistance. We look forward to assisting you. This is a service you pay for in your premiums, and we hope you will use it.

MIEC

6250 Claremont Avenue
Oakland, California 94618

How to Report a Possible Claim

MIEC

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MIEC's Claims Department will answer your questions, provide access to legal advice, help prevent claims, and handle them when they occur.

Please call the MIEC Claims Department if you:

- Have a question about a request for medical records
- Want to report a claim or untoward medical incident
- Want advice about withdrawing from a patient's care
- Receive any legal papers, including a notice of intent to sue, or request for pre-litigation screening (outside California), or demand for arbitration of a claim
- Have received a deposition notice, or a request for a meeting or a report from an attorney representing a patient who may file a claim against you
- Need legal advice or attorney representation at a deposition
- Want to know the status of a pending claim against you

How to report a claim or incident:

In California: call 415/428-9411 (Outside 415 area code, call collect)

In Alaska and Nevada: call toll-free 800/227-4527

In Hawaii where we have a claims office: call 808/545-7231

In Idaho where we have a claims office: call 208/345-3040

And always available to our non-California insureds is the toll-free 800/227-4527.

When you call to report a new claim or incident, a claims assistant will ask your name, specialty, address and the nature of your call. When you call, please have available the patient's chart and any legal papers you have received. A claims representative will promptly return your call.

It is important that you personally report incidents or potential claims to MIEC. Do not delegate this to your office personnel.

We may ask you to send us a copy of the patient's chart, copies of legal documents you have received in regard to a patient, and a confidential summary of your treatment.

If you wish to discuss the status of or provide further information about an existing claim, please call the MIEC claims representative assigned to the case.

For Your Protection

a. **Get advice early.** Potential claims can be prevented if we know about them early and can obtain legal advice or representation for you, if indicated.

b. **Don't call a patient's attorney or the patient after receiving legal papers.** Such conversations are discoverable in court and may be used against you. MIEC's claims representative or defense counsel will contact the patient's attorney when appropriate.

c. **Do not alter the medical record.** It is against the law in most states and may affect your MIEC coverage as well as your license to practice. Charting changes can be used against you in court. If you discover errors or omissions in the record after you receive notice of a claim, call MIEC for advice on how to make appropriate corrections.

For the Medical Office Staff: MIEC's
purpose is to help you prevent, identify and
report medical malpractice. For advice
on malpractice prevention, call MIEC at
415-428-9431. Outside California, call
toll free, 800-227-4527.

Preventing Patient Injuries

RECOMMENDATIONS
FOR THE MEDICAL OFFICE STAFF

MIEC

Medical Insurance Exchange of California

6250 Claremont Avenue
Oakland, California 94618-1324

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Medical Insurance Exchange of California

Physicians and their staffs can be liable for failing to exercise ordinary or reasonable care to prevent personal injuries to patients and visitors. The law defines ordinary or reasonable care as "care which persons of ordinary prudence would use in order to avoid injury to themselves or others." You can prevent personal injuries in your office by giving attention to possible safety defects. MIEC recommends:

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Premises

A gross inspection of the premises is conducted to identify and eliminate potential hazards. Among the premise inspection criteria are:

1. The physical premises are spacious, clean, and well-organized.
2. The reception area and treatment rooms are clean and comfortable.
3. Treatment rooms each have a four-legged chair for patient use.
4. Well-balanced stepping stools are available in each treatment room.
5. Drugs and syringes are secured in a locked area.
6. Prescription pads are out of sight and away from patient areas.
7. Equipment is safely stored out of walkways.
8. Escape routes are clearly marked and unencumbered.
9. There is an adequate maintenance program for biomedical equipment.
10. The staff periodically checks expiration dates on pharmaceuticals.

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Medical Office Claims Prevention Surveys



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MIEC's Claims Prevention Survey of a physician's office practice has five goals:

1. To identify potential areas of liability exposure in the practice and to offer constructive recommendations for eliminating or reducing the exposure.
2. To evaluate the quality of medical record documentation and to determine whether these records, needed in the physician's defense in litigation, will assist or jeopardize that defense.
3. To educate the physician about specific liability issues in his or her specialty, and to assure that the physician is knowledgeable about current laws affecting the delivery of medical services.
4. To educate the physician's office staff about liability issues, to ensure that the staff is adequately prepared and qualified to perform services requested by the physician.
5. To assess the risk of personal injury to patients or staff due to hazards on the premises.

No legal advice is given during the survey. Legal questions are referred to an attorney.

The Claims Prevention Survey does not evaluate a physician's competence or ability to practice medicine. Such determinations may be made only by other physicians.

Claims Prevention Surveys are never used punitively. A policyholder's insurance coverage is not terminated solely on the basis of a survey. If the results of the survey, together with other underwriting factors lead MIEC to recommend discontinuance of coverage, the policyholder may request peer review of any such decision, through his or her medical society, and ultimately to MIEC's Underwriting Committee.

Surveyor Selection: Claims Prevention Surveys are performed only by individuals experienced in either claims management or loss prevention. If an evaluation of a

physician's medical competence is required, an MIEC Liability and Risk Assessment (LARA) survey is conducted by a team of physicians.

Physician Selection: MIEC's Underwriting or Claims Department selects the physicians who might benefit from a Claims Prevention Survey. Typically, those who receive priority are physicians who:

- Are new in practice.
- Have multiple claims for which payments were made, or in which practice or procedural deficiencies (such as poor charting) adversely affected the disposition of the claims.
- Apply for insurance coverage and have been uninsured for a period of time immediately prior to their application.
- Request this service from MIEC.

In addition to surveys for individual practices, Claims Prevention Surveys may be conducted for group practices, multi-specialty practices, radiology departments, dialysis units, clinical laboratories, blood banks, outpatient surgery or emergency facilities, and urgent care centers.

Components of the Survey

Documentation Audit: Before meeting with the physician or staff, the surveyor reviews a random sampling of medical records to assess the doctor's charting practices. (See Documentation.)

Conference with the physician: There is a 90-minute conference at which the surveyor meets with the physician to discuss:

- Office policies (see listing below)
- The scope of the doctor's practice.
- Informed consent policies.
- Informed refusal.

- Approaches to patient education.
- Charting issues, including a summary of the findings of the documentation audit.
- Communication/consultation with other health care professionals.
- How to report claims and obtain legal advice or assistance.
- On-call coverage.
- Medication policies and factors related to litigation.
- The role of the office staff in the practice.
- The most frequent allegations in malpractice litigation against the physician's specialty.

The meeting provides the physician with an opportunity to ask questions about his or her practice and to learn about a number of liability issues. Statistical information, informative articles, and prototype forms are given to the physician. Each physician whose practice is surveyed receives a complimentary subscription to the private newsletter series, *Malpractice Prevention for Physicians*.

Conference with the office staff: There is a 30-45 minute discussion with the office staff to review the staff's role as the doctor's public relations department. Topics include:

- Telephone etiquette.
- Methods for ensuring that supervised staff have been adequately oriented and trained.
- Confidentiality of medical information.
- Retention and release of medical records.
- Legal papers and how to respond to them.
- Documentation by the staff.
- Maintaining the safety of the premises.
- Legal limitations against practicing medicine or dispensing drugs by medical assistants and nurses.

- Safety precautions for children and elderly patients.
- Ways to improve collections and avoid billing problems which could lead to patient dissatisfaction and litigation.
- Legal methods for discharging a patient from the practice.

Inspection of the premises: A walk-through inspection of the premises is done to identify potential hazards which could result in injury to patients or staff. (See Premises.)

Written report: A comprehensive summary of the survey findings is prepared for the physician. Documentation deficiencies are detailed, along with recommendations for improvements. The report commends those aspects of the doctor's practice, including good charting techniques, which reduce liability exposure. If the survey discloses practice or documentation deficiencies which make the physician an increased insurance risk, MIEC's underwriters encourage the physician to make the recommended improvements. A re-visit to assess the physician's response to the recommendations may be scheduled within a year.

What the Surveyor Reviews

Policies and Procedures

Information for Patients: The surveyor evaluates written information patients receive about the doctor's practice, and about policies concerning billing, insurance forms, limitations on medication refills, advice about on-call coverage when the doctor is not available, cancellation of appointments, and the patient's responsibilities in the doctor-patient relationship.

Staffing: The surveyor reviews the duties of aides the doctor employs, including nurses, medical assistants, nurse practitioners, midwives, physician's assistants, technologists,

and clerical staff. Also discussed are the staff's orientation, training, supervision, and evaluation. The surveyor reviews written protocols or guidelines for basic office policies and determines that the staff does not dispense medical advice or refill medications without the physician's specific approval. The surveyor determines if the staff knows how to handle legal forms, such as requests for medical records and subpoenas, how to contact MIEC for advice and assistance, and how to respond in emergencies.

Scheduling: Patient scheduling patterns are reviewed to determine if they are reasonable, if sufficient time is set aside for each patient visit, if patients wait too long to see the doctor, or if patients complain about waiting.

Documentation

The criteria for review of medical records vary according to the physician's medical specialty and type of practice. Basic criteria used for reviews include:

1. Current medication and allergy histories are recorded.
2. Allergies are prominently noted on the chart cover.
3. Progress notes are adequate and include the reason for the visit, physician's examination findings—including pertinent negatives—impression or diagnosis, treatment today and/or planned treatment.
4. Medication administered in the office (including dose, site, route, patient's response) is properly documented.
5. All handwritten entries in the charts are identified.
6. Questionnaires and health history forms are complete and include evidence the physician has reviewed them.
7. All entries are legible.

8. Evidence is documented that lab and x-ray reports were reviewed by the physician.
9. Evidence is documented that incoming correspondence was reviewed by the physician.
10. Each office visit note includes a recommended return date (or "return prn").
11. A Medication Control Record or another effective method is used for documenting all prescriptions and refills.
12. Important phone calls to and from patients are documented.
13. Strikeovers, crossouts, and improper corrections are avoided.
14. Operative, consultation, and discharge summary reports are promptly dictated.
15. Informed consent discussions are documented.
16. The patient's refusal of or failure to follow advice for treatment or diagnostic studies is documented.
17. Evidence is documented that the patient received educational materials or advice, including written information about prescribed drugs.
18. Failed or cancelled appointments are documented in the patients' charts.
19. Squeezed-in entries are avoided.
20. Referrals to other physicians are unambiguously documented.
21. Obstetrical charts include adequate prenatal records, including evidence of risk evaluation and prenatal testing.

Additional or alternative screening criteria are used for physicians in surgical specialties, obstetrics, dialysis, radiology, pathology, and emergency medicine.

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RECOMMENDATIONS
FOR THE MEDICAL OFFICE STAFF

Your telephone communication with a patient is important in shaping that patient's impression of your office. MHIC's Loss Prevention Department offers these suggestions for making that impression a positive one.

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12 Keep prescription pads away from patient care areas. Stolen prescription blanks may be negotiable and could be a liability problem for the physician.

13 Keep drugs and drug samples in a secured area away from patient care areas. Controlled substance samples must be kept in a locked container.

If you have questions about medication-related claims, if you want to report an incident, or need legal advice or assistance, please call MIEC at 415/428-9411; outside California, call toll free: 800/227-4527.

MIEC

Medical Insurance Exchange of California

6250 Claremont Avenue
Oakland, California 94618-1324

Preventing Medication-Related Malpractice Claims

RECOMMENDATIONS
FOR THE PHYSICIAN
AND MEDICAL OFFICE STAFFS

MIEC

Medical Insurance Exchange of California

Ten percent of the malpractice claims against physicians and hospitals involve medications. The average cost of a medication-related claim now exceeds \$25,000.

The following guidelines will assist physicians to reduce their liability for medication-related malpractice claims:

1 Use a medication control record, such as the sample in MIEC's claims prevention information packet. Staple the record to the inside cover of each patient's chart. Your staff can document all original prescriptions and refills. In the refill section on the form, space is provided for the date of the refill, the initials of the aide who passes the doctor's authorization to the pharmacist, the pharmacist to whom the refill authorization was given, changes in the original prescription, and the initials of the physician if there is more than one in the same office.

2 Take and document a complete medication and allergy history the first time the patient is seen, and periodically thereafter, especially if you do not see the patient frequently or if you are not the patient's primary doctor. Ask about over-the-counter medications, including vitamins. (This information can be obtained by an aide when patients arrive for their appointments.)

3 Ask patients to tell you when another doctor has prescribed a medication or if they develop an allergy not previously

reported to you. If patients indicate they are taking medication you did not prescribe, ask who prescribed it and why. In some cases, it may be prudent to contact other physicians who are treating your patient to ensure you have a complete medical as well as medication history.

4 Avoid prescribing medications for other doctors' patients, except in limited quantity or in an emergency. If you do prescribe for another doctor, be sure to tell him or her. These precautions are especially important in a group practice and when the medications prescribed can be habit-forming or harmful if taken in excess.

5 Don't prescribe medications for a condition being treated by another doctor. Your prescription may duplicate the other doctor's order or interfere with his or her planned therapy, including the reduction of medication.

6 Don't prescribe a medication indefinitely, unless in your judgment it is medically necessary. Support such a judgment with documentation of periodic evaluation of the patient's progress and the drug's efficacy.

7 According to the National Council on Patient Information and Education (NCPPIE), more than half of the 1.6 billion prescriptions doctors order each year are taken improperly or are not taken at all. Each year, says NCPPIE, 125,000 people die as the result of improperly-taken medications. Educating patients about the drugs you prescribe can prevent injury and a possible lawsuit against you when a patient improperly uses prescription drugs. To reduce your liability, dispense the AMA's Patient Medication Instruction

sheets (PMIs) or similar drug information materials. Written information should tell the patient: (a) what the drug is for, (b) how the drug works, (c) what the patient should do if a dose is missed, (d) what precautions the patient should follow while using the drug, (e) what liquids not to take the drug with, (f) what side effects are transient or minor and need not concern the patient, and (g) what side effects should be reported promptly to the physician.

8 Don't prescribe controlled substances or dangerous drugs without an adequate examination. Medical ethics and the law require physicians to perform a physical examination to verify the need for drugs prescribed.

9 Do not permit unlicensed office staff to prescribe or refill medications without your specific authorization. Laws in most states do not permit nurses, physician assistants, or other aides to prescribe medications. Standing orders which give authority to non-physicians to prescribe drugs may be illegal. Each state's medical licensing board can provide copies of laws concerning drug prescriptions.

10 On prescriptions and on hospital orders for medications, write legibly. Use accepted abbreviations and nomenclature. Be especially careful in writing digits and decimal points.

11 Consider an office policy of refilling medications only during regular office hours, except in emergencies. Many physicians ask patients and pharmacies to call for refills during certain hours of the day. That practice enables the staff to pull the patients' charts for the physician's review and for documenting the refill information.

RISK PREVENTION

The Doctor-Patient Relationship: Effective Defense Against Litigation

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RISK PREVENTION

The Doctor-Patient Relationship: Effective Defense Against Litigation

by David Karp

Malpractice defense attorneys and insurance experts know that a sound doctor-patient relationship is one of the best deterrents to litigation. Some lawsuits result from a breakdown in rapport which may be occasioned by non-medical events. Patients aren't as likely to sue physicians with whom they have a good relationship. Establishing an effective doctor-patient relationship is not difficult. Both the physician and his or her staff can contribute to the type of professional, friendly, and comforting practice every patient desires. These guidelines can help:

Carefully select office staff

Choose an office staff that views itself as your patient-relations department. Every patient's impression of you is influenced by the way he or she is treated from the first contact with your office through each subsequent association with your staff, by telephone or in person. The staff that treats patients courteously, respectfully, and patiently promotes your practice.

Avoid automatic first name familiarity. Many people, particularly senior citizens and women, object to being addressed by their first name the first time they call an office, or at anytime if the office staff is younger than they are. Getting on a first-name basis with patients is a desirable goal to achieve, but it should not be assumed. Have your staff ask patients the first time they come to the office how they want to be addressed. Don't be surprised to find many people initially prefer Mr., Mrs., Ms., or Miss.

Teach your staff how to use the telephone effectively. Some staff members do not appreciate how annoying it is to an ill patient to be put on hold for a long time, to be asked too many questions, or be made to feel that calling your office for help is an irritation. Check out your answering service's telephone etiquette by calling it after hours. If patients who reach the service do not receive the same courteous and attentive reception they receive from your staff, the answering service is harming your practice.

Encourage staff to report complaints

Ask your staff to let you know if a patient has a complaint. A doctor's office staff often know a patient's dissatisfaction long before the patient has the courage to talk with the doctor. Tell your staff to report seemingly innocuous complaints about your treatment, fees,

waiting time, test results, or other matters. With advance warning, you have an opportunity to discuss the problem with the patient before it interferes with doctor-patient rapport.

Also encourage your staff to inform you if they become aware that the patient is not following your advice. Patients sometimes confide in staff that they have not been taking their medication or restricting activities as the doctor directed.

Insurance carriers require prompt notification of potential claims. The patient's first complaint may be reason enough to inform the carrier and obtain legal advice.

Evaluate scheduling practices

Find out if patients are being kept waiting too long. This is the most common complaint about physicians that American patients have. Everyone believes his or her time is valuable. Parents, housekeepers, truck drivers, laborers, secretaries and professionals all have schedules to keep which are as important to them as the doctor's schedule is to him or her. Some patients may not be paid for the time they take off from work to come to the office. Others may have budgeted their time without allowing for an inordinate delay.

When you fall behind in your daily schedule—and one emergency or drop-in patient can upset the timing—avoid making other patients angry. Better

*Check out your
answering
service's telephone
etiquette by
calling it after
hours.*

scheduling techniques can keep delays to a minimum. Telephone 'triage' by the staff enables aides to set time for each patient depending on the reason for the visit. Creating an unscheduled time slot in the morning and afternoon allows extra time for unexpectedly extended appointments or emergency drop-ins. Even with good planning, delays occur and patients may have to wait. Tell your staff to inform patients upon their arrival if there will be a delay so that they can reschedule the appointment or do an errand or two. A simple apology from the doctor assuages resentment occasioned by a long wait.

Develop an informative patient brochure

Prepare a brochure for your patients that emphasizes the fact that the doctor-patient relationship is a two way relationship in which the patient as well as the physician has responsibilities. The brochure should include the following: (a) information about the doctor(s) including medical education, certification, hospital privileges and staff appointments, and areas of special interest; (b) office hours and preferred times for receiving non-emergency phone call or drug refill requests; (c) information about fees and billing cycles. (It is preferable to indicate that fee information is available from your receptionist rather than including details in the brochure.)

Mention charges for completing insurance forms, whether or not you accept insurance assignment, or if you require payment at the time of service; (d) list the names and phone numbers of doctors who cover for you and the hospital emergency department you prefer patients to go to if you or your colleague are not available; (e) describe the patients' responsibilities to keep appointments or to let the office know if they can't make it; to follow medical advice; to ask questions if they do not understand something; to report problems promptly; to let the doctor know if they are seeing other doctors or taking medications other doctors prescribed; and to report complaints.

Ask for patient feedback

Studies have shown that most patients are reluctant to voice dissatisfaction, except by changing doctors. One study, published in the November 28, 1985 *New England Journal of Medicine*, indicates that as many as 85 percent of the patients surveyed had changed doctors or had considered changing within the previous five years. Most of the reasons related to dissatisfaction with attitudes, poor communication, and other non-medical problems

Do not permit medical assistants or nurses to perform services which may be illegal...

which could be corrected if the doctor knew. An effective way to find out what your patients think is to use a questionnaire for patients to mail back anonymously. In the questionnaire, ask patients if they were treated courteously by the staff, what they like most about your practice, and how service could be improved.

Limit staff responsibilities

Do not permit medical assistants or nurses to perform services which may be illegal and for which you and they could be charged with criminal offenses and civil liabilities. California regulates what medical assistants can and cannot do. The Nurse Practice Act describes the responsibilities and limitations of nurses. Physicians who employ these specialists should be aware of their legal limitations. Do not permit staff to prescribe or refill medication. In California, only physicians, dentists, podiatrists,

and veterinarians are privileged to prescribe and refill medication. Do not permit staff to practice medicine. Develop written guidelines for what your staff can say when patients call with minor problems and request advice. Tell the staff what types of calls should be directed to you and when you should be interrupted to take a call from a patient.

Keep track of patients

Consider methods other physicians have developed to keep track of patients and promote their practices. An effective tickler file reminder card system was suggested in the November/December 1987 issue of *California Family Physician*: Prepare an index file box with monthly dividers. Each time a patient comes for an annual visit or serial test (complete physical exam, Pap smear, mammogram, EKG, blood pressure check, lab study, etc.) your staff should ask the patient to self-address an envelope while sitting in the reception room awaiting examination. The aide inserts a preprinted appointment reminder card, with check boxes to indicate the type of return visit needed, into an envelope and files it behind the appropriate monthly divider. At the beginning of each month, the aide pulls the pre-addressed envelopes for that month and mails them. The system takes virtually no time to manage. Some physicians use the tickler system to remind them to send a birthday, graduation, or anniversary card to patients, and to keep track of referrals to specialists.

Make sure staff knows collection laws and etiquette

If your office staff is responsible for collections, be sure aides are comfortable about money matters. Staff should know California's laws concerning collection practices, including the patient's right to privacy and confidentiality, prohibitions on harassment, and false threats. Collecting unpaid accounts can be highly successful without alienating patients. Additional suggestions on collection practices were offered in the March/April 1988 issue of *CFF*. ■

Lawyers

Article 1. The Alaska Bar Association.

Section

- 10. Creation of Alaska Bar Association
- 20. Members

Sec. 08.08.010. Creation of Alaska Bar Association. The created an instrumentality of the state known as the Alaska Association, referred to in this chapter as the Alaska Bar. The Alaska Bar shall have a common seal, may sue and be sued, and may, for purpose of carrying into effect and promoting the objects of the Alaska Bar, enter into contracts and acquire, hold, encumber and dispose of real and personal property. (§ 2 ch 196 SLA 1955)

NOTES TO DECISIONS

The Alaska Bar Act is valid and must be complied with. In re Paul, 17 Alaska 360 (1957).
 Quoted in In re Petition of Moody, Ct. Op. No. 1065 (File No. 2035), 524 P.2d 1261 (1974).

Sec. 08.08.020. Members. (a) Every person licensed to practice law in the state shall become a member in the Alaska Bar. All active and inactive members in good standing as of September 14, 1976, shall be considered to be members.

(b) A person licensed to practice law in the state who, on September 14, 1976, is not enrolled on the membership rolls, shall be reinstated as a member only in accordance with the Alaska Bar Rules. (§ 2 ch 196 SLA 1955; am § 2 ch 181 SLA 1976)

Cross references. — For eligibility to take the bar examination, see AS 08.08.205.

NOTES TO DECISIONS

Quoted in In re Petition of Moody, Sup. Ct. Op. No. 1065 (File No. 2035), 524 P.2d 1261 (1974).

Article 2. The Board of Governors and Officers.

Section

- 30. Governance of the Alaska Bar
- 40. Board of Governors of the Alaska Bar
- 50. Selection of the board
- 60. Election of officers
- 70. Vacancies on the board

Section

- 75. Meetings of the board
- 80. Powers of board
- 85. Annual report to legislature
- 90. Power of the bar to make or amend bylaws and regulations
- 100. Administrative Procedure Act

Title 7
Boroughs

Title 8
Business and Professions

Title 9
State and Financial Institutions

Bar Association.

Alaska Bar Association. There is a state known as the Alaska Bar Association as the Alaska Bar. The Alaska Bar Association is a corporation, may sue and be sued, and may, for the purpose of promoting the objects of the Alaska Bar Association, hold, encumber and dispose of real and personal property. (196 SLA 1955)

PROVISIONS

p. No. 255 (File No. 532), 395 P.2d 864 (1964).
Quoted in In re Petition of Moody, Sup. Ct. Op. No. 1065 (File No. 2035), 524 P.2d 261 (1974).

Any person licensed to practice law in the Alaska Bar. All active members as of September 14, 1976.

Any person in the state who, on September 14, 1976, was a member of the Alaska Bar Association shall be reinstated to the Alaska Bar Rules. (§ 4 ch 196 SLA 1976)

PROVISIONS

Governors and Officers.

- Section
- 5. Meetings of the board
- 10. Powers of board
- 15. Annual report to legislature
- 10. Power of the bar to make or change bylaws and regulations
- 10. Administrative Procedure Act

Sec. 08.08.030. Governance of the Alaska Bar. The Alaska Bar is governed by the Board of Governors of the Alaska Bar. The board has the powers and duties conferred by this chapter and by the Alaska Bar Rules. Members of the board do not receive a salary. (§ 6 ch 196 SLA 1955; am § 3 ch 181 SLA 1976)

Sec. 08.08.040. Board of Governors of the Alaska Bar.
(a) There is created a Board of Governors of the Alaska Bar to be elected under bylaws and regulations adopted by the board.
(b) The board consists of nine active members elected by the active members of the Alaska Bar and three persons appointed by the governor who are not attorneys. (§ 5 ch 196 SLA 1955; am § 1 ch 178 SLA 1960; am § 4 ch 181 SLA 1976; am § 2 ch 52 SLA 1981)

Sec. 08.08.050. Selection of the board. (a) Two members of the board shall be elected by and from among the members of the association resident in the first judicial district; four members of the board shall be elected by and from among the members of the association resident in the third judicial district; two members by and from among the members of the association resident in the combined area of the second and fourth judicial districts; and one member at large from the entire state. Three members who are not attorneys shall be appointed by the governor and are subject to confirmation by the legislature in joint session.

(b) Members of the Board of Governors shall hold office for three years and until their successors are elected or appointed and qualified.

(c) Four board members shall be selected on the following triennial rotation:

(1) in the first year, one member from the first judicial district, one member from the combined area of the second and fourth judicial districts, one member from the third judicial district, and one appointed member;

(2) in the second year, one member at large, two members from the third judicial district, and one appointed member; and

(3) in the third year, one member from the combined area of the second and fourth judicial districts, one member from the third judicial district, one member from the first judicial district, and one appointed member. (§ 5 ch 196 SLA 1955; am § 1 ch 178 SLA 1960; am §§ 1, 2 ch 9 SLA 1971; am §§ 3 — 5 ch 52 SLA 1981)

Sec. 08.08.060. Election of officers. The active members of the Alaska Bar who are in actual attendance at the association's annual convention shall elect by a majority vote during the convention the association's officers from the membership of the Board of Governors. (§ 5 ch 196 SLA 1955; am § 1 ch 178 SLA 1960)

Title 7
Boroughs

Sec. 08.08.070. Vacancies on the board. (a) The board shall fill a vacancy in the elected membership of the board until the next annual election.

(b) The governor shall appoint a member to fill a vacancy in the appointed membership of the board for the unexpired term. 196 SLA 1955; am § 1 ch 178 SLA 1960; am § 6 ch 52 SLA 1981

Sec. 08.08.075. Meetings of the board. AS 44.62.312 apply to the meetings of the board. Members of the Bar and the public shall be given 30 days' notice of meetings of the board except for emergency meetings. Meetings of the board shall be held at a place in the state. (§ 7 ch 52 SLA 1981)

Title 8
Business and Professions

Sec. 08.08.080. Powers of board. (a) Except as may be otherwise provided in this chapter or the Alaska Bar Rules, the board shall approve and recommend to the state supreme court rules

(1) concerning admission, discipline, licensing, continuing legal education, and defining the practice of law;

(2) providing for continuing legal education and for certification of attorneys;

(3) establishing a program for the certification of attorneys.

(b) The board may adopt bylaws and regulations consistent with this chapter and the Alaska Bar Rules

(1) concerning membership and the classification of members of the Alaska Bar;

(2) fixing the annual membership fees;

(3) concerning annual and special meetings.

(c) Consistent with this chapter and the Alaska Bar Rules, the board may

(1) provide for employees of the Alaska Bar, the time, place, method of their selection, and their respective powers, duties, term of office, and compensation;

(2) establish, collect, deposit, invest, and disburse membership admission fees, penalties, and other funds;

(3) sue in the name of the Alaska Bar in a court of competent jurisdiction to enjoin a person from doing an act constituting a violation of this chapter;

(4) provide for all other matters affecting in any way the organization and functioning of the Alaska Bar. (§ 7 ch 196 SLA 1960; §§ 2, 3 ch 178 SLA 1960; am § 5 ch 181 SLA 1976; am § 8 ch 52 SLA 1981)

a) The board shall remain in place until the next meeting.

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Cross references. — See Alaska Bar Rules adopted by the Alaska supreme court.

NOTES TO DECISIONS

Final power and authority to determine standards for admission to the practice of law in Alaska resides in the supreme court, which has the inherent power to intercede at any time in admission matters. In re Luna, Sup. Ct. Op. No. 1503 (File No. 2789), 569 P.2d 789 (1977).

Practice of law not defined. — There is no rule defining the practice of law nor is there a statute defining the term except in the context of the requirements of active practice of law as a qualification for justices. In *re Robson*, Sup. Ct. Op. No. 1573 (File No. 3448), 575 P.2d 771 (1978). See also In *re Babcock*, Sup. Ct. Op. No. 178 (File No. 408), 387 P.2d 694 (1963), decided prior to the 1976 and 1981 amendments to this section.

For case construing board's power to define the practice of law prior to the 1976 amendment of this section, see *In re Moody*, Sup. Ct. Op. No. 1065 (File No. 2035), 524 P.2d 1261 (1974).

A superior court law clerk should be regarded as practicing law for the purposes of membership classification. In re Moody, Sup. Ct. Op. No. 1065 (File No. 2035), 524 P.2d 1261 (1974).

Activities constituted practice of law in violation of supreme court's suspension order. — Where a person held himself out as a lawyer; performed legal services and gave legal advice in set-

ting up a prepaid legal service plan, completing and filing necessary forms; signed a letter of the type usually written by an attorney with "attorney at law" printed aside his name; permitted another person to refer to him in court as his attorney without making any clarifying comments and typed and edited a newsletter indicating his availability to serve as attorney for a union and its members, the cumulative effect of these activities leads to the inescapable conclusion that he was engaged in the practice of law in violation of the supreme court's order suspending him from practice. In re Robson, Sup. Ct. Op. No. 1573 (File No. 3448), 575 P.2d 771 (1978).

Board exceeded its authority in requiring a cash deposit before allowing an unsuccessful applicant to the Alaska Bar to exercise his right to discovery in an appeal to the board. In re Luna, Sup. Ct. Op. No. 1503 (File No. 2789), 569 P.2d 789 (1977).

Applied in *Horowitz v. Alaska Bar Ass'n*, Sup. Ct. Op. No. 2059 (File Nos. 4310, 4311), 609 P.2d 39 (1980).
Quoted in *In re Houston*, Sup. Ct. Op. No. 129 (File No. 325), 378 P.2d 644 (1963).

Cited in *Skuse v. State*, Ct. App. Op. No. 582 (File No. A-885), 714 P.2d 368 (1986).

Collateral references. — Procedural due process requirements in proceedings involving applications for admission to bar. 2 ALR3d 1288.

Criminal record as affecting applicant's

moral character for purposes of admission to the bar. 88 ALR3d 192.

Violation of draft laws as affecting character for purposes of admission to the bar.
92 ALR3d 807.

Sec. 08.08.085. Annual report to legislature. (a) The Board of Governors shall report annually to the legislature on all matters concerning admissions, discipline of members, and disbarment proceedings, except for those matters defined as confidential by court rule.

(b) The annual report of the Board of Governors shall note

(1) each addition, modification, or repeal of a bylaw or regulation of the Alaska Bar;

(2) each addition, modification, or repeal of the Alaska Bar Rules proposed to or adopted by the state supreme court.

Title 7
Bar

(c) The annual report of the Board of Governors may recommend the legislature changes to this chapter and to the provisions of law generally. (§ 6 ch 181 SLA 1976; am § 9 ch 52 SLA 1976)

Sec. 08.08.090. Power of the bar to make or change bylaws and regulations. Any bylaw or regulation adopted by the Board of Governors may be modified or rescinded, or a new bylaw or regulation may be adopted, by a vote of the active members of the association under bylaws and regulations to be adopted by the Board of Governors. (§ 7 ch 196 SLA 1955; am § 3 ch 168 SLA 1960; am § 7 ch 181 SLA 1976)

Sec. 08.08.100. Administrative Procedure Act. The bylaws and regulations adopted by the board or the members of the Alaska Bar Association under this chapter are not subject to the Administrative Procedure Act (AS 44.62). (§ 7 ch 196 SLA 1955; am § 3 ch 178 SLA 1960; am § 8 ch 181 SLA 1976)

Title 8
Business and Professions

NOTES TO DECISIONS

The language of this section exempts the bylaws and regulations themselves, not merely their method of adoption, from the Administrative Procedure Act, both by naming that act and by referring to the chapter number, AS 44.62. There is nothing in this language

which hints that the exemption is any narrower in scope. *Horowitz v. Bar Ass'n*, Sup. Ct. Op. No. 300 No. 4310, 4311, 609 P.2d 397 (1980). Stated in *In re Simpson*, Sup. Ct. No. 2517 (File No. 5963), 645 P.2d 1000 (1982).

Secs. 08.08.110 — 08.08.120. Admission, suspension and disbarment; disqualification to hear disciplinary matters. [Repealed, § 11 ch 181 SLA 1976.]

Article 3. Admission to Alaska Bar.

Section
136. Assistance from law enforcement officers
137. Fingerprints

Section
201. Administration of bar examination
206. Eligibility to take bar examination
207. Law clerks

Sec. 08.08.130. Eligibility for admission. [Repealed, § 11 ch 181 SLA 1976.]

Sec. 08.08.135. Study of law in office of practicing attorney. [Repealed, § 2 ch 135 SLA 1967; § 11 ch 181 SLA 1976.]

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Sec. 08.08.136. Assistance from law enforcement officers. State and local law enforcement officers shall assist the Board of Governors in the processing of fingerprints of applicants seeking admission to the Alaska Bar Association and shall release the resulting information to the association. (§ 1 ch 8 SLA 1985)

Sec. 08.08.137. Fingerprints. The Board of Governors shall require an applicant for admission to be fingerprinted. The fingerprints shall be used to determine whether the applicant has a record of criminal convictions in this state or another jurisdiction. The Board of Governors may use the information obtained from the fingerprinting only in its official determination of the character and fitness of the applicant for admission to the Alaska Bar Association. (§ 1 ch 8 SLA 1985)

Cross references. — For effect of this § 2, ch. 8, SLA 1985 in the Temporary section on Alaska Bar Rules 3 and 5, see and Special Acts.

Secs. 08.08.140 — 08.08.200. Out-of-state attorneys; fee provisions; procedure for admission. [Repealed, § 11 ch 181 SLA 1976.]

Sec. 08.08.201. Administration of bar examination. (a) The Board of Governors shall administer the bar examination under the Alaska Bar Rules.

(b) The Board of Governors may contract with another state or a testing organization for the preparation and grading of a portion of the Alaska Bar examination.

(c) The Board of Governors shall contract with persons experienced in the administration of bar examinations for advice on the preparation and grading of the portion of the bar examination prepared under the direction of the board.

(d) The Board of Governors shall establish and maintain standards for experience and training of persons who administer the portion of the bar examination prepared under the direction of the board. (§ 10 ch 52 SLA 1981)

NOTES TO DECISIONS

Access to multistate bar examination. — The Alaska Supreme Court interpreted Alaska Bar Rule 4(5) to allow a failing applicant access to multistate bar examination questions and answers and to the applicant's own answers. In re Obermeyer, Sup. Ct. Op. No. 3040 (File No. S-950), 717 P.2d 382 (1986).

Challenge of examination administration and grading. — With the exception of the argument that he was entitled to a representative sampling of overall

passing and failing exams and to an opportunity to review multistate bar examination questions and answers, one who had failed the Alaska bar examination stated criticisms of the administration of the exam that amounted to no more than disputes with the Alaska Bar Association about the ideal way to handle the bar exam; they did not establish violations of equal protection or due process rights. In re Obermeyer, Sup. Ct. Op. No. 3040 (File No. S-950), 717 P.2d 382 (1986).

Access to sampling of overall passing and failing exams. — An applicant who fails the Alaska bar examination is entitled to a representative sampling of the examination papers of other appli-

cants who received overall passing and failing grades, not mark answers. In re Obermeyer Op. No. 3040 (File No. S-960) 382 (1986).

Sec. 08.08.205. Eligibility to take bar examination. Any person who has not graduated from an accredited law school but is otherwise qualified may take the bar examination if they have completed clerkship in the manner prescribed by AS 08.08.207. (§ 12 ch. 1976)

Cross references. — For admission to practice law, see Alaska Bar Rule 5, adopted by the Alaska supreme court.

NOTES TO DECISIONS

Thirty-day residency requirement unconstitutional. — The 30-day residency requirement of Alaska Bar Rule 2(1)(e) violates the privileges and immunities clause of U.S. Const., art. IV, § 2,

since it is a form of prohibited protectionism. *Sheley v. Alaska Bar Ass'n*, Sup. Ct. Op. No. 2191, 5148, 620 P.2d 640 (1980).

Collateral references. — Court review of bar examiners' decision on applicant's examination. 39 ALR3d 719.

Sec. 08.08.207. Law clerks. (a) Every person who desires to qualify as a general applicant for admission to the Bar without having been graduated from an approved law school may register as a law clerk as provided by this section. The person must present satisfactory proof that the person has been granted a bachelor's degree, other than bachelor of laws, by a college or university offering the degree on the basis of a four-year course of study, and has successfully completed the first year of studies at a law school.

(b) The applicant shall obtain regular and full-time employment as a law clerk in the office of a judge of a court of record or an attorney in a firm of attorneys licensed to practice law in Alaska and engaged in the general practice of law. The person by whom the applicant is employed, or, if the applicant is employed by a firm, the person in whose direction the applicant is to study, must have been admitted to practice law in this state for at least five years at the time the application for registration is filed, and be otherwise eligible to act as an attorney. Before the commencement of the study of law under this section, the applicant shall file with the university an application to register as a law clerk. The application shall be made on a form to be provided by the university and shall require answers to interrogatories the university may determine from time to time to be relevant to a con-

take bar examination. Applicants who graduated from an accredited law school but are otherwise ineligible for the examination if they have completed the requirements prescribed by AS 08.08.207. (§ 12 ch 181 SL 1997)

to
5.

NO DECISIONS

since it is a form of prohibited economic protectionism. *Sheley v. Alaska Bd. Ass'n*, Sup. Ct. Op. No. 2191 (File No. 5148), 620 P.2d 640 (1980).

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(a) Every person who desires sub-
applicant for admission to the Alaska
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regular and full-time employment a-
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erson by whom the applicant is em-
ployed by a firm, the person un-
to study, must have been admitted
east five years at the time the applic-
d be otherwise eligible to act as a
e study of law under this section, the
iversity an application to register as
be made on a form to be provided by
e answers to interrogatories the un-
ie to time to be relevant to a consider-

ation of the application. Proof of a fact stated in the application may be required by the university. If the applicant fails or refuses to furnish any information or proof or answer any interrogatory required by the application, or independently by the university, in a manner satisfactory to the university, the application may be denied.

(c) Accompanying the application there must be submitted a statement under oath of the person by whom the applicant is employed as a law clerk, or, if the applicant is employed by a firm, of the person under whose direction the applicant is to study, certifying to the fact of the employment and that that person will act as tutor for the applicant and will faithfully instruct the applicant in the branches of the law prescribed by the course of study adopted by the university. A person is not eligible to act as tutor while disciplinary proceedings (following the service of a formal complaint) are pending against the person, or if the person has ever been censured, reprimanded, suspended or disbarred. If a registered law clerk finds it necessary to change tutors during the period of study, a new application for registration as a law clerk is required and such credit given for study under a prior tutor as the university may determine.

(d) A law clerk whose registration has been approved by the university must pursue a course of study for three calendar years of at least 44 weeks each year, with a minimum each week of 35 hours of study (it being understood that the time actually spent in the performance of the duties of law clerk is to be considered as time spent in the study of law). The tutor must give personal direction regularly and frequently to the clerk, must examine the law clerk at least once a month on the work done in the previous month, and must certify monthly as to compliance with the requirements of this subsection and (e) and (g) of this section.

(e) The examinations shall be written and not oral, and shall be answered by the clerk without research or assistance during the examination. The monthly certificate of compliance submitted by the tutor shall be accompanied by the originals of all written examinations and answers given during the period reported. If the certificates, together with the required attachments, are not filed timely with the university, no credit may be given for any period of the default.

(f) If a registered law clerk does not furnish evidence of completion of law studies within a period of six years after registration, the university may cancel the registration.

(g) The course of study to be pursued by a registered law clerk shall cover subjects, text books, case books, and other material the university may from time to time require.

(h) A registered law clerk who has attended either an approved or a nonapproved law school may, in the discretion of the university, receive credit for work done and obtain advanced standing. In no event

will credit be given for fractional parts of semesters or term correspondence school work.

(i) In this section

(1) "law school" means a law school accredited, approved or the standards of the Council of Legal Education of the American Association or the Association of American Law Schools; or a Alaska offering a course of study which the university approve equivalent to a year's study in a law school under this sec

(2) "university" means the University of Alaska. (§ 12 ch 11 1976; am §§ 1 — 8 ch 119 SLA 1978; am § 4 ch 67 SLA

Cross references. — For effect of the 1978 amendment on Alaska Bar Rule 2, see § 9, ch. 119, SLA 1978 in the Temporary and Special Acts.

Effect of amendments. — The 1983

amendment in subsection (a) in the sentence deleted "must be a bona fide resident of the state and" following "son" and made other, minor changes.

NOTES TO DECISIONS

Quoted in In re Urie, Sup. Ct. Op. No. 2172 (File Nos. 4392, 4326, 4608), 617 P.2d 505 (1980).

Collateral references. — Activities of law clerks as illegal practice of law. 13 ALR3d 1137.

Article 4. Unlawful Acts.

Section

210. Who may practice law

230. Unlawful practice a misdemeanor

Sec. 08.08.210. Who may practice law. (a) A person may engage in the practice of law in the state unless the person is licensed to practice law in Alaska and is an active member of the Alaska Bar or a member of the bar in good standing in another jurisdiction and may appear in the courts of the state under the rules the supreme court has adopted.

(b) The practice of law shall be defined in the Alaska Bar Rules.

(c) This section and AS 08.08.230 do not apply to the practice of law for the legislature by a person employed by or under contract with the legislature until the results are released of the third Alaska Bar Examination following that person's employment.

(d) Employees of the Department of Law whose activities constitute the practice of law under this chapter and under the Alaska Bar Rules are required to obtain a license to practice law in Alaska no later than 10 months following the commencement of their employment.

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law school under this section
rsity of Alaska. (§ 12 ch 181 SLA
1978; am § 4 ch 67 SLA 1982)

amendment in subsection (a) in the
sentence deleted "must be a bona fide
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son" and made other, minor punctu
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DECISIONS

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ment. (§ 12 ch 196 SLA 1955; am § 9 ch 181 SLA 1976; am § 5 ch 59
SLA 1982)

Cross references. — For provisions re
lating to practice in state courts by attor

neys from other jurisdictions, see Rule 81,
Alaska Rules of Civil Procedure.

NOTES TO DECISIONS

Practice of law not defined. — There
is no rule defining the practice of law nor
is there a statute defining the term except
in the context of the requirements of ac
tive practice of law as a qualification for
justices. In re Robson, Sup. Ct. Op. No.
1573 (File No. 3448), 575 P.2d 771 (1978).
Applied in Skuse v. State, Ct. App. Op.

No. 582 (File No. A-885), 714 P.2d 368
(1986).

Quoted in In re Houston, Sup. Ct. Op.
No. 129 (File No. 325), 378 P.2d 644
(1963); In re Moody, Sup. Ct. Op. No. 1065
(File No. 2035), 524 P.2d 1261 (1974).

Stated in Noll v. Alaska Bar Ass'n,
Sup. Ct. Op. No. 2546 (File No. 5782), 649
P.2d 241 (1982).

Collateral references. — 7 Am. Jur.
2d, Attorneys at Law, §§ 12-24.

7 C.J.S., Attorney and Client, §§ 19-24.

Validity and construction of statutes or
rules conditioning right to practice law
upon residents or citizenship. 53 ALR3d
1163.

Pardon as restoring public office or li

cense or eligibility therefor. 58 ALR3d
1191.

Attorney's right to appear pro hac vice
in state court. 20 ALR4th 855.

Right of attorney to act or become li
censed to act as real estate broker. 23
ALR4th 230.

Sec. 08.08.220. Disciplinary proceedings and review. [Repealed,
§ 5 ch 94 SLA 1980.]

NOTES TO DECISIONS

Construction of former law. — For
cases construing statutes, see United
States v. Stringer, 15 Alaska 183, 124 F.
Supp. 705 (D. Alas. 1954), rev'd on other
grounds, 16 Alaska 305, 233 F.2d 947 (9th
Cir. 1956); In re Paul, 17 Alaska 360
(1957); In re Mackay, Sup. Ct. Op. No. 279
(File No. ABA 8), 416 P.2d 823 (1965),
cert. denied, 384 U.S. 1003, 86 S. Ct. 1907,

16 L. Ed. 2d 1016, rehearing denied, 385
U.S. 890, 87 S. Ct. 11, 17 L. Ed. 2d 121
(1966); In re Mackay, Sup. Ct. Op. No. 596
(File No. ABA 8), 464 P.2d 304 (1970); In
re Crosby, Sup. Ct. Op. No. 782 (File No.
1567), 495 P.2d 1270 (1972); In re Moody,
Sup. Ct. Op. No. 1065 (File No. 2035), 524
P.2d 1261 (1974).

Sec. 08.08.230. Unlawful practice a misdemeanor. (a) Any per
son not an active member of the Alaska Bar and not licensed to prac
tice law in Alaska who engages in the practice of law or holds out as
entitled to engage in the practice of law as that term is defined in the
Alaska Bar Rules, or an active member of the Alaska Bar who wilfully
employs such a person knowing that the person is engaging in the
practice of law or holding out as entitled to so engage is guilty of a
class A misdemeanor.

(b) This section does not prohibit the use of paralegal personnel as
defined by rules of the Alaska supreme court. (§ 13 ch 196 SLA 1955;
am § 10 ch 181 SLA 1976; am § 11 ch 52 SLA 1981)

Title 7
Barreths

Revisor's notes. — The supreme court has never adopted rules defining the use of paralegal personnel under (b) of this section.

Cross references. — For sentences for misdemeanors, see AS 12.55.035 and 12.55.135.

Opinions of attorney general. — The

activity of presenting cases at an administrative hearing before the Human Commission or one of its hearing by a non-attorney staff member commission does not constitute the full practice of law. September 19 Op. Att'y Gen.

NOTES TO DECISIONS

Practice of law not defined. — There is no rule defining the practice of law nor is there a statute defining the term except in the context of the requirements of active practice of law as a qualification for justices. In re Robson, Sup. Ct. Op. No. 1573 (File No. 3448), 575 P.2d 771 (1978).

Lay representation not precluded.

— This section does not preclude the exercise of discretion by a court to allow representation. Skuse v. State, Op. No. 582 (File No. A-885), 714 P.2d 1986.

Stated in Noll v. Alaska Bar, Sup. Ct. Op. No. 2546 (File No. 573), P.2d 241 (1982).

Sec. 08.08.240. Suspension upon conviction of certain crimes [Repealed, § 11 ch 181 SLA 1976.]

Article 5. General Provisions.

Section
250. Short title

Sec. 08.08.245. Definitions. [Repealed, § 3 ch 135 SLA 1965]

Sec. 08.08.250. Short title. This chapter may be cited as Alaska Integrated Bar Act. (§ 1 ch 196 SLA 1955)

Chapter 11. Audiologists.

Section
10. Qualifications for audiologist license
20. Temporary license to practice audiology as an audiologist
30. Renewal of license
40. Display of license
50. Fees
70. Dealing in hearing aids

Section
80. Grounds for imposition of disciplinary sanctions on an audiologist
90. Disciplinary sanctions
100. Prohibited acts
110. Penalty
120. Exemptions
130. Procedures
200. Definitions

Cross references. — For legislative findings and purpose related to this chap-

ter, see § 1, ch. 131, SLA 1965 Temporary and Special Acts.

ALASKA BAR

A S S O C I A T I O N

October 26, 1989

Representative Sam Cotton
Alaska State Legislature
Box 33932
Juneau, AK 99803

Attention: David Rogers, Esq.

RE: Attorney Discipline Statistics

Dear Mr. Cotton,

Last week, David Rogers called the Bar Association and asked if we could tell him whether a small percentage of lawyers were responsible for most of the attorney discipline problems.

The Bar Association maintains discipline statistics on all discipline cases in which some type of discipline was imposed. We converted from a manual system to a computer system in 1982 and have refined this system over the years to keep track of cases which have been dismissed and not accepted for investigation. When membership numbers were assigned, we became able to cross-reference complaints which had been filed against an attorney by his or her member number.

The following reflects historical information for disciplinary matters in which discipline was imposed, cases were dismissed, or cases were not accepted for investigation as that information presently exists on our computer records.

In the data studied, there were 1505 complaints against 710 attorneys. 57% of the attorneys had only one complaint against them which accounted for 27% of the complaint volume. 18% of the attorneys had two complaints against them which accounted for 17% of the complaint volume. The remaining 25% of the attorneys had three or more complaints against them and were responsible for 56% of the complaint volume.

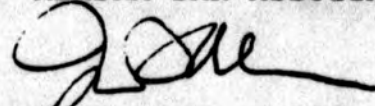
Representative Sam Cotton
October 26, 1989
Page 2 of 2

Mr. Rogers also asked for some information concerning the nature of complaints made against attorneys. In its quarterly report to the Supreme Court, the Bar Association lists the number of open cases by nature of the violation alleged. I have included a copy of the latest report for the period ending September 30, 1989. That report shows that 28% of the open disciplinary files alleged neglect, 28% alleged misconduct which interferes with the justice process, 11.5% alleged trust violations concerning client funds or property, 11.5% alleged misrepresentation or fraud, 10% alleged problems with the attorney/client relationship, 8% alleged conflict of interest, 2% alleged excessive fees, and 1% involved a criminal conviction.

If there is any further information which the Bar Association can provide the Liability Insurance Task Force concerning the attorney discipline process, please do not hesitate to contact us.

Sincerely,

ALASKA BAR ASSOCIATION



Jeffrey M. Feldman
President

Enclosure

BC: 17

III. DISCIPLINE OF MEMBERS

The activities of attorneys admitted to practice within the State of Alaska are governed by the Rules of Disciplinary Enforcement promulgated by the Alaska Supreme Court. As will be seen below, the substance and procedure of the rules of the Bar Association and the Supreme Court in regulating the practice of law within Alaska are entirely different from those of agencies of the State of Alaska charged with the regulation of legislatively controlled businesses and professions. For example, a ruling as to a permit or license issued by the Alcoholic Beverage Control Board is final and binding, subject only to the right of a party to appeal questions of law to the Superior Court and, thereafter, if desired, to the Supreme Court. In matters involving public censure, probation, suspension, or disbarment of attorneys, however, the Supreme Court is the decision maker, acting not as an appellate body but as the final forum with authority to make and enforce disciplinary decisions.

A thorough revision of the Rules of Disciplinary Enforcement was accomplished by the Board in 1984 and made effective by the Supreme Court on January 1, 1985. The most significant change is the opening of attorney discipline proceedings to the public after a Petition for Formal Hearing is filed. Now, the public is able to attend formal discipline hearings conducted before hearing committees and the Disciplinary Board in the same way as they have been able to attend court or other government proceedings. The following discussion reflects the revised procedures in effect.

A. The Supreme Court's Authority

The Supreme Court has held that an attorney's license to practice law is "a continuing proclamation by the Court that the holder is fit to be entrusted with professional and judicial matters...as an officer of the courts."

Attorneys are, therefore, bound to act in conformity with standards adopted or recognized by the Supreme Court of Alaska. The Supreme Court has also declared that any attorney admitted to practice in Alaska, or who appears or participates in legal matters within the State, is subject to the jurisdiction of the Supreme Court of Alaska and the Disciplinary Board which the Court established.

Due to the vastness of the size of the State of Alaska and the great distance between population centers, the Supreme Court has established three disciplinary areas: 1) the First Judicial District; 2) the combined Second and Fourth Judicial

Districts; and 3) the Third Judicial District. Charges of misconduct against a lawyer are assigned to be heard by members of the hearing committee established for the district in which the attorney lives or practices. Such charges may be based upon a violation of the Code of Professional Responsibility, Ethics Opinions adopted by the Board of Governors, criminal convictions, or misconduct within or arising from disciplinary proceedings themselves. Depending on the severity of the misconduct, violations may result in disbarment, suspension, probation, or public censure by the Court or, in less serious cases, in public or private reprimand by the Disciplinary Board or written private admonition by Bar Counsel.

B. The Disciplinary Board

As discussed above, the Board of Governors acts as the Disciplinary Board for the Supreme Court. The day-to-day workings of the disciplinary process have been delegated to Bar Counsel and Assistant Bar Counsel, attorneys hired by the Board, whose functions include assisting the public in the grievance process, maintaining records, investigating, processing, and prosecuting grievances and appeals.

The procedures for disciplinary enforcement begin upon the filing of a grievance by any person alleging misconduct on the part of any attorney. During this stage, grievances against attorneys are confidential by court rule. Bar Counsel reviews the grievance to determine whether it is properly completed and contains allegations which, if true, would constitute grounds for discipline. If Bar Counsel determines that the allegations are inadequate or insufficient to warrant an investigation, an investigation will not be opened. If a grievance is accepted for investigation, the attorney involved is required to provide full and fair disclosure in writing of all the facts and circumstances pertaining to the alleged misconduct.

If Bar Counsel determines that probable cause exists to believe that attorney misconduct as occurred, permission may be requested from a Hearing Committee member to issue a written private admonition (in less serious cases) or to file a Petition for Formal Hearing in serious matters. Once the petition is filed, the proceedings are open to the public.

SUMMARY OF PUBLIC DISCIPLINE ACTIONS IN 1989

The Alaska Supreme Court suspended three attorneys from the practice of law in 1989: (1) Scott D. Harless for four years effective March 2, 1989; (2) Homer L. Burrell for 90 days effective August 21, 1989; and (3) Ranauld H. Jarrell for four years effective November 3, 1989.

1989 DISCIPLINE CASE STATISTICS*

Open cases pending as of January 1, 1989 166

New cases opened in 1989 (+) 117

Cases closed in 1989:

Closed after disbarment by Supreme Court

Closed after suspension by Supreme Court 6

Closed after public censure by Supreme Court . . .

Closed after public reprimand

by Disciplinary Board

Closed after private reprimand

by Disciplinary Board 4

Closed after private admonition

by Bar Counsel 17

Closed after probation ended 4

Dismissed by Bar Counsel 91

TOTAL cases closed. (-) 122

Open cases as of December 31, 1989 161

STATUS OF OPEN CASES AS OF 12-31-89

Pending Supreme Court. 2

Pending Disciplinary Board

Pending Stipulation.

Pending Area Hearing Committee 2

Pending Petition Approval.

Pending Private Admonition 2

Attorney on Probation. 4**

In abeyance pending outcome of related

fee arbitration proceeding 1

In abeyance pending conciliation

In abeyance pending outcome of civil case 2

Under investigation by Bar Counsel 148

161

*All numbers reflect individual complaints filed and not the number of attorneys under investigation.

**There are two attorneys on probation: one attorney with three complaints, and one attorney with one complaint.

C. The Hearing Committee

Investigations which result in the filing of a Petition for Formal Hearing by Bar Counsel are referred to a Hearing Committee in the relevant geographical area. The attorney may thereafter file a written answer admitting or denying the charges, or setting forth a claim of mitigation. Hearings are then held before the Committee. At the hearing, Bar Counsel prosecutes the case on behalf of the Bar Association. The responding attorney may be represented by counsel. Either party may call, examine, and cross-examine witnesses and otherwise request the production of evidence. The burden of proving misconduct by clear and convincing evidence is placed upon Bar Counsel. The Committee may direct the submission of briefs.

At the conclusion of the hearing, the Committee must file a written report to the Board, together with the recorded transcript, briefs, findings, conclusions and recommendations. If either party appeals from the Committee's recommendation, briefs may be filed with the Board. If desired, the matter may be orally argued to the Board. The Board must then conduct a review of the record and briefs and enter its order or recommendation to the Court.

D. The Recommendation

If the Board's decision recommends either public censure, probation, suspension, or disbarment, the recommendation is filed with the Supreme Court, which makes the final decision. The Board must submit a case record, including the hearing transcript, to the Supreme Court. The parties are required to file briefs in accordance with the Supreme Court rules for regular civil and criminal appeals; oral argument is available. It is only after review of this record by the Court that the Court enters its order relating to the attorney's discipline. The Court may also issue an opinion published in the Pacific Reporter which becomes a precedent for future cases.

The Board may order public reprimand by the Board if it decides the matter can be resolved appropriately without referral to the Court. The Board may also consider stipulations of proposed discipline entered into between Bar Counsel and a respondent attorney and enter an order for a private reprimand by the Board or submit its recommendation on the stipulation to the Supreme Court.

As with civil litigation, many of the above procedures may be lengthy or protracted before the issuance of a Hearing Committee report or a Board order. Thus, a need exists -- and

a procedure has been formulated -- whereby either party can make an interlocutory appeal to the Supreme Court for review of the procedures and evidentiary rulings of the Hearing Committee.

E. Interim Suspension

The Rules of Disciplinary Enforcement anticipate situations requiring immediate action against an attorney for protection of the public pending the completion of the full disciplinary process. One such situation exists when an attorney is convicted of a serious crime, such as a felony or when he is convicted of certain other crimes including those relating to interference with justice, false swearing, fraud, deceit, misappropriation or theft.

Conviction of such a crime is conclusive evidence that disciplinary action is necessary. The sole issue for determination is the nature of the final discipline to be imposed. Such a conviction also requires interim suspension, regardless of whether the conviction is based on a jury verdict or a plea of guilty, and regardless of whether an appeal is pending. In the event the conviction is reversed, the suspension is lifted, but formal disciplinary proceedings may nevertheless continue to final disposition.

Further, if Bar Counsel shows that an attorney's conduct constitutes a substantial threat of irreparable harm to his or her clients or prospective clients or where there is a showing that the attorney's conduct is causing great harm to the public by a continuing course of conduct, the Court may impose interim suspension.

An attorney facing disciplinary charges cannot avoid the consequence of his misconduct by simply leaving the practice of law, thus leaving open the possibility of a future return to the profession. The Rules of Disciplinary Enforcement do permit discipline by consent of attorneys under disciplinary investigation but only upon the free and voluntary admission by the attorney that he is guilty of the charges, and with the consent of Bar Counsel, the Board and/or the Court.

F. The Court's Order

When either disbarment, suspension or probation is ordered by the Court, more is involved than a simple order to that effect. There are various notification requirements to that attorney's clients, to opposing counsel and other jurisdictions in which the attorney is admitted. Sworn proof that these

Notification requirements have been met must be filed Court. Proof of compliance with these requirements prerequisite to any subsequent reinstatement.

The Bar Rules, however, do not rely solely on notification by the disbarred, or suspended attorney. They also require the Board to publish notice of disbarment and suspension in a newspaper in Anchorage, Fairbanks and Juneau, the official Bar publication and a newspaper serving the community where the attorney practiced. The Board must also advise the presiding judges of all courts within the State and, through the Attorney General, all administrative agencies.

G. Reinstatement

Disbarred or suspended attorneys can, under certain circumstances and procedures, be reinstated to the practice of law. However, in cases of disbarment, a minimum of five years must pass before the attorney is eligible for reinstatement.

Petitions for reinstatement are filed with the Supreme Court and served upon the Executive Director for the initiation of reinstatement proceedings.* As with the imposition of discipline, the findings and recommendations of the Hearing Committee -- and thereafter the Board -- are only advisory, and the final determination on reinstatement is made by the Supreme Court. In order to be reinstated, a disbarred attorney or an attorney suspended for more than one year has the primary burden of establishing that he or she possesses the moral qualifications, competency, and knowledge of law required for admission to practice and that the attorney's resumption of practice will not be detrimental to the integrity and standing of the Bar, or to the administration of justice, or subversive of the public interest.

H. Disability

The Rules of Disciplinary Enforcement also anticipate circumstances where the need for protection of the public arises from an incapacitating illness, addiction to drugs or

*Attorneys who have been suspended for one year or less will be automatically reinstated by the Court unless Bar Counsel files an opposition to automatic reinstatement. Attorneys who have been disbarred or suspended for more than one year must appear before an appropriate Area Hearing Committee.

intoxicants, senility, death, disappearance, or judicially declared incompetence of an attorney, rather than actual misconduct by the attorney. Upon a finding by the Supreme Court that such a disability exists, an order is entered transferring the attorney to disability inactive status until further order of the Court during which time the attorney is prohibited from engaging in the practice of law. As with public discipline, notice of the Court's action must be published. Likewise, presiding judges of all courts and administrative agencies are also notified. However, while the Court's final order is public, the disability proceedings themselves are confidential.

Reinstatement of the right to practice can thereafter only be granted by the Supreme Court upon a showing by the attorney that the disability no longer exists and that he or she is fit to resume the practice of law.

While the above procedures are designed to remove the disabled attorney from active status, it is essential that the interests of the clients of the disabled, deceased or unavailable attorney are also protected. Thus, the Bar Rules provide for appointment by the Superior Court of Trustee Counsel to protect the interests of this unavailable attorney and his clients. Trustee Counsel, on behalf of the unavailable attorney, exercises powers similar to those of a personal representative of a deceased person, but does so only in those matters specifically provided in the rules and allowed by State law.

I. Alternative Proceedings

Some grievances do not rise to the level of professional misconduct warranting formal discipline. Nevertheless, two other forums are available to review the reasons for a client's dissatisfaction.

If the matter involves a dispute concerning the fee charged by an attorney, it is referred to a Fee Arbitration Panel. If the allegations involve a grievance which is not amenable to either discipline or fee arbitration, it is referred to a Conciliation Panel. Both are more fully discussed in Section VIII of this booklet.

J. Discipline Staff and Budget

The Discipline Section is currently staffed by Bar Counsel, Assistant Bar Counsel, a half-time assistant Bar Counsel, one part time Discipline Assistant, and two Discipline Secretaries. Bar Counsel has the overall responsibility for the review, investigation, prosecution and appeal of attorney grievance cases. This level of staffing is a reflection of the continued commitment by the Board to the efficient and thorough processing of grievance matters.

Expenditures for the Discipline Section totalled \$301,538 in 1989, a substantial commitment of Bar Association resources and a reaffirmation of the Bar Association's responsibility for the protection of the public through the attorney discipline process.

K. Bar Rule Changes in 1989

The Supreme Court revised Bar Rule 15(b) to prohibit disbarred or suspended attorneys from providing legal advice or preparing legal documents for another even if they are not compensated for the service. This change is effective January 15, 1990.

The Court amended Bar Rules 21(c) and 22(b) to authorize a trial judge to allow the discovery of discipline files under certain circumstances in criminal cases.

Bar Rule 38(c) of the fee arbitration rules was changed to explicitly authorize the fee arbitration executive committee to refer apparent violations of the Bar Rules for disciplinary investigation.

The Court approved a name change from "discipline counsel" to "bar counsel" for the attorneys employed by the Bar Association in the disciplinary process.

Finally, although not a Bar Rule, the court made an amendment to Disciplinary Rule 9-102 which requires an attorney to provide a notice of whether he or she intends to maintain an IOLTA trust account. IOLTA stands for Interest on Lawyer Trust Accounts. The program provides that interest on nominal sums or short term deposits in an attorney's care which would ordinarily be kept by a financial institution is instead paid to the Alaska Bar Foundation to provide funds for civil legal services to the poor. Further information on the IOLTA program can be found in this report under section IX, ADJUNCT INVOLVEMENT.

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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OTHER PROCEEDINGS REPORT

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STATUS

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PENDING HEARING COMMITTEE

FILE#	FILED	PROCEEDING TYPE	CASE NAME	ATY AS OF	#
86.005	861117	CLIENT SECURITY FUND	CONFIDENTIAL	CJA 890629	1

Subtotal

PENDING TC REPORT

86.002	860730	TRUSTEE COUNSEL	FYFE, EDWARD J. (JACK)	SVG 860805	2
86.003	860821	TRUSTEE COUNSEL	SHELLEY, ROBERT, R.	SVG 860826	3
88.003	880503	TRUSTEE COUNSEL	DENAUULT III, H. JOHN	SVG 880503	4

Subtotal

Grand Total

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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ADMISSIONS STATUS REPORT

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STATUS

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CLOSED BY DISMISSAL

FILE NO.	DATE FILED	COUNSEL	CODE AS OF	#
=====	=====	===	=====	=====
89.003	89/07/17	SVG	89/08/15	1

				1

Subtotal

PENDING BOARD

89.001	89/07/03	SVG	89/09/07	2

				1

Subtotal

PENDING HEARING MASTER

89.002	89/07/05	SVG	89/07/06	3

				1

Subtotal

3

Grand Total

Report Date 3RD QUARTER 9/89
Last Revision Date :89/10/04

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FEE ARB QUARTERLY REPORT

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STATUS

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DECISION FINAL

CASE #	FILED	JUD. DIST.	RED. ASKED	RED. AWRDED	STATUS CHNG	#
88.052	88/12/20	3	2,500.00	262.50	89/08/15	67
88.061	88/12/23	3	390.00	0.00	89/07/13	68
88.062	88/12/23	3	1,500.00	1,250.00	89/09/14	69
89.001	89/01/11	4	637.82	616.00	89/09/14	70

						10

Subtotal

DECISION APPEALED

82.023	82/07/21	1	20,000.00	9,814.45	84/08/27	71
87.052	87/09/30	4	5,500.00	1,215.00	89/03/20	72

						2

Subtotal

SUSTAINED ON APPEAL

87.021	87/04/29	3	6,436.00	5,936.34	89/08/18	73

						1

Subtotal

Grand Total

73

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Report Date 3RD QUARTER 9/89
Last Revision Date :89/10/04

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FEE ARB QUARTERLY REPORT

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CASE # FILED	JUD. DIST.	RED. ASKED	RED. AWARDED	STATUS CHNG	#
=====	=====	=====	=====	=====	=====

Subtotal

3

DISMISSED W/O PREJ.

89.030	89/06/02	3	3,500.00	89/09/20	47
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1

Subtotal

DECISION ISSUED

88.015	88/04/18	1	13,926.13	1,268.00	89/08/18	48
88.028	88/08/11	1	19,000.00	0.00	89/07/31	49
88.041	88/11/02	3	27,500.00	27,500.00	89/09/11	50
88.042	88/11/08	3	1,482.43	0.00	89/07/07	51
89.005	89/02/03	3	4,273.41	579.00	89/08/24	52
89.006	89/02/07	4	29,000.00	21,688.82	89/07/25	53
89.014	89/03/10	3	2,000.00	0.00	89/07/18	54
89.015	89/03/15	3	6,000.00	4,500.00	89/07/26	55
89.016	89/03/24	3	1,861.00	550.00	89/09/01	56
89.020	89/03/30	3	3,156.01	59.51	89/09/25	57
89.024	89/04/20	3	2,352.00	1,852.00	89/08/31	58
89.025	89/04/21	3	1,220.00	0.00	89/07/31	59
89.031	89/06/08	3	1,800.00	1,800.00	89/09/08	60

13

Subtotal

DECISION FINAL

86.027	86/07/09	3	500,233.33	385,233.33	89/08/17	61
88.022	88/06/03	3	250.00	769.84	89/07/08	62
88.023	88/06/10	3	3,771.50	0.00	89/08/07	63
88.025	88/07/14	3	5,906.16	0.00	89/08/30	64
88.031	88/09/12	1	3,600.00	2,411.74	89/07/27	65
88.046	88/11/15	3	954.35	954.35	89/07/09	66

Report Date 3RD QUARTER 9/89
Last Revision Date :89/10/04

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FEE ARB QUARTERLY REPORT

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STATUS

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PENDING DECISION

CASE #	FILED	JUD. DIST.	RED. ASKED	RED. AWRDED	STATUS CHNG	#
88.011	88/02/23	1	8,258.20		89/06/19	34
88.048	88/11/16	3	13,700.00		89/05/16	35
89.002	89/01/17	1	10,000.00		89/08/22	36
89.010	89/02/22	3	6,500.00		89/09/14	37
89.017	89/03/28	3	6,000.00		89/07/11	38
89.028	89/05/24	3	6,702.21		89/09/12	39
89.032	89/06/12	3	700.00		89/09/06	40

Subtotal

7

PETITION WITHDRAWN

89.036	88/09/23	3	35,000.00		89/08/07	41
89.034	89/06/21	3	920.00		89/07/25	42

Subtotal

2

PETITION REJECTED

89.051	89/09/05	3	1,752.00		89/09/14	43
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Subtotal

1

CLOSED: SETTLEMENT

89.026	89/04/24	3	700.00		89/07/07	44
89.027	89/05/22	4	0.00		89/08/16	45
89.038	89/07/20	4	1,105.06		89/08/29	46

Report Date 3RD QUARTER 9/89
Last Revision Date :89/10/04

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FEE ARB QUARTERLY REPORT

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STATUS

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PENDING STAY

CASE #	FILED	JUD. DIST.	RED. ASKED	RED. AWRDED	STATUS CHNG	#
89.047	89/08/24	3	325.00		89/08/25	22
89.048	89/08/25	3	0.00		89/08/29	23
89.054	89/09/18	4	1,000.00		89/09/20	24
89.055	89/09/25	3	0.00		89/09/25	25

Subtotal

9

PET RET'D/COMPLETION

89.022	89/04/14	3	0.00		89/04/20	26
89.040	89/08/02	1	0.00		89/08/07	27

Subtotal

2

PANEL ASSIGNED

88.004	88/01/29	3	430.00		88/03/31	28
89.012	89/02/23	3	25,796.01		89/08/10	29
89.013	89/03/07	3	3,796.68		89/08/31	30
89.037	89/07/19	3	10,733.54		89/08/25	31
89.041	89/08/07	3	600.00		89/08/23	32

Subtotal

5

REMAND/RECONSIDERATN

89.003	89/01/09	3	3,945.39	1,496.00	89/07/18	33
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Subtotal

1

Report Date 3RD QUARTER 9/89

Last Revision Date :89/10/04

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FEE ARB QUARTERLY REPORT

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STATUS

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PANEL NOT ASSIGNED

CASE #	FILED	JUD. DIST.	RED. ASKED	RED. AWARDED	STATUS CHNG	#
89.004	89/01/30	3	10,000.00		89/01/30	1
89.011	89/02/23	3	2,000.00		89/08/25	2
89.021	89/04/07	1	17,000.00		89/04/20	3
89.029	89/05/26	3	5,042.28		89/06/19	4
89.035	89/06/26	3	10,000.00		89/06/26	5
89.039	89/07/26	1	720.09		89/08/07	6
89.043	89/08/15	3	9,333.33		89/08/17	7
89.045	89/08/18	3	1,000.00		89/08/18	8
89.049	89/08/31	3	1,279.00		89/08/31	9
89.050	89/09/05	3	2,500.00		89/09/06	10
89.052	89/09/13	3	242.00		89/09/14	11
89.053	89/09/18	1	600.00		89/09/20	12

12

Subtotal

UNDER REVIEW

89.056	89/09/29	3	75,000.00		89/09/29	13
89.057	89/09/29	3	392.40		89/09/29	14
89.058	89/09/29	1	10,651.74		89/09/29	15
89.059	89/09/29	1	155.00		89/09/29	16

4

Subtotal

PENDING STAY

89.033	89/06/19	3	4,977.27		89/06/19	17
89.036	89/06/28	3	1,300.00		89/06/29	18
89.042	89/08/09	3	752.31		89/08/09	19
89.044	89/08/16	1	2,129.22		89/08/18	20
89.046	89/08/18	3	11,132.25		89/08/22	21

FEE ARBITRATION REPORT

July 1, 1989 to September 30, 1989

Section A Summary

Open cases at beginning of quarter	49
Cases closed	(-) 18
New cases initiated	(+) 24
Open cases at end of quarter	55

Section B Description of Open Cases

Under Review	4
Pending Stay	9
Petition Returned For Completion	2
Panel not Assigned	12
Pending Settlement	0
Panel Assigned	5
Remand/Reconsideration	1
Pending Decision	7
Decision Issued	13
Decision Appealed	2
	55

Section C Description of Closed Cases

No Atty./Client Relationship	0
Fee Set by Court/Statute	0
Petition Withdrawn	2
Petition Rejected	1
Closed: Settlement	3
Dismissed w/o prejudice	1
Dismissed w/prejudice	0
Decision Final	10
Reversed on Appeal	0
Sustained on Appeal	1
	18

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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DISCIPLINE STATUS REPORT

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CODE NAME

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FILED/UNDER REVIEW

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
89.067	89/03/27	00	SVG		89/03/28	233
89.105	89/05/30	00	SVG		89/05/31	234
89.113	89/06/14	00	SVG		89/06/14	235
89.120	89/06/20	00	SVG		89/06/23	236
89.121	89/06/27	00	SVG		89/06/27	237
89.123	89/06/28	00	SVG		89/06/28	238
89.129	89/07/11	00	SVG		89/07/12	239
89.130	89/07/12	00	SBC		89/07/12	240
89.134	89/07/20	00	SVG		89/07/20	241
89.136	89/07/21	00	SVG		89/07/24	242
89.139	89/07/25	00	SVG		89/07/31	243
89.153	89/08/11	00	SVG		89/08/11	244
89.155	89/08/11	00	SVG		89/08/11	245
89.158	89/08/23	00	SVG		89/08/24	246
89.168	89/09/06	00	SVG		89/09/06	247
89.189	89/09/12	00	SVG		89/09/26	248
89.177	89/09/13	00	SVG		89/09/13	249
89.181	89/09/20	00	SVG		89/09/22	250
89.182	89/09/20	00	SVG		89/09/22	251
89.183	89/09/20	00	SVG		89/09/22	252
89.184	89/09/20	95	SVG		89/09/22	253
89.186	89/09/25	00	SVG		89/09/25	254
89.187	89/09/25	00	SVG		89/09/25	255
89.188	89/09/25	00	SVG		89/09/25	256
89.190	89/09/29	00	SVG		89/09/29	257
89.191	89/09/29	00	SVG		89/09/29	258

Subtotal

26

Grand Total

258
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DISCIPLINE STATUS REPORT

CODE NAME

UNDER INVESTIGATION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
89.106	89/05/30	03	SVG	MW	89/06/23	201
89.109	89/06/01	07	SVG		89/06/27	202
89.108	89/06/02	04	SVG		89/09/07	203
89.110	89/06/07	07	SVG		89/09/14	204
89.111	89/06/07	03	SVG	CJA	89/09/01	205
89.114	89/06/21	07	SVG		89/09/14	206
89.115	89/06/21	07	SVG		89/09/14	207
89.117	89/06/22	03	SVG	MW	89/07/21	208
89.127	89/07/05	07	SVG	CJA	89/08/17	209
89.132	89/07/06	03	SVG	CJA	89/08/17	210
89.128	89/07/11	05	SVG	MW	89/08/17	211
89.133	89/07/18	03	SVG		89/08/18	212
89.142	89/07/26	03	SVG	CJA	89/08/21	213
89.143	89/07/28	03	SVG	CJA	89/09/01	214
89.144	89/07/31	03	SVG	MW	89/09/01	215
89.147	89/08/07	07	SVG	CJA	89/09/12	216
89.149	89/08/08	04	SVG	CJA	89/08/21	217
89.150	89/08/08	02	SVG		89/09/07	218
89.156	89/08/10	03	SVG	MW	89/09/07	219
89.159	89/08/24	03	SVG		89/09/25	220
89.160	89/08/24	03	SVG	CJA	89/09/12	221
89.161	89/08/25	07	SVG	MW	89/09/12	222
89.162	89/08/31	07	SVG		89/09/11	223
89.167	89/09/05	04	SVG	CJA	89/09/21	224
89.174	89/09/07	01	SVG	CJA	89/09/21	225
89.175	89/09/11	05	SVG	MW	89/09/26	226
89.170	89/09/12	04	SVG		89/09/26	227
89.171	89/09/12	01	SVG		89/09/20	228
89.173	89/09/12	01	SVG	MW	89/09/21	229
89.178	89/09/14	03	SVG	CJA	89/09/21	230
89.179	89/09/15	04	SVG	CJA	89/09/25	231
89.180	89/09/18	03	SVG	CJA	89/09/21	232

145

Subtotal

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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DISCIPLINE STATUS REPORT

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CODE NAME

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UNDER INVESTIGATION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
88.240	88/12/02	05	SVG		89/03/31	164
88.241	88/12/02	05	SVG		89/03/31	165
88.242	88/12/02	05	SVG		89/03/31	166
88.246	88/12/07	03	SVG		88/12/30	167
88.247	88/12/08	05	SVG		88/12/14	168
88.253	88/12/15	07	SVG		89/02/09	169
88.261	88/12/15	07	SVG		89/02/09	170
88.258	88/12/27	03	SVG		89/02/01	171
88.259	88/12/29	02	SVG		89/02/01	172
89.001	89/01/03	07	SVG	MW	89/02/02	173
89.004	89/01/04	03	SVG	CJA	89/09/15	174
89.002	89/01/05	03	SVG	CJA	89/02/02	175
89.009	89/01/13	07	SVG		89/05/10	176
89.010	89/01/13	03	SVG		89/02/02	177
89.026	89/01/19	07	SVG		89/02/03	178
89.013	89/01/24	03	SVG	MW	89/02/02	179
89.023	89/01/24	01	SVG		89/02/03	180
89.025	89/01/24	04	SVG		89/02/03	181
89.027	89/01/27	07	SVG		89/03/16	182
89.028	89/01/27	07	SVG		89/03/17	183
89.031	89/02/10	01	SVG	CJA	89/02/28	184
89.039	89/02/23	07	SVG		89/02/28	185
89.043	89/02/27	03	SVG		89/03/17	186
89.045	89/03/01	01	SVG	CJA	89/03/17	187
89.047	89/03/03	07	SVG	CJA	89/03/17	188
89.048	89/03/06	02	SVG		89/03/17	189
89.053	89/03/15	03	SVG		89/03/23	190
89.054	89/03/16	03	SVG		89/04/18	191
89.057	89/03/16	02	SVG	MW	89/03/24	192
89.068	89/03/28	05	SVG		89/03/31	193
89.097	89/04/05	07	SVG	CJA	89/05/10	194
89.082	89/04/24	03	SVG	MW	89/05/12	195
89.091	89/05/01	03	SVG		89/05/09	196
89.095	89/05/03	03	SVG	CJA	89/05/15	197
89.098	89/05/04	05	SVG		89/05/12	198
89.083	89/05/22	03	SVG		89/05/26	199
89.101	89/05/22	03	SVG	MW	89/06/26	200

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

DISCIPLINE STATUS REPORT

CODE NAME

UNDER INVESTIGATION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
88.097	88/04/04	03	SVG	MW	88/04/27	127
88.088	88/04/06	04	SVG	CJA	88/04/27	128
88.098	88/04/27	03	SVG	MW	88/05/16	129
88.105	88/05/09	01	SVG		88/06/21	130
88.106	88/05/11	04	SVG		88/05/17	131
88.132	88/05/17	01	SVG	CJA	88/06/21	132
88.109	88/05/18	05	SVG	MW	88/05/18	133
88.111	88/05/19	07	SVG	CJA	88/06/21	134
88.117	88/05/26	01	SVG		88/05/31	135
88.118	88/05/26	02	SVG	CJA	88/06/20	136
88.125	88/06/03	05	SVG	CJA	88/06/22	137
88.126	88/06/03	07	SVG		88/07/27	138
88.141	88/06/30	07	SVG		88/07/20	139
88.145	88/07/06	03	SVG	MW	88/07/26	140
88.147	88/07/06	03	SVG		88/07/26	141
88.150	88/07/11	04	SVG		88/11/02	142
88.176	88/07/11	02	SVG	MW	89/03/24	143
88.153	88/07/13	07	SVG	CJA	88/07/26	144
88.157	88/07/15	01	SVG	CJA	88/07/26	145
88.158	88/07/18	03	SVG	MW	88/07/19	146
88.164	88/08/01	07	SVG		88/09/01	147
88.189	88/08/01	07	SVG		88/09/01	148
88.190	88/08/01	07	SVG		88/09/01	149
88.178	88/08/18	07	SVG	CJA	88/08/22	150
88.187	88/08/30	07	SVG	CJA	88/09/21	151
88.188	88/08/30	03	SVG		88/09/23	152
88.191	88/09/01	03	SVG	CJA	88/09/22	153
88.192	88/09/12	06	SVG		88/09/27	154
88.195	88/09/19	05	SVG		88/09/21	155
88.211	88/10/01	04	SVG		89/03/29	156
88.209	88/10/04	05	SVG		88/10/25	157
88.208	88/10/06	07	SVG		88/10/31	158
88.207	88/10/07	02	SVG	CJA	88/10/25	159
88.214	88/10/11	07	SVG		88/10/31	160
88.215	88/10/11	07	SVG		88/10/31	161
88.217	88/10/13	07	SVG		88/10/31	162
88.220	88/10/26	03	SVG		88/11/21	163

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DISCIPLINE STATUS REPORT

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CODE NAME

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UNDER INVESTIGATION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
86.023	86/02/05	07	SVG	CJA	86/02/20	90
86.134	86/06/27	07	SVG		86/07/17	91
86.225	86/11/12	07	SVG		86/12/05	92
86.237	86/12/01	04	SVG	JRL	89/01/27	93
87.013	87/01/15	04	SVG		87/01/21	94
87.070	87/03/12	03	SVG	CJA	87/03/23	95
87.079	87/03/19	05	SVG		87/09/11	96
87.088	87/03/27	02	SVG	CJA	87/09/22	97
87.110	87/04/17	01	SVG		87/04/23	98
87.126	87/05/12	04	SVG		87/05/29	99
87.128	87/05/13	07	SVG	JRL	87/06/18	100
87.129	87/05/13	07	SVG	JRL	87/06/18	101
87.130	87/05/13	07	SVG	JRL	87/06/18	102
87.131	87/05/13	07	SVG	JRL	87/06/18	103
87.133	87/05/14	02	SVG	MW	87/05/21	104
87.139	87/05/27	04	SVG	CJA	88/12/30	105
87.146	87/06/01	03	SVG	MW	87/06/15	106
87.177	87/07/09	03	SVG	CJA	87/07/24	107
87.182	87/07/20	07	SVG		87/08/03	108
87.197	87/07/30	06	SVG		88/01/04	109
87.215	87/08/31	01	SVG	CJA	87/09/09	110
87.222	87/09/11	01	SVG		87/09/16	111
87.242	87/10/09	03	SVG		87/10/13	112
87.247	87/10/15	05	SVG		87/10/20	113
87.255	87/10/26	03	SVG		87/12/02	114
87.256	87/10/26	07	SVG		87/11/04	115
87.273	87/11/18	03	SVG		87/12/02	116
87.296	87/12/11	07	SVG		87/12/16	117
88.002	87/12/31	07	SVG		88/01/25	118
88.015	88/01/18	05	SVG		88/01/25	119
88.026	88/01/28	07	SVG		88/02/04	120
88.035	88/02/08	07	SVG		88/02/24	121
88.062	88/03/07	02	SVG		88/09/28	122
88.064	88/03/08	02	SVG	MW	88/03/25	123
88.063	88/03/09	06	SVG	CJA	88/03/10	124
88.067	88/03/11	01	SVG	CJA	88/03/24	125
88.078	88/03/22	01	SVG		88/04/27	126

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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DISCIPLINE STATUS REPORT

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CODE NAME

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PENDING ADMONITION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	==	==	=====	=====
85.170	85/09/26	04	SVG	MW	89/08/21	77
86.169	86/08/13	03	SVG	JRL	89/04/20	78
88.011	88/01/14	01	SVG	MW	89/08/21	79
88.107	88/05/17	06	SVG	CJA	89/08/09	80
88.166	88/08/05	07	SVG	MW	89/08/28	81
					-----	5

Subtotal

PENDING FEE ARB.

86.083	86/04/21	04	SVG		86/07/08	82
89.011	89/01/20	01	SVG	CJA	89/08/30	83
					-----	2

Subtotal

ABEYANCE/ COURT CASE

83.327	83/05/24	03	SVG		86/05/06	84
84.139	84/08/20	03	SVG		86/05/07	85
87.087	87/03/27	05	SVG		87/11/05	86
87.236	87/09/29	01	SVG		88/03/11	87
					-----	4

Subtotal

UNDER INVESTIGATION

85.186	85/10/11	02	SVG		85/10/11	88
86.011	86/01/14	02	SVG		86/05/08	89

Report Date 3RD QUARTER 1989
Last Revision Date :89/10/05

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DISCIPLINE STATUS REPORT

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CODE NAME

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ATTY ON PROBATION

FILE NO.	DATE FILED	GRIEVANCE	BC	ABC	CODE AS OF	#
=====	=====	==	===	===	=====	=====
86.076	86/04/14	03	SVG		88/03/18	70
86.209	86/10/13	05	SVG		88/03/18	71

						4

Subtotal

PENDING SUPREME CT.

86.184	86/09/12	05	SVG		89/09/11	72
87.078	87/03/19	05	SVG		89/09/11	73
87.159	87/06/22	03	SVG		89/03/30	74

						3

Subtotal

PENDING DISC. BOARD

88.010	88/01/14	09	SVG		89/07/13	75

						1

Subtotal

PENDING HRG. COMM.

88.225	88/11/07	07	SVG	CJA	89/08/09	76

						1

Subtotal