ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4659.1 HJUD HB 67 - HB 70

Number 016

Rep. Springer asked if there were any witnesses who wished to testify on HB 67.

Number 020

Rep. Lyman Hoffman, sponsor of HB 67, addressed the Committee. He explained that HB 67, at the present time, would not affect any communities. Bethel, however, would be affected in the future if the population exceeded 4,500. HB 67 did not include the first Judicial District. He did not know why, but did not see a problem with that matter. Rep. Hoffman also stated he would not object to any amendments to include the first Judicial District in HB 67.

Number 051

Rep. Collins questioned the impact of HB 67 on other areas.

Number 059

Rep. Hoffman answered that the definition of "rural," as it applied to HB 67, was for loan programs.

Number 069

Rep. Zawacki asked if there was a specific reason for delineating the population relative to the District.

Number 074

Rep. Hoffman was not aware of any such reason.

Number 077

Rep. Zawacki clarified that Rep. Hoffman would not object to an amendment or Committee Substitute regarding the loan program that applied.

Number 081

Rep. Hoffman acknowledged that Rep. Zawacki was correct.

Number 082

Rep. Springer asked if there were any other questions or other people who wished to testify.

STATE O ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

REQUEST:

Bill Version: HB 67
Publish Date:

Revision Date:
Title: "An Act relating to the rural housing program..."
Sponsor: Repr. Hoffman
Requestor: Repr. Hoffman

Agency Affected: Department of Law
BRU: Legal Services

Components: Legal Services Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Please see attached analysis.

Richard I. Pegues

Prepared by: Richard I. Pegues, Director
Phone: 465-3672
Division: Administrative Services
Date: Jan. 28, 1987

Richard I. Pegues /FR
Approved by Commissioner: Ronald W. Lorenson, Acting Attorney General
Date: Jan. 28, 1987
Agency: Department of Law

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

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 67

This bill amends AS 44.47.560 by changing the definition of rural to mean a community in the second, third, or fourth judicial district of the state with a population of 5,500 or less that is not connected by road or rail to Anchorage or Fairbanks. Existing statute places the population maximum at 4,500, in these areas. Administration of the state's rural housing program is a central responsibility of the Department of Community and Regional Affairs, and it does not usually involve the Department of Law. Consequently, there will not be a fiscal impact for the Department of Law.

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version : SB-52/HB-67
Publish Date :

REQUEST:

Revision Date:
Title : An Act relating to the rural housing program of DCRA
Sponsor : Binkley/Hoffman
Requestor :

Agency Affected : DCRA
BRU : Housing Assistance
Components : Housing Loan

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

ANALYSIS : (Attach a separate page if necessary)

This bill will have no fiscal impact on the Housing Loan Program (see position paper).

Prepared by : Clark D. Boston CDB
Division : Housing Assistance Division
Phone : 561-0900
Date : 1-25-87

Approved by Commissioner : Ward G. Hoffman
Agency : Community and Regional Affairs
Date : 1-28-87

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

HB

70

JOHN SUND, REPRESENTATIVE
2504 2nd Avenue
Ketchikan, Alaska 99901
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While in Juneau
P. O. Box V
Juneau, Alaska 99811
(907) 465-4919

February 17, 1987

MEMORANDUM

TO: House Judiciary Committee

FROM: Representative John Sund

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

.....

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

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

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

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

M E M O R A N D U M February 17, 1987

SUBJECT: Sectional analysis of HB 70, relating to the State Medical Board

TO: Representative John Sund

FROM: Edward H. Hein
Legislative Counsel

Section 1 requires that the amount of fees collected by the state for medical licenses, permits, and applications during the previous calendar year shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board.

Sec. 2 requires that applicants for medical license examinations submit their applications to the State Medical Board 120 days before the examination date, rather than 40 days before the examination date.

Sec. 3 eliminates oral examinations for licenses to practice medicine or osteopathy.

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

Sec. 5 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a). These acts are: (1) securing a license through deceit, fraud, or intentional misrepresenta-

tion; (2) engaging in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities; (3) advertising professional services in a false or misleading manner; (4) having been convicted of a felony or other crime substantially related to the licensee's qualifications, functions, or duties, or a crime involving unlawful procurement, sale, prescription, or dispensing of drugs; (5) having procured, sold, prescribed or dispensed drugs in violation of law; (6) intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards, even if the patient was not injured; (7) failing to comply with the provisions of AS 08.64, or a regulation or order of the board; (8) demonstrating professional incompetence, gross negligence, or repeated negligent conduct, or addiction to drugs, or unfitness because of physical or mental disability; (9) engaging in unprofessional, lewd, or immoral conduct while serving a patient; (10) performing an abortion (A) without a license; or (B) outside of a hospital or other facility approved by the Department of Health and Social Services or a federal hospital; or (C) on an unmarried minor without consent of the minor's parent or guardian; or (D) on a woman who has not been in the state for at least 30 days before the abortion; (11) violating any ethical code regulation adopted by the board; (12) denying care or treatment to a patient or person seeking treatment solely because the patient or person fails or refuses to agree to arbitrate under AS 09.55.535(a); or (13) having had a medical license or certificate suspended or revoked in anotner state, U.S. territory, or Canadian province, unless the suspension or revocation was for failure to pay fees.

Sec. 6 adds to current law a requirement that a hospital that places a consultation requirement on, revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.

Sec. 7 clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a

practitioner is a danger to the health or welfare of the public or the practitioner's patients". This section also specifically authorizes the board to suspend the licensee's license before appointing the committee or before receiving the committee's report.

Sec. 8 adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Sec. 9 adds two new statutes. AS 08.64.337 gives the medical board subpoena power and the power to administer oaths for purposes of an investigation of a licensee. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board expense, and may include tests requested by the examining physician.

Sec. 10 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings.

Sec. 11 repeals provisions relating to license examinations to reflect the board's current examining practices.

EHH:mkr
m9/018

Department of Commerce & Economic Development / POSITION PAPER

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

Section 1: proposes amending AS 08.01.065 by requiring the department to allocate an amount equal to the fees collected during the previous year to be used on behalf of the State Medical Board by the Division of Occupational Licensing.

Currently, all licensing fees collected are deposited directly into the general fund. By law, medical licenses are renewed on a quadrennial basis, therefore, generating large sums of revenue every fourth year. While the average annual revenue generated through licensing fees exceeds the board's budget in a given fiscal year, licensing fees generated each fiscal year other than the renewal year account only for 20% of the average revenues. The department would not support this proposal since an allocation to the State Medical Board based on the amount equal to the fees collected in the previous year would need to be supplemented by general funds or licensing fees generated by other licensed occupations.

Instead, the department would recommend amending AS 08.01.065 by adding the new subsection to read:

> "(e) The Division of Occupational Licensing shall allocate funding for licensed occupations under AS 08.01 based to the extent possible upon the average amount of fees collected for applications, licenses and permits in the previous two fiscal years."

In addition, Section 5 of AS 08.01.100 should be amended to read:

> "(a) [EXCEPT AS OTHERWISE PROVIDED IN THIS TITLE] licenses must [SHALL] be renewed biennially on the dates set by the department with the approval of the respective board."

These two statutory changes would enable the division to renew all licenses every two years and budget for all occupations based on the amount of fees collected by the division. Fees could be more easily adjusted to ensure operating costs of the licensing boards were covered in accordance with AS 08.01.065(c).

*Section 2: proposes amending AS 08.64.210(b) by changing the number of days which an application must be submitted prior to the examination date from 40 to 120.

The examination administered to medical applicants is a national exam for which filing dates are set on a national level. Because the filing date can be changed by the national federation of state licensing board, the department recommends that the filing date be established in regulations instead of statutes. This will allow the board to amend the application filing deadline according to national requirements. The department offers the following change:

"(b) The application for examination shall be submitted to the board in accordance with the application date established by regulation [AT LEAST 40 DAYS BEFORE THE EXAMINATION DATE]."

Section 3: proposes amending AS 08.64.220(a) to eliminate the oral examination requirement. The department supports this proposal since oral examinations are more subjective in nature and more difficult to defend when examination results are appealed.

Section 4: clarifies that any licensee who practices medicine in the State of Alaska must possess an active license. The department supports this proposed clarification.

*Section 5: grants the board the authority to impose a civil fine of not more than $10,000.

*Section 6: adds reporting requirements for physicians and hospitals when a hospital places a consultation requirement on, revokes, suspends or conditions the privileges of a licensee.

*Section 7: authorizes the board to summarily suspend a license if the board has reason to believe that the licensee poses a danger to the health or welfare of the public or the licensee's patients.

*Section 8: grants immunity from civil liability for a physician, hospital or hospital committee who complies with reporting requirements of the State Medical Board.

*Section 9: grants the board subpoena powers to secure books, papers and records of a person who the board believes has information relevant to an investigation. The section also grants the board authority to order a licensee to submit to a medical or psychiatric examination at the expense of the board.

The department supports Sections 5, 6, 7, 8 and 9 since these proposals would increase the medical board's power to enforce their licensing statutes.

In summary, the department supports all sections of HB 70 except Section 1 which we would support if amended as proposed by the department.

J. Anthony Smith, Commissioner
Department of Commerce & Economic Development

Date: 2/13/87

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transferred, nor shall the public credit be used, except for a public purpose.

Dedicated Funds

SECTION 7. The proceeds of any state tax or license shall not be dedicated to any special purpose, except as provided in section 15 of this article or when required by the federal government for state participation in federal programs. This provision shall not prohibit the continuance of any dedication for special purposes existing upon the date of ratification of this section by the people of Alaska.

(The amendment to this section was approved by the voters of the state November 2, 1976 and became effective February 21, 1977. This amendment inserted "as provided in section 15 of this article or" in the first sentence.)

State Debt

SECTION 8. No state debt shall be contracted unless authorized by law for capital improvements or unless authorized by law for housing loans for veterans, and ratified by a majority of the qualified voters of the State who vote on the question. The State may, as provided by law and without ratification, contract debt for the purpose of repelling invasion, suppressing insurrection, defending the State in war, meeting natural disasters, or redeeming indebtedness outstanding at the time this constitution becomes effective. [Amendment approved November 2, 1982]

Effect of amendments. - The amendment approved November 2, 1982, inserted "or unless authorized by law for housing loans for veterans" in the first sentence.

Local Debts

SECTION 9. No debt shall be contracted by any political subdivision of the State, unless authorized for capital improvements by its governing body and ratified by a majority vote of those qualified to vote and voting on the question.

Interim Borrowing

SECTION 10. The State and its political subdivisions may borrow money to meet appropriations for any fiscal year in anticipation of the collection of the revenues for that year, but all debt so contracted shall be paid before the end of the next fiscal year.

Exceptions

SECTION 11. The restrictions on contracting debt do not apply to debt incurred through the issuance of revenue bonds by a public enterprise or public corporation of the State or a political subdivision, when the only security is the revenues of the enterprise or corporation. The restrictions do not apply to indebtedness to be paid from special assessments on the benefited property, nor do they apply to refunding indebtedness of the State or its political subdivisions.

Budget

SECTION 12. The governor shall submit to the legislature, at a time fixed by law, a budget for the next fiscal year setting forth all proposed expenditures and anticipated income of all departments, offices, and agencies of the State. The governor, at the same time, shall submit a general appropriation bill to authorize the proposed expenditures, and a bill or bills covering recommendations in the budget for new or additional revenues.

Expenditures

SECTION 13. No money shall be withdrawn from the treasury except in accordance with appropriations made by law. No obligation for the payment of money shall be incurred except as authorized by law. Unobligated appropriations outstanding at the end of the period of time specified by law shall be void.

Legislative Post-Audit

SECTION 14. The legislature shall appoint an auditor to serve at its pleasure. He shall be a certified public accountant. The auditor shall conduct post-audits as prescribed by law and shall report to the legislature and to the governor.

Alaska Permanent Fund

SECTION 15. At least twenty-five per cent of all mineral lease rentals, royalties, royalty sale proceeds, federal mineral revenue sharing payments and bonuses received by the State shall be placed in a permanent fund, the principal of which shall be used only for those income-producing investments specifically designated by law as eligible for permanent fund investments. All

MEMO

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

The Problem:

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

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

3) The need for minor housekeeping changes.

Proposed Remedy:

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

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

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

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

1. Revise 08.64.010 to read: Creation and membership of State Medical Board. There is created an executive instrumentality of the state known as the Alaska State Medical Licensing Board, referred to in this chapter as the State Medical Board. The State Medical Board shall have a common seal shall, after scrutiny of qualifications, issue licenses to physicians, osteopaths and podiatrists, and permits to paramedics and physician assistants; shall investigate infractions of rules and statues, particularly as they relate to malpractice by any members, new applicants or those already licensed or permitted of the regulated groups and on findings of deficiencies take corrective action up to and including refusal of licenses or permits to applicants or revocation of previously issued licenses or permits. Further the State Medical Board shall review existing regulations and shall propose and adopt such new regulations as shall be necessary from time to time to ensure that quality medical care be readily and efficiently available to the population. The State Medical Board shall also advise the Legislature on necessary change of statutes to ensure these ends.

As an instrumentality of the state, the State medical Board shall be empowered to set and collect fees, disburse funds, enter into contracts, hire administrative and investigative personnel and hold, encumber and dispose of real and personal property. As an executive instrumentality, under legislative oversight, it shall enter into a contract with the Division of Occupational Licensure, Department of Commerce and Economic Development for administrative support, the collection and disbursement of fees, personnel management of board employees, the preparation of budgets and annual reports, and other day to day matters supportive of board function.

The State Medical Board shall consist of five physicians licensed in the state and residing in as many separate geographical areas of the state as possible, and two persons with no direct financial interest in the health care industry. These members shall be appointed the governor with legislative confirmation.

Comment: This is the pivotal revision from which most of the rest follows. It is an idea derived from AS 08.08 the Alaska Integrated Bar Act and arises from the observation that the State Bar is effective in imposing discipline among its members as it has access to the necessary funds and is invested with sufficient authority to carry out its tasks albeit indirectly through the authority of the Supreme Court.

There are some differences of course. In the case of the State Bar the administrative machinery resides with the Bar Association while the power to impose sanctions vests (officially) with the Supreme Court. It is clear of course that the Court generally just adds an imprimatur to that which is decided by the State Bar. In the case of the State Medical Board the administrative machinery would officially reside with the board but would effectively (by contract) be run by the Division of Occupation Licensing, while the authority to impose discipline would both officially and in actuality remain with the board as it does now.

As things now stand the State Medical Board is languishing in ineffectiveness with inadequate funds to carry out its statutory functions. It is clear, in consultation with the State Medical Association, that the will exists with the state's physicians to make the medical board an effective instrument and to pay in fees whatever it takes to accomplish this end.

The stumbling block is Chapter IX, Section 7 of the State Constitution which prohibits the dedication of public funds to specific purposes. It would appear the State Bar has found an effective way around the difficulty by its designation as an instrumentality of the state. Acknowledging the lead of the State Bar in this area, the State Medical Board in the proposed revision of AS 08.64.010 seeks to follow suit.

The State Medical Board would of course have no objection to deriving its budget from the general fund if such could be relied on for sustenance. It is however clear that such is not possible. Several years ago in return for a verbal guarantee to provide adequate funds for board function the board gave its support to a significant increase in licensing fees only to have the agreement abrogated by both the legislature and the governor.

Recognizing its former naivetee in relying on verbal agreements and understanding that access to monies from the general fund will vary from year to year depending on political and financial forces beyond its (or perhaps anyones) control the board seeks by this change to ensure its continuing effectiveness while not burdening the taxpayer with the cost of its maintenance.

2. Revise 08.64.101 Duties.
3) Submit an annual report of its proceedings to the governor. [including a statement of money received and disbursed] - add 6) Submit an annual budget to the governor detailing administrative, travel, per diem, investigative, contractual and legal expenses and advising what fee levels assessed against licensed and permitted members regulated by the State Medical Board will be required to cover expenses and achieve a balanced budget.

Comment. An obvious corollary of AS 08.64.010.

3. Revise 08.64.110 Per diem and expenses. The members of the board are entitled to per diem and expenses [authorized by law] at prevailing state rates. These expenses shall be drawn from the State Medical Board's annual operating budget.

Comment: Necessitated by changes above as per diem and expenses will be drawn from the budget not from general funds.

4. Revise 08.64.210(b) The application for examination shall be submitted to the board at least [40] 120 days before the examination date.

Comment: 40 days is insufficient lead time for ordering exams. Currently an application deadline of 120 days prior to exam is set by regulation [12AAC 40.015(b)] so, at present, statute and regulation are in conflict.

5. Revise 08.64.220 Contents of examination and grading (a) the board shall make the examination written and [oral]... - delete oral.

Comment: We do not require oral examination at present as it can easily be considered arbitrary and capricious and has been so considered in case law. It is not a necessary protection and its requirement could open the state to unnecessary civil litigation and liability.

6. Delete 08.64.260(b), (c) and (d) 08.64.260(a) should remain unchanged.

Comment: The exam now offered is the FLEX [Federation of State Medical Boards Licensure Exam], a standardized national exam, that as of 1985 is a two part rather than a three part exam. Details of the comparison and application of the two exams are tedious. After prolonged consideration the State Medical Board promulgated regulations 12AAC 40.020(a-h) to cover the subject. 08.64.260(b)(c) and (d) are in conflict with these as they refer to the old examination. They are applied in connection with the prior regulations under 12AAC 40.020 when considering examinees who took the FLEX prior to May 18, 1985. The three part FLEX is no longer available from the Federation of State Medical Boards.

7. Revise AS 08.64.311 to read: "Licenses and permits will be renewed annually; renewal dates may be staggered depending on the time of first issuance.

Comment: Annual renewal will be required at least in the initial stages of the new program till the board can determine actual costs. It may later be possible to extend the licenses and permits to two or three years as the board gains more experience with actual costs. Staggering renewal dates will distribute the work load and has precedent in the Division of Motor Vehicles, etc.

8. Revise 08.64.313: Inactive license. A licensee [residing outside Alaska] may renew a license issued under this chapter as inactive. If the licensee practices [intermittently] no matter how infrequently in Alaska, the licensee may not hold an inactive license.

Comment: Present statute seems to discriminate against state residents. The presumption of the present statute is understood but it would seem the rest of the state codes work on the presumption of good faith unless the facts prove otherwise so this statute should work in like fashion.

9. Revise 08.64.315 Fees. Fees will be imposed on a year to year basis in such manner as to raise sufficient revenue to permit a balanced budget. The fees will be distributed on a capitation basis with the exception that the board shall be given authority to reduce or forgive the fees of no more than 3% of its regulated membership on the basis of demonstrated financial hardship.

Comment: The new program to function on a zero-based budgetary basis will obviously have to adjust fees to cover expenses. The power to forgive or reduce fees in a limited number of cases will permit the board to deal with legitimate cases of hardship - the physician or other health care providers medically incapacitated for a substantial portion of the year, provider working for limited salary at a mission station, etc. It adds a grace note of humane concern to the process.

10. Revise 08.64.320 Disposition of fees. Fees collected shall be deposited with the State Medical Board.

Comment: An obvious correllary of the foregoing. Other acceptable language would be "...deposited with the Division of Occupational Licensing, State of Alaska, for the sole use of the State Medical Board." But the proposed language is cleaner.

11. Revise 08.64.331(a) - delete present (7) and replace with new (7), to wit: 08.64.331(a)(7) impose a fine not to exceed $10,000; or (new 8) impose one or more of the sanctions set out in (1)-(7) of this subsection.

Comment: Though likely to be used by the board infrequently it is a useful tool to have available especially in dealing with sociopaths. In such cases arranging for the malefactor to in effect pay for board expenses incurred in pursuing the matter seems both just and sensible. Collecting such fines in selected cases also reduces the burden on the vast majority of licensees and permittees who would continue to practice competently and within the law even if the board were not to exist.

12. Revise 08.64.336(b) to read: A hospital that places a consultation requirement upon, revokes, suspends, restricts, conditions, or refuses to grant hospital privileges to a person licensed to practice medicine or surgery or osteopathy in this state (because that person poses a danger to the public) shall report to the board the name and address of the person and the reason for restricting, revoking, suspending, conditioning or refusing to grant hospital privileges or for placing upon the practitioner a consultation requirement. This shall occur in all cases except those instances where the sole and only cause for taking adversive action was failure of the practitioner to complete hospital records in a timely manner or failure to attend staff or committee meetings. It shall also occur whether the action taken was agreed to voluntarily by the practitioner or not.

Revise 08.64.336(c) to read: Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and upon (a finding of reasonable cause) a finding that reasonable cause exists to believe the practitioner may constitute a danger to the health and welfare of his/her own patients or the public, may appoint a committee of three qualified physicians to examine the licensee and report their findings to the board.

Add 08.64.336(e) to read: Nothing in this section shall preclude the board from invoking the provisions of 08.64.331(c) if deemed necessary.

Add 08.64.336(f) to read: Immunity. A physician, hospital or hospital committee (who) which, in good faith, makes a report to the State Medical Board under this section or (who) which participates in board investigations or judicial proceedings related to the submission of reports under this section, is immune from any civil or criminal liability which might otherwise be incurred or imposed.

Add 08.64.336 (g) to read: Evidence not privileged. Neither the physician - patient privilege nor the exclusion of a hospital staff, governing body or hospital committee from compliance with Administrative Procedures Act Public Meetings Section [44.62.310(d)(4&5)] shall be grounds for excusing the failure to submit a required report under this section or for excluding evidence presented to the board or in a judicial proceeding arising wholly or partly out of the submission of such a report.

Comment: We are finding that hospital administrators, staffs, and committees and individual practitioners, fearful that a reported physician will initiate civil suit, have tended to adopt a very narrow interpretation of what they are required to report. They argue that either the action taken isn't restriction or refusal to grant privileges (but rather a conditioning, consultation requirement, suspension or revocation) or that the practitioner involved could be said (usually by liberal interpretation) not to be endangering his/her patients or the public.

To obviate the problem we propose requiring all actions be reported except for minor actions involving delinquent medical records or failure to attend meetings (these actions tend to be automatic and a minor tool used by hospital staffs to prod members into carrying out day to day functions). It creates more work for us but give greater assurance that we will hear of problems. In general physicians and hospital staffs suspect incipient problems before they come to public notice so we need an effective way of tapping into the resource. To do so we need to remove discretion from hospital staffs and thus insulate them from torts. The additional protection offered by 08.64.336 (f & g) should further insulate those who report and hopefully make them more willing to come forward - the idea is drawn from the Child Protection Statute AS 47.17.

Given sovereign immunity (which should clearly apply in this situation), the state does not take on the liability shed by the individual physician or hospital staff. AS 08.64.336(e) is added to block a potential loophole...if egregious misconduct is involved , we don't wish to be esstopped by a requirement to filter the matter through an appointed committee, etc., with resultant delays, if the matter may result in serious harm or death.

13. Add a new section 08.64.337 Power of the Board to Command Appearance. The board shall have the authority to require a licensee or permittee under its jurisdiction to appear before the board to answer questions about his/her licensure status, prohibited acts, allegations or impairment or incompetence or other matters at the board's discretion. The requirement to appear shall be in writing with assured service. The reason for the appearance shall be stated in writing and shall be a part of the permanent record. Where possible, the decision to require appearance will be voted on by the whole board; between board meetings, it shall be the responsibility of the chairperson, in consultation with the Assistant Attorney General assigned to this function and with the concurrence in writing of two other board members, to determine that sufficient cause exists to command appearance of a licensee or permittee.

Failure of a licensee or permittee to appear before the board when commanded to do so shall constitute grounds to impose disciplinary sanctions under 08.64.326(a)(8) and 08.64.331.

Comment: We may use this once in five to ten years, but it should obviously be available if someone decides to thumb his or her nose to the board. Curiously, we have no authority to require anyone to appear at present or so the Attorney General's office informs the board. Obviously, we aren't barbarians and we will, of course, ask first, then try to persuade and only as a final recourse command.

14. Add a new section 08.64.338 Power of the Board to Command an Examination. The board shall have the authority to require a licensee or permittee under its jurisdiction to submit to a medical and/or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board to make such an examination at board expense and submit his/her findings to the board. Submission of biological specimens advised by the appointed examiner shall be considered an intregal part of the required examination.

The requirement to submit to an examination shall be in writing with assured service. The decision to require such an examination shall be by vote of the whole board in official session and shall be taken after consultation with the Assistant Attorney General assigned to the function to determine that sufficient cause exists to command an examination.

Failure of a licensee or permittee to submit to an examination, in whole or in part, when commanded to do so shall constitute grounds to impose disciplinary sanctions under 08.64.320(a)(8) and 08.64.331.

Comment: From time to time in various ways the board becomes aware of practitioners who are medically or psychiatrically impaired or suffering from substance abuse problems [or the board has strong reason to believe such is the case on medical grounds]. Unless these practitioners are reported to the board under 08.64.336 or come to public attention by harming someone we are apparently (under present rules as interpreted by the AG's office) prevented from effectively investigating the matter much less trying to intervene. The board, at its last meeting, heard of three such cases and was effectively prevented from taking any action. The power to order an examination, though less than an assurance that we will be successful in these situations, may go a long way to either solving individual problems or inducing "voluntary cooperation."

ALASKA STATE MEDICAL BOARD

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

November 3, 1986

Dear Alaska Physician:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

T. L. Conley

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

TLC:ts

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CITIZENS COALITION FOR TORT REFORM

PRIORITY

Representative John Sund
Judiciary Committee, Alaska State House
PO Box V
Juneau, Alaska 99811

Feb 2, 1987

Representative Sund,

On behalf of the Coalition for Tort Reform I would like to advise you of our very strong support of HB70, An Act relating to the State Medical Board; and amending Rule 510(d) of the Alaska Rules of Evidence. We respectfully request your assistance in moving this important legislation through the system as rapidly as possible. We believe this will do much in establishing important consumer trust in the medical profession.

We have reviewed this legislation very carefully and find that it directly addresses many of the concerns of the Coalition. As you know we are a broadly based coalition of statewide associations and consumer groups concerned with the continuing liability insurance crisis. Last year we focused on reform of the state tort laws. Our agenda is far broader. We are very supportive of efforts, such as HB70 because it addresses related components of this serious socio-political problem.

We look forward to listening in on your committee hearings this week and hope you will allow the Coalition an opportunity to testify on insurance reform as well as other issues this year.

I believe you have met our new Executive Director, Ric Davidge. We wish to emphasize our desire to work closely with you during this legislature.

Best wishes,

Al Tamagni
Chairman of the Board

738 H Street, Suite 100 • Anchorage, Alaska 99501 • (907) 276-1135

An Overview of State Medical Discipline

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

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

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

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

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

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

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

LITTLE RISE IN BOARD RESOURCES

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

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

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

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

INSPECTOR GENERAL'S ROLE

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

From the scandals involving fraudu-

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

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

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

The study took place between July 1985 and March 1986 and involved visits to 14 states, where we met with medical board officials and many others, including representatives of medical societies, hospitals, and peer review organizations (PROs). We also had telephone discussions with medical board directors in another ten states, and met with representatives of the American Medical Association, the Federation of State Medical Boards (FSMB), the American Association of Medical Colleges, the Educational Commission for Foreign Medical Graduates, and other major national organizations concerned with medical licensure and discipline. Altogether, the states we visited or had telephone discussions with account for 72% of the physicians licensed in the United States.[1]

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

OTHER FORCES INFLUENCING BOARDS

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

Foreign Medical Graduates

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

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

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

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

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

Changed Public Perception and Malpractice

In recent years, public perception about the adequacy of board disciplinary actions has shifted. Newspaper exposés have berated boards for not better protecting the public. Headlines scream, "Doctor Sued 14 Times, But No State Hearing," (*Chicago Tribune*, May 10, 1982, p1) and "Doctors Practice While Wheels Turn" (*Detroit Free Press*, April 1, 1984, p 11a). (The *Detroit Free Press*' examination was a particularly extensive one. It led to a seven-part report published between April 1 and 8, 1984.) This has placed a lot of pressure on boards to examine their practices.

The editor of the *New England Journal of Medicine*, Arnold S. Relman, MD, expressed this view in a March 1985 editorial: "All the evidence suggests that most if not all the States have been too lax—not too strict—in their enforcement of medical professional standards."[3]

The public is also frustrated with the length of time that due process takes, and blames boards for "dragging their feet" on cases. As one high-level official noted, "The public perceives that bad doctors shouldn't be practicing medicine, but we must give these doctors due process. Not everyone understands this."

Physicians' status in society has also been eroding, partially as a result of the liability crisis as it relates to malpractice claims. Many Americans' view of physicians has shifted from reverence to questioning. Indeed, a large number of patients who feel they have been wronged by physicians have been willing to litigate in increasing numbers,

with higher dollar awards made by courts and the skyrocketing cost of liability insurance. All of this has put renewed pressure on state medical boards to "weed out" bad doctors.

Organizational Changes

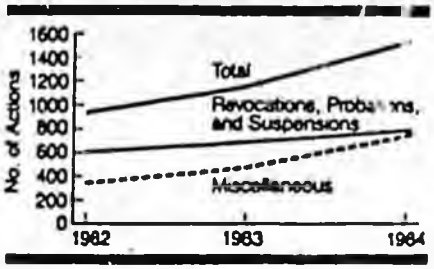
Boards have experienced other significant changes in recent years in addition to rising work loads greater than the resources to deal with them. Both the organizational structure and size of boards have changed. While in 1969, only 16 boards were housed under the aegis of a central agency, currently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

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

STATE BOARDS' RESPONSE

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

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



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

Incidence of Disciplinary Actions

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

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

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

Types of Violations

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

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

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

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

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

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

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

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

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

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

Source of Disciplinary Actions

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

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

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

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

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

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

Information Sharing

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

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

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

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

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

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

CONCLUSION AND RECOMMENDATIONS

We have shown how boards have been confronted with increased work loads, inadequate financial support, and many conflicting pressures. Yet, their ability to act as necessary is predicated on their resource level. Accordingly, we believe physician license renewal fees should be set at a level sufficient to support expansion and improvement of the enforcement activities of the boards. (A recent report by the Public Citizen Health Research Group called for an increase in annual physician renewal fees to at least $500, "with all of the money going to identification and discipline of doctors who are incompetent or otherwise practicing bad medicine."[1]) These fees should be dedicated to board activities and not be diverted to general revenue funds. At the end of 1985, the average annual renewal fee rose to $51, a level that barely kept pace with inflation in the 1980s.

Of the issues previously addressed, the boards' inability to help abate the flood of malpractice cases is the most troublesome. In recent years, the small increases in funding made available to boards have often been made with the expectation that boards would help stem the tidal wave of cases. Some of the recent initiatives have been noted; however, without doubt, the public's expectations have been rising much faster than boards have been able to respond.

Medical malpractice that is not rectified is a twofold problem for American society. Clearly, the safety and well-being of patients seeking medical care is threatened when incompetent physicians remain in practice—however large or small their numbers. (We believe that the current level of litigation overrepresents the number of physicians who perform negligently. Not all physicians who are sued for malpractice are guilty of negligence or misconduct, in our opinion. However, it is important to eliminate poor practitioners through disciplinary action, whenever possible.) Additionally, all patients pay higher prices due to the escalating cost of premiums and awards and the defensive medicine practiced to minimize the likelihood of successful malpractice suits. Many observers also believe that incompetent physicians also unnecessarily add billions of dollars annually to the nation's health expenditures.

In a speech read before the American Medical Association on Feb 21, 1986, Otis R. Bowen, MD, the first physician to be the Secretary of Health and Human Services, made it clear that the development of an effective system of medical discipline is crucial to a resolution of the nation's malpractice problem:

> We cannot expect Americans to endorse any solution to the malpractice issue unless we address the central question of the physician's responsibility. If we ignore the "bad apple" in our profession, then we contribute to the malpractice problem. We then do not deserve any legislative relief.

For boards to play an important part in addressing this problem, it is clear that there must be substantial changes in the legal ground rules governing their handling of malpractice cases. The fear of being sued has had a chilling effect on reporting of incompetence. Perhaps states should consider ways to limit the liability of those making good-faith referrals at the same time that they create affirmative legal duties to report professional misconduct or incompetency. No less clear than the chilling effect of potential litigation is the fact that the resources available to boards must be increased. At present, most boards lack sufficient resources to devote serious attention to such cases without jeopardizing their other disciplinary and licensing responsibilities. We are hopeful that an increase in renewal fees, which boards are allowed to keep, could help eliminate this problem.

We in the federal government can provide some help in improving medical discipline efforts without undermining the central state role in this arena. One form of assistance we can provide is to assure more affirmative action within our own domain. That is, we can help ensure that PROs and Medicare carriers provide more extensive and timely reporting to state medical boards of cases involving physician misconduct or incompetence. In fact, based on our report, Secretary Bowen has directed that regulations and instructions intended to foster this objective be developed.

Another potentially significant form of federal assistance is represented by the Medicare and Medicaid Patient and Program Protection Act (HR 1868), passed by the US House of Representatives in 1985 in response to concerns about physicians being sanctioned in one state and then moving their practice to another state. Parallel legislation (S 1323) is now being considered in the US Senate and is widely supported. (The Medicare and Medicaid Patient and Program Protection Act failed to be enacted by the 99th US Congress, but we expect it to be reintroduced in this upcoming session.)

Passage of this legislation would close many existing loopholes, facilitate more efficient sanctioning by DHHS, and promote more extensive and effective sharing of disciplinary action among the states and DHHS. It would provide a much-needed vehicle for fostering (1) further and more timely reporting of disciplinary actions to a central clearinghouse, (2) more extensive nationwide distribution of information on such actions, and (3) more consistent definitions of the type of violations committed by physicians. This last issue is important when one considers that currently there is total reciprocity among states for licensing, but not for disciplinary decisions.

The federal government's reliance on state medical boards to provide the front line of protection for millions of Medicare and Medicaid patients creates an important stake in the improvement by the individual state regarding state medical discipline. A spirit of partnership involving federal and state government and the medical profession is vital if we are to accelerate and sustain progress in this direction.

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State Medical Discipline: Defects and Hindrances

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

See also p 820.

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

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

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

between the US Department of Health and Human Services and the states, foster improvement in the centralized reporting and distribution of disciplinary action information, and stimulate more consistent definitions of violations.

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

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

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

As fundamental as the recommendations made by Kusserow et al are, it should be noted that other specific steps are called for. Mandatory reporting to boards exists in one form or another in all but three of the licensing jurisdictions responding to a federation survey.[8,9] Though mandatory reporting should be broadened to include more sources of information in a number of jurisdictions, it is a clear-cut trend. However, enforcement of mandatory reporting has been less than adequate and should be improved. Obviously, liability protection should be offered those reporting to boards in good faith. Forty-two licensing jurisdictions report having some such form of protection now.[8,9] It should be provided in all jurisdictions for all good-faith reporting, not simply that required by law. Board members, board staffs, and others serving the boards should be provided legal immunity and indemnification for good-faith actions taken as a result of their board responsibilities. Efforts must also be made at the federal level to provide effective protection from federal suits to board members performing their duties in good faith under state law as well as to those engaged in good-faith peer-review activities.

These points made, it must be emphasized that Kusserow et al deserve congratulations for their fresh documentation and restatement of the challenges facing the state boards. The federation is encouraged that responsible federal officials have listened so attentively to the boards and have gained an appreciation of the difficulties with which the boards deal on a daily basis. In the long run, this clearer understanding must contribute to improving the environment in which the boards function.

The success of efforts to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of the state boards. These can only come from state legislatures willing to act responsibly. The appeal of Dr Colwell in 1913, the work of the federation and the boards over 75 years, the concerns of the public and the media, and the recommendations of the authors all come back to the same critical point. Those who sit in the legislatures of the various states must recognize that the effective regulation of medical practice is in their hands. The work of the state medical boards will always be a direct reflection of the will and purpose of the state legislatures.

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ACTION KIT

JANUARY 1987

ANTITRUST IMMUNITY FOR HOSPITALS AND PHYSICIAN PEER REVIEWERS

HOSPITAL LAW CHAPTER: AIDS

P.L. 99-660 Sec. 401 et seq.

cc: Towell HAA Exec Committee

FEB 3 1987

The Health Care Quality Improvement Act of 1986

A major new federal law known as the Health Care Quality Improvement Act of 1986 can radically change — for the better — the credentialling and quality management programs of every hospital in this country.

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

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

IMMUNITY PROVISIONS

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

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

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

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

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

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

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

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

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

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Due Process Hearings — New Care Needed

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

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

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

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

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Liable For Radiation Therapy Service

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

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

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

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

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

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

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

The record also showed that the X-ray department was located on the main floor of the defendant h[illegible] In order to reach it, plaintiff and other outpatients had to enter through the hospital's main entrance, proceed through its lobby, turn right down a main corridor and pass through a set of swinging doors labeled "X-ray Department." These doors also bore the names of Dr. Greenberg and his associates and the designation "Department of Radiation Therapy."

The same X-ray department served both inpatients and outpatients, and appointments for radiation therapy for both types of patients were ultimately scheduled by the same technician who was employed by Dr. Greenberg. There was no dress code or other manner by which patients or the general public could differentiate employees of Dr. Greenberg's group from other employees in the hospital.

The trial court granted the defendant hospital's motion for summary judgment. The plaintiff appealed that decision.

The Illinois appellate court ruled that even where there is not an actual agency relationship, hospitals may be held liable for the acts of independent physicians practicing on the premises. The court then noted that several other states have adopted the "apparent agency" doctrine to preclude the entry of summary judgment under circumstances where a person, like the plaintiff, goes to a hospital, which holds itself out as a full service institution offering a range and variety of services such as radiation treatment, under the assumption that such services are, in fact, being provided by the hospital. These decisions, said the court, "have been based upon the presumption that when a person goes to a full service

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Improvement Act of 1986 cont'

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

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

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

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

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

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

REPORTING REQUIREMENTS

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

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

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

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

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

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

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

How To Take Advantage Of The Act

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

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

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

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

CONTINUED ON PAGE 4

Due Process Hearings — (cont.)

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

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

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

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

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

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

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

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

Therapy Service (cont.)

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

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

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

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

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

Advantage Of The Act (cont.)

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

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

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

ACTION-Kit for hospital law is written by members of the firm of Horty, Springer & Mattern, P.C.

JOHN HORTY, editor

ERIC SPRINGER • LINDA HADDAD • BARBARA BLACKMOND • DAN MULHOLLAND • JIM McMANUS • CHARLOTTE JEFFERIES • CAROL COLABRESE • HENRY CASALE • MARIANNE MULROY • PAUL VERARDI • MARGARET BARKER, Manager • BARBARA GETZ, Circulation

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(7)

HOUSE COMMITTEE REPORT

Date referred: 2/20/87

FURTHER REFERRALS: Finance

DATE: 3-9-87

The Judiciary Committee has considered HB 70

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

RECOMMENDS:

[✓] replace with CSHB 70(Judiciary) [✓] the same title
[ ] a new title

[ ] attached amendment(s)

[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[✓] same as previous fiscal note published 2/20/87
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

Chairman's signature

STATE OF ALASKA
THE LEGISLATURE

POUCH V · STATE CAPITOL
JUNEAU, ALASKA 99811
907·465·3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H. JUD.	3-9-87	1:30p.m.
H. JUD	3-5-87	1:30p.m.
H. JUD	2-24-87	1:30p.m.

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 24, 1987

SUBJECT: Amendments to CSHB 70 (L&C)

TO: Representative John Sund

FROM: Edward H. Hein EH
Legislative Counsel

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

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

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

EHH:mkr
m9/047

Enclosures

5-0291Ba
Hein

A M E N D M E N T

Offered in the HOUSE By Sund

TO: CSHB 70(L&C)

Page 1, after line 9:

Insert a new bill section to read:

"* Section 1. AS 08.01.065(a) is amended to read:

(a) Except as provided in AS 08.64.315, the [THE] department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter and for real estate brokers and salesmen under AS 08.88."

Renumber the following bill section accordingly.

Page 1, line 12:

Delete "An"

Insert "To the extent that appropriations are available for the purpose, and notwithstanding the requirement of AS 37.07.080(e) that approval of the Office of the Governor is required, an"

Page 1, after line 16:

Insert a new bill section to read:

"* Sec. 3. AS 08.64.101 is amended to read:

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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

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

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

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

(6) hire an executive director and necessary staff;

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

Renumber following bill sections accordingly.

Page 2, after line 2:

Insert a new bill section to read:

"* Sec. 8. AS 08.64.315 is amended to read:

Sec. 08.64.315. FEES. The board [DEPARTMENT] shall set fees [UNDER AS 08.01.065] for each of the following:

(1) application;

(2) license by examination;

(3) license by endorsement or waiver of examination;

(4) temporary permit;

(5) locum tenens permit;

(6) license renewal, active;

(7) license renewal, inactive;

(8) license by reexamination."

Renumber following bill section accordingly.

Page 2, after line 22:

Insert a new bill section to read:

"* Sec. 10. AS 08.64 is amended by adding a new section to read:

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

Renumber following bill sections accordingly.

Page 2, line 27:

Delete "this"

Insert "<u>the</u> [THIS]"

Page 3, line 2, after "privileges.":

Insert "<u>A hospital shall also report to the board the name and address</u>

of a person licensed to practice medicine and surgery or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital."

CS For HB 70 (Judiciary)

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office.

Section 1 requires that to the extent possible and despite AS 37.07.080(e), which prohibits transfers between appropriations without legislative authority and transfers between line items without the governor's approval, one half of the amount of fees collected by the state for medical licenses, permits, and applications during the previous two calendar years shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board. The two-year average is specified because the department renews all licenses at the same time. This will prevent a yearly imbalance of appropriations, i.e., a large appropriation one year followed by a small appropriation the next. ~~The appropriations will be made~~

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

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

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

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

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

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

Section 8 rewrites the statute relating to inactive medical licenses. Current law requires that a licensee must reside outside the state in order to obtain an inactive license. As rewritten, a licensee's residence would be irrelevant. The only criterion would be whether the licensee practices

in the state. If the licensee does practice in the state, no matter how infrequently, the licensee must hold an active license.

Section 9 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a).

Section 10 is a housekeeping measure to remove the term "surgery" from statute. Surgeons do not hold separate licenses from other physicians.

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

Section 12 adds to current law a requirement that a hospital that revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.
The hospital must also report the name and address of a physician if that physician resigned while under an investigation that could have lead to a restriction, suspension, condition, etc.
This section also clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a practitioner is a danger to the health or welfare of the public or the practitioner's patients." This section also specifically authorizes the board to suspend the licensee's license before appointing the committee or before receiving the committee's report.
Finally, this section adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Section 13 adds a new statute. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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Section 13 adds a new statute. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board

expense, and may include tests requested by the examining physician.

Section 14 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that unless the identity of a patient would be revealed, a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings. The amendment includes, however, that the court may decide it necessary to reveal the identity of a patient in order to serve justice.

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

CHANGES MADE TO CS HB 70 (L&C) IN JUDICIARY CS

1. Gave the Board the power to set licensing fees instead of the Department. (Sections 1 and 9)

2. Made appropriations to the Board subject to availability and despite AS 37.07.080(e), which prohibits transfers between appropriations without legislative authority and transfers between line itmes without the governor's approval. (Section 2)

3. Allowed payments made annually to the Board to be calculated on a biennial basis. This is to conform with the renewal policy of the division in which all licenses are renewed at the same time. (Section 2)

4. Added to the Board's duties the power to hire an executive secretary and necessary staff and to contract out an impaired medical professional program for licensees with substance abuse problems. (Section 3)

5. Required the Board to check all applicants through the Federation of State Medical Boards disciplinary data bank. (Section 4)

6. Made the department responsible for setting the license renewal date. (Section 7)

7. Took "surgery" out of the bill as a housekeeping measure. (Sections 11 and 13)

8. Required the board to report all disciplinary action to the Federation of State Medical Board data bank. (Section 12)

change 9. Defined "consultation requirement" to mean "requirement of peer review of the patient orders." (Section 13)

10. Added that a hospital must report the name and address of a physician to the Board if that physician resigned while under an investigation that could have led to a result that requires reporting under AS 08.64.336. (Section 13)

11. Deleted subpoena power - Sec 13

12 added privacy of records Sec 14 interview

5-0291L

Original sponsors: Sund, Koponen,
Taylor and Zawacki

Stein
3/10/87

del. to Sund

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

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

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

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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

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

(4) after a hearing, impose disciplinary sanctions on

persons who violate this chapter, or the regulations or orders of the board;

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

(6) hire an executive secretary and necessary staff;

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

* Sec. 3. AS 08.64.200 is amended by adding a new subsection to read:

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

* Sec. 4. AS 08.64.210(b) is repealed and reenacted to read:

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

* Sec. 5. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 6. AS 08.64.255 is amended to read:

Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licensure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in person by at least one member of the board before a license will be issued. The interview must [SHALL] be recorded. If [, AND, IF] the application is denied on the basis of the interview, the denial must [SHALL] be stated in writing, with the reasons for it, and the record must [SHALL] be preserved.

* Sec. 7. AS 08.64.311 is repealed and reenacted to read:

Sec. 08.64.311. LICENSE RENEWAL. The department shall establish

license renewal dates. Licenses shall be renewed biennially, unless the commissioner, by regulation, provides for more frequent renewals.

* Sec. 8. AS 08.64.313 is repealed and reenacted to read:

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

* Sec. 9. AS 08.64.331(a) is amended to read:

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

(1) permanently revoke a license to practice;

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

(3) censure a licensee;

(4) issue a letter of reprimand;

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

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

(B) limit practice to those areas prescribed;

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

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

(7) <u>impose a civil fine of not more than $10,000; or</u>

<u>(8)</u> impose one or more of the sanctions set out in <u>(1) - (7)</u> [(1) - (6)] of this subsection.

* Sec. 10. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR

INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the board determines that the person has been restored to reason.

* Sec. 11. AS 08.64 is amended by adding a new section to read:

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

* Sec. 12. AS 08.64.336 is repealed and reenacted to read:

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

(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or imposes a consultation requirement on, a person licensed to practice medicine or osteopathy

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

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

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

safety to the person's patients or to the public, the board shall initiate action to suspend, revoke, limit, or condition the person's license to the extent necessary for the protection of the person's patients and the public.

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

(f) A physician or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 13. AS 08.64 is amended by adding a new section to read:

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

* Sec. 14. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

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

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

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

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

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

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336, other than information that would

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

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

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

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

Adopted CS 3/9 +3 Amds

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5-0291L
Hein
3/6/87

Original sponsors: Sund, Koponen,
Taylor and Zawacki

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

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

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

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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

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

(4) after a hearing, impose disciplinary sanctions on

persons who violate this chapter, or the regulations or orders of the board;

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

(6) hire an executive secretary and necessary staff;

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

* Sec. 3. AS 08.64.200 is amended by adding a new subsection to read:

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

* Sec. 4. AS 08.64.210(b) is repealed and reenacted to read:

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

* Sec. 5. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 6. AS 08.64.311 is repealed and reenacted to read:

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

* Sec. 7. AS 08.64.313 is repealed and reenacted to read:

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

* Sec. 8. AS 08.64.331(a) is amended to read:

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

(1) permanently revoke a license to practice;

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

(3) censure a licensee;

(4) issue a letter of reprimand;

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

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

(B) limit practice to those areas prescribed;

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

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

(7) impose a civil fine of not more than $10,000; or

(8) impose one or more of the sanctions set out in (1) - (7) [(1) - (6)] of this subsection.

* Sec. 9. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the

board determines that the person has been restored to reason.

* Sec. 10. AS 08.64 is amended by adding a new section to read:

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

* Sec. 11. AS 08.64.336 is repealed and reenacted to read:

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

(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or requires peer review of the patient orders of, a person licensed to practice medicine or osteopathy in the state shall report to the board the name and address of the person and the reasons for the action. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a

requirement of peer review of the person's patient orders. A report is required under this subsection regardless of whether the person voluntarily agrees to the action taken by the hospital. A report is not required if the sole reason for the action is the person's failure to complete hospital records in a timely manner or to attend staff or committee meetings.

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

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

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

(f) A physician or hospital may n t refuse to submit a report under this section or withhold from the board or its investigators

evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 12. AS 08.64 is amended by adding a new section to read:

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

* Sec. 13. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

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

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) Crime or Fraud. If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone

to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

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

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

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336.

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

(7) Criminal Proceeding. For physician-patient

communications in a criminal proceeding. This exception does not apply to the psychotherapist-patient privilege.

* Sec. 14. AS 08.64.260(b), (c), and (d) are repealed.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM March 7, 1987

SUBJECT: AS 08.64.336(e) in CSHB 70 (Jud)

TO: Representative John Sund
Chairman, House Judiciary Committee

FROM: Edward H. Hein EHH
Legislative Counsel

Under AS 08.64.336(e), which appears at page 5, lines 23 - 27 of CSHB 70 (Judiciary), a physician, hospital, or hospital committee that submits a report required under AS 08.64.336(a) or (b), or that participates in an investigation or judicial proceeding related to the report, could not be held liable civilly or criminally for submitting the report or for participating in the investigation or judicial proceeding. The only exception is if the submission of the report or the participation in the investigation or proceeding was done in bad faith, i.e., falsely.

This provision makes it clear that a physician or hospital that complies with its statutory duty to report certain information to the board cannot be sued for doing so. This provision is intended to encourage reporting by people who might be reluctant to do so for fear of being sued, even though they are required by law to do so.

AS 08.64.336(e) is very similar to AS 18.23.010(a). That provision makes any person immune from civil liability for furnishing any information to the State Medical Board or other "review organization", unless the person knew or should have known that the information was false.

EHH:csh
c7/083

5-0291La
Hein

Adopted

AMENDMENT #1

Offered in the HOUSE

By Sund/Cotton

TO: CSHB 70(Jud)

Page 4, lines 20 - 21:

Delete "requires peer review of the patient orders of"

Insert "imposes a consultation requirement on"

Page 5, line 1:

Delete "requirement of peer review of the person's patient orders"

Insert "consultation requirement"

Page 5, line 6, after "meetings.":

Insert "In this subsection "consultation requirement" means a restriction placed on a person's existing hospital privileges requiring consultation with a designated physician or group of physicians in order to continue to exercise the hospital privileges."

Adopted #2

A M E N D M E N T

Offered in the House By Gruenberg

To: C S. for HB 70 (Judiciary)

Page 7, line ~~15~~, following "AS 08.64.336" delete: "." and insert: "other than information that would establish the identity of a patient unless the court finds that it is necessary to admit such identifying information in order to serve the interests of justice."

A M E N D M E N T

3/9/87

Offered in the HOUSE Judiciary Committee By ~~AAG Peter Ferchlich~~ Ed Ford

TO: CSHB 70(L&C)

Page 1, line 21 ← page 2, line 9

Delete new AS 08.64.101(6) and (7) and substitute the following:

* Sec. 2. AS 08.64.101 is amended by adding a new subsection to read:

(b) The department may, after consultation with the board,

(1) hire an executive secretary; and

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

Page 2, line 11:

Delete "board" and insert "department."

#3 Cotten Adopted

Page 2, line 20:

Insert new Sec. 6 to read:

* Sec. 6. AS 08.64.255 is amended to read:

Sec. 08.64.255. INTERVIEW REQUIRED. All applicants for licensure must [A LICENSE UNDER AS 08.64.250 SHALL] be interviewed in person by at least one member of the board before a license will be issued. The interview must [SHALL] be recorded. If[, AND, IF] the application is denied on the basis of the interview, the denial must [SHALL] be stated in writing, with the reasons for it, and the record must [SHALL] be preserved.

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 5, 1987

SUBJECT: Amendment to HB 70, State Medical Board bill

TO: Representative John Sund
Chairman, House Judiciary Committee

FROM: Edward H. Hein EHH
Legislative Counsel

Enclosed is the CS draft requested for you by Shari Kochman. At her request I am explaining why I have retained the amendment to AS 08.01.065 that I recommended in amendments dated 2/24/87 and that appears in Sec. 2 of the CS.

The clause "To the extent that appropriations are available for the purpose," has been inserted to avoid the argument that this section unconstitutionally attempts to restrict the legislature's power to appropriate.

The second clause, "and notwithstanding the requirement of AS 37.07.080(e) that approval of the office of management and budget is required," is needed to clarify that the requirement of this section applies regardless of whether OMB approves. Without this language, this section conflicts with AS 37.07.080(e).

If, after reviewing this memo, you still wish to delete these two clauses, please let me know and I will change it.

EHH:csh
c7/078

Enclosure

5-0291L
Hein
3/5/87

Original sponsors: Sund, Koponen,
Taylor and Zawacki

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 70 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

* Section 1. AS 08.01.065(a) is amended to read:

(a) Except as provided in AS 08.64.315, the [THE] department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter and for real estate brokers and salesmen under AS 08.88.

* Sec. 2. AS 08.01.065 is amended by adding a new subsection to read:

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

* Sec. 3. AS 08.64.101 is amended to read:

Sec. 08.64.101. DUTIES. The board shall

(1) examine and issue licenses to applicants;

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

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

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

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

(6) hire an executive secretary and necessary staff;

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

* Sec. 4. AS 08.64.200 is amended by adding a new subsection to read:

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

* Sec. 5. AS 08.64.210(b) is repealed and reenacted to read:

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

* Sec. 6. AS 08.64.220(a) is repealed and reenacted to read:

(a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

* Sec. 7. AS 08.64.311 is repealed and reenacted to read:

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

* Sec. 8. AS 08.64.313 is repealed and reenacted to read:

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

* Sec. 9. AS 08.64.315 is amended to read:

Sec. 08.64.315. FEES. The board [DEPARTMENT] shall set fees [UNDER AS 08.01.065] for each of the following:

(1) application;

(2) license by examination;

(3) license by endorsement or waiver of examination;

(4) temporary permit;

(5) locum tenens permit;

(6) license renewal, active;

(7) license renewal, inactive;

(8) license by reexamination.

* Sec. 10. AS 08.64.331(a) is amended to read:

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

(1) permanently revoke a license to practice;

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

(3) censure a licensee;

(4) issue a letter of reprimand;

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

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

(B) limit practice to those areas prescribed;

(C) continue professional education until a

satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

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

(7) impose a civil fine of not more than $10,000; or

(8) impose one or more of the sanctions set out in (1) - (7) [(1) - (6)] of this subsection.

* Sec. 11. AS 08.64.332 is repealed and reenacted to read:

Sec. 08.64.332. AUTOMATIC SUSPENSION FOR MENTAL INCOMPETENCY OR INSANITY. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication of a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the board determines that the person has been restored to reason.

* Sec. 12. AS 08.64 is amended by adding a new section to read:

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

* Sec. 13. AS 08.64.336 is repealed and reenacted to read:

Sec. 08.64.336. DUTY OF PHYSICIANS AND HOSPITALS TO REPORT. (a) A physician who professionally treats a person licensed to practice medicine or osteopathy in this state for alcoholism or drug addiction,

or for mental, emotional, or personality disorders, shall report it to the board if the physician providing treatment feels that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice. The report shall state the name and address of the person and the condition found.

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

(c) Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and, upon a finding that there is reasonable cause to believe that the person who is the subject of the report is a danger to the health or welfare of the public or to the person's patients, the board may appoint a committee of three qualified physicians to examine the person and report its findings to

the board. Notwithstanding the provisions of this subsection, the board may summarily suspend a license under AS 08.64.331(c) before appointing an examining committee or before the committee makes or reports its findings.

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

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

(f) A physician or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310.

* Sec. 14. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.337. SUBPOENA POWER. For the purposes of an investigation under this chapter, the board may issue a subpoena to, administer or cause to be administered an oath to, and examine or cause to have examined the parts of the books, papers, and records of a person to whom the board has issued a license or permit or to a person the

board reasonably believes has information relevant to the investigation. The superior court, on application of the board, shall enforce the attendance and testimony of witnesses and the production and examination of books, papers, and records.

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

* Sec. 15. Rule 504(d) of the Alaska Rules of Evidence is amended to read:

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

(1) Condition and Element of Claim or Defense. As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

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

(3) Breach of Duty Arising Out of Physician-Patient

Relationship. As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

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

(5) Required Report. As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336.

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

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

* Sec. 16. AS 08.64.260(b), (c), and (d) are repealed.

5 March 87

Dear John,

After discussing the teleconference with the Medical Board and subsequently the Alaska State Medical Association the following is suggested:

) Section 13

AS 08.64.336 (b) [Page 5 of Judiciary CS for HB 70] lines 4-10 ... to grant hospital privileges to, [or requires peer review of the patients orders of] or limits previously granted privileges of, a person ...

and lines 17-18 ... hospital privileges, [or in the imposition of a requirement of peer review of the person's patient orders.] or in the imposition of limitations on previously granted privileges.

AS 08.64.336 (f) [Page 6 of Judiciary CS for HB 70]. Add new sentence at line 23: The board shall hold such reports confidential and they shall be non-discoverable unless and until the board shall issue a final order of disciplinary action under AS 08.64.331(b)

Section 14

AS 08.64.338 [Page 7 of Judiciary CS for HB 70] Line 6:

"... under this chapter, and on a finding of reasonable cause, the board..."

[This is a request from ASMA for language that will help to reassure the board doesn't act in an arbitrary & capricious fashion and is fine with us - indeed we are enjoined in various other sections from so acting.].

Section 15

Rule 504(d)(5) of the Alaska Rules of Evidence. [Page 8 of Judiciary CS for HB 70] Line 15:

We would support insertion of language requiring the deletion of patients names from such reports if not materially necessary to the case.

During my absence from 5 March to 16 March George Rhymer M.D in Anchorage has agreed to serve as liason and will be available to testify if needed. His address is 3340 Providence Dr / Suite 552 / Anchorage 99508. Phone contact is

(day) 662-2211 + ask operator to page.
Alternate day number 561-3211. Home
number 694-9600.

Again thanks for all the help.
All think of you all while Jim skiing ...
but maybe not too often.

Peace
Tom

JEFF Partnow
FBI

Rm 11
St Bernard
Lodge
Taos Ski Valley

Questions to answer on HB70

Dr. Conley:

1. Amendment #1: Problem making Medical Board only board in Division exempt from the Department setting fees.

2. Amendment #4: Same problem as in #1.

3. Amendment #3: Problem with board having authority to hire staff and that position of executive director doesn't exist. Change to executive secretary, which Nursing Board hires, and approval is subject to the Division.

Sister Barbara:

1. Amendment #7: How to define investigation. It must be an investigation that resulted in a consultation requirement, revocation, suspension, condition, restriction or refusal of hospital privileges. But does that restriction come after or before investigating. If after, then how do we define investigation.

2. Need definition of consultation requirement. - need panel need peer approval of orders patient

Ed Hein:

1. Grant immunity to treating physicians for reporting a patient physician's drug, alcohol, etc. problem. Give immunity to members of hospital peer review group. Use Health Care Quality Improvement Act of 1986 as guideline. Just state in statute "in compliance with the Health Care Quality Improvement Act of 1986."

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

APR 15 1987

April 8, 1987

Representative John Sund
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John:

I got word yesterday that House Bill 70 passed the House by a unanimous vote. The news was very gratifying.

I would again like to thank you for all hard work and the many hours you and your staff have spent on this bill. I will continue to be available as the bill moves into the Senate and will contact Senator Hensley's office tomorrow to make myself available for whatever committee hearings, etc. are deemed necessary for it's passage.

Again many thanks. Your efforts are very much appreciated. A particularly thanks to Shari and Howard for all the work that they have put in on this plus doubtless other members of your staff who are working behind the scenes.

Sincerely,

Tom

Thomas L. Conley, M.D.
Chairman

TLC:ts

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

APR 18 1988

April 15, 1988

Honorable John Sund
PO Box V
Juneau, Alaska 99811

Dear Representative Sund:

The State Medical Board would like to urge your support of SB 501 which would place the board's Executive Secretary in the partially exempt service.

It was assumed at the time of the passage of HB 70 creating the executive secretary position last year that it was a partially exempt one and such was reflected in the fiscal note. Unfortunately the specific language wasn't in the bill proper.

The board went through a time consuming and moderately expensive process of screening, interviewing and choosing an incumbent for the position. The potential evident in the candidate we selected has proved out and by dint of involving herself in extensive training she is at the point of becoming a really effective board administrator. This is particularly important as we prepare to launch the impaired physician program. The development of the program has been primarily her responsibility and the board is looking forward to her direction of it as it is implemented.

Unfortunately, since the position is not listed as partially exempt, the best that could be done was to make the position a temporary classified one that will shortly have to be readvertised. Given lay-off preferences we might well loose a now trained and effective executive. In the short run that will set the board back almost a year.

More importantly in the long run, the precedent of having the board's executive not serve at the pleasure of the board has significant potential for vitiating the effectiveness of the position. Mutual trust and a community of interest between the board and its executive is a must and it therefore seems logical that the position should be a partially exempt one.

Your support of this effort would be greatly appreciated. The board and I will be happy to answer any questions you might have on the matter.

Sincerely,

Thomas L. Conley, MD
Chairman

TLC:ts

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 17, 1987

SUBJECT: Sectional analysis of HB 70, relating to the State Medical Board

TO: Representative John Sund

FROM: Edward H. Hein
Legislative Counsel

Section 1 requires that the amount of fees collected by the state for medical licenses, permits, and applications during the previous calendar year shall be allocated by the Department of Commerce and Economic Development for the following fiscal year to the division of occupational licensing to be used for services provided to or on behalf of the State Medical Board.

Sec. 2 requires that applicants for medical license examinations submit their applications to the State Medical Board 120 days before the examination date, rather than 40 days before the examination date.

Sec. 3 eliminates oral examinations for licenses to practice medicine or osteopathy.

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

Sec. 5 amends the statute relating to disciplinary sanctions by allowing the board to impose a civil fine of $10,000 or less if the board finds that a licensee has committed an act set out in AS 08.64.326(a). These acts are: (1) securing a license through deceit, fraud, or intentional misrepresenta-

tion; (2) engaging in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities; (3) advertising professional services in a false or misleading manner; (4) having been convicted of a felony or other crime substantially related to the licensee's qualifications, functions, or duties, or a crime involving unlawful procurement, sale, prescription, or dispensing of drugs; (5) having procured, sold, prescribed, or dispensed drugs in violation of law; (6) intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards, even if the patient was not injured; (7) failing to comply with the provisions of AS 08.64, or a regulation or order of the board; (8) demonstrating professional incompetence, gross negligence, or repeated negligent conduct, or addiction to drugs, or unfitness because of physical or mental disability; (9) engaging in unprofessional, lewd, or immoral conduct while serving a patient; (10) performing an abortion (A) without a license; or (B) outside of a hospital or other facility approved by the Department of Health and Social Services or a federal hospital; or (C) on an unmarried minor without consent of the minor's parent or guardian; or (D) on a woman who has not been in the state for at least 30 days before the abortion; (11) violating any ethical code regulation adopted by the board; (12) denying care or treatment to a patient or person seeking treatment solely because the patient or person fails or refuses to agree to arbitrate under AS 09.55.535(a); or (13) having had a medical license or certificate suspended or revoked in another state, U.S. territory, or Canadian province, unless the suspension or revocation was for failure to pay fees.

Sec. 8 adds to current law a requirement that a hospital that places a consultation requirement on, revokes, suspends, or conditions a licensee's hospital privileges (as well as restricting or refusing to grant hospital privileges) report that fact to the board and explain the reasons for the action. This report is required even if the licensee voluntarily agrees to the action. A report is not required if the only reason for the hospital's action was the licensee's failure to complete hospital records on time or failure to attend staff or committee meetings.

Sec. 9 clarifies that the reasonable cause necessary to authorize the board's appointment of three physicians to examine a licensee is "reasonable cause to believe that a

practitioner is a danger to the health or welfare of the public or the practitioner's patients". This section also specifically authorizes the board to suspend the li ensee's license before appointing the committee or before receiving the committee's report.

Sec. 8 adds two new subsections to the reporting law, AS 08.64.336. Subsection (e) provides immunity from civil and criminal liability for submitting a report or participating in an investigation of a licensee in good faith. Subsection (f) provides that the confidentiality of the physician-patient relationship and the psychotherapist-patient relationship is not grounds for refusing to submit a report, nor is the fact that the matter that is required to be reported was the subject of a meeting that was exempt from the public meeting law.

Sec. 9 adds two new statutes. AS 08.64.337 gives the medical board subpoena power and the power to administer oaths for purposes of an investigation of a licensee. AS 08.64.338 allows the board to order medical and psychiatric exams of a licensee under investigation by the board. The exams are at board expense, and may include tests requested by the examining physician.

Sec. 10 amends the Alaska Rule of Evidence pertaining to the physician-patient and psychotherapist-patient testimonial privilege. The amendment provides that a report submitted to the medical board under AS 08.64.336, and matters reasonably raised by the report, are not covered by the privilege in judicial proceedings.

Sec. 11 repeals provisions relating to license examinations to reflect the board's current examining practices.

EHH:mkr
m9/018

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 98111

February 18, 1987

Representative John Sund
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John,

Please find enclosed the proposed amendments to HB70 we discussed. After much consideration I elected to delete the amendment calling for ordering of re-examination in cases of suspected "intellectual" incompetence due to considerations of the complexity of the matter and the need to hear from all respondents before proceeding.

As you know wide-ranging, general, written exams (generally either the FLEX exam or an even more comprehensive three part exam offered over a period of years to most all U.S. medical students / post graduate fellows referred to as the National Board of Medical Examiners Test) are required at the point of initial licensing in whatever jurisdiction that occurs. This is appropriate as one needs a good overview of the whole discipline before specializing in its sub-branches. It is however questionable how appropriate it would be to require such an exam of someone who has been in specialty practice for many years if his/her competence were to be questioned. One could for instance be well qualified in cardiology and be unable to appropriately manage complicated obstetrics or orthopedic-subjects on which a general exam demands knowledgeable responses.

Perhaps the answer is to let the board tailor its choice of an appropriate re-examination of an individual suspected of incompetence in a purely medical sense (as opposed to psychiatric, physical or substance abuse generated incompetence) to the individual case. Various specialty exams are available for this purpose but the logistics are complicated.

The Medical Board faces sunset this year and legislation re-authorizing it for (probably) four years is due to be introduced at a latter date. Most likely, pending further thought and input from a number of sources, it would be best to hold on this area for now and if deemed a solid proposal submit such as a rider on that legislation.

I'm very impressed with and appreciative of the speed with which HB70 is moving and would do nothing to hinder it; thus I think this area is one to hold off on for now till mature judgment can be brought to bear.

As you know the board has given considerable thought to the impaired physician question. In addition to wishing to set up a monitored treatment program for licensees under board supervision (i.e. those who come to board attention) it is desired by having the program in place to encourage individuals to voluntarily enter such programs before coming to board notice. Such creates somewhat of a problem in that part of the purpose of the program for voluntary referrals would be vitiated if the individuals were reported to the board.

Thomas L. Conley, M.D. *Chairman* 3612 Tongass Avenue, Ketchikan, Alaska 99901

The FSMB publication "A Guide to the Essentials of a Modern Medical Practice Act" suggests that those conducting such a board approved program should be exempt from the mandatory reporting requirements relating to impaired physicians (voluntarily) participating satisfactorily in the program.

I bring the subject up to query if we need such language or whether we can depend on the present 08.64.336(a) which requires a physician who professionally treats another physician for alcoholism or drug addiction to report to the board if "the physician providing treatment feels that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice." I actually think I'm bringing up the question to answer it if the subject arises. The language would seem to give us the necessary authority to write regulatory provisions for treatment programs to ensure reporting of the individual who voluntarily enters a monitored treatment program and then relapses. Thus this also seems an area to hold on to permit the bill to go forward.

Sincerely,

Yours

Thomas L. Conley, M.D.

TLC/mm

ALASKA STATE MEDICAL BOARD
Pouch D
Juneau, Alaska 99811

January 22, 1987

Representative John Sund
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear John,

Please find enclosed the proposed changes to the Medical Board Bill I spoke to Howard about today (they were messaged up to him in rough form via Legislative Affairs this morning). Subsequent to contacting Howard, I discovered that though Ed Hein in his memo concerning the draft copy stated that he had included deletion of 08.64.260 (b) (c) &(d) it did not appear in the draft so I have included it with the proposed changes.

The addition of language to the new subsection 08.01.065 (d) [Ibelieve it must be (d) rather than (e) since the present 08.01.065 has only subsections (a) through (c)] stating that fees shall be set by the board is designed to prevent future problems. At present our relations with the department and division are excellent so that there should be no difficulties in getting fees set in such manner as to support adequate functioning, including hiring of an Executive Director, etc. However the players change over time and the board could find itself facing hostility to its functioning in the future as it has on occassion in the past. One way this hostility could be played out would be for the division to set fees below the level necessary for the board to function adequately. I recognize this sounds somewhat paronoid but our experience supports the contention that the problem can exist. Thus rather than leaving things to the mercy of personalities it seems better to set it in law relying on the wisdom of the admittedly somewhat artificial concept that the "rule of Law" is perferable to "rule of individuals".

Of course the argument can cut both ways and I won't argue that in past power struggles between the board and the division that the board has had a monopoly on virtue. However it is clear that physicians around the state are indeed willing to pay higher fees to support an effective licensing activity and it would thus be a shame to see the effort thwarted at some future point by internicine squabbling.It's a touchy business I realize, for it does indeed increase the power of a subsidiary activity of the Division of Occupational Licensing. To be able to accept that with grace and equanimity requires a mature and self-confident division administrator and I don't think we can rely on always having such a person in the position. Fortunately at this critical junction we do.

The proposed additions to AS08.64.101 are designed to formalize in law two critical means by which the board hopes to carry out its function. While it might be argued that the duty and authority to do these things is implicit in the legislation it seems on balance better to state them explicity. That we need a day to day administrator to carry out board policy and supervise enforcement is abundantly obvious to the board members and is in no way an extravagant move. Moreover as the funds to achieve such will come from those regulated it will not be a drain on the state's budget at a time of economic decline.

T.L. Conley, Chairman * 3612 Tongass Avenue, Ketchikan, AK 99901 * (907) 225-5146
5144

The authority to set up an impaired professional's program by contractual arrangement has been discussed before, AS08.64.101 (7) formalizes this. Funding will be via charges to the licensee requiring the services except for the administrative aspects which will derive from fees.

Deletion of AS08.64.260 (b) (c) and (d) is justified by changes in the FLEX exam, a standardized national exam, that as of 1985 is a two part rather than a three part exam.. Details of the comparison and application of the two exams are tedious. After prolonged consideration the State Medical Board promulgated regulations 12AAC40.020 (a-h) to cover the subject. AS08.64.260 (b) (c) and (d) are in conflict with these as they refer to the old examination. They are applied in connection with prior regulations under 12AAC40.020 when considering examinees who took the FLEX prior to May 18, 1985. The three part FLEX is no longer available from the Federation of State Medical Boards. In future it would probably be best to leave close details such as interpretation of tests that change from time to time in regulation rather than statute for obvious reasons.

When I spoke with Howard today, he mentioned you had some hesitancies about AS08.64.336 (e) & (f) the provision covering immunity for those reporting to the board in good faith. Our experience suggests this is a critical element in the revisions and the lack of such assurances is the principal cause of our failure to hear about infractions and incidents and patterns of malpractice. Just before talking to Howard I got a call asking for advice about how to handle just such a situation wherein the medical staff of one of the state's hospitals wishes to deny renewal of privleges to two physicians on the grounds of incompetence and a pattern suggesting malpractice. They were told that the hospital, whose governing board has the final say in such matters (something of which many people are unaware), would not accept their recommendation because the hospital would then be obliged to report such and feared civil suit for so doing. During the last year I have gotten five calls of similar nature concerning variants of the same problem.

Enclosed I have also sent you a copy of a Federation of State Medical Boards publication entitled Essentials of a Modern Medical Practice Act. I would particularly direct your attention to Section XII, Compulsory Reporting and Investigation. It may be a little broader than one may care to enact (for instance one could interpret it to imply that an offending physician is required to report himself which is likely impractical and may offend concepts of self incrimination) but is gives food for thought. It does advise that penalties should be established for demonstrated failure to report which may be an excellent idea. It may also be a good idea to require reporting in the circumstance that a physician resigns from a hospital staff while under investigation regarding privleges, etc.

Finally we are somewhat in confusion as to how to manage and fund the transition period from our present way of conducting business to that which we would hope to have on line next year if the legislation passes. At present physicians licenses are issued for four years and are next due to expire on 12/31/88. Thus the bulk of fee income comes to the state in December every fourth year with only a trickle from new licenses and temporary licenses between those times.

Thus being funded at the fee income level of 1987 will not permit us to do even the present inadequate job in 1988. In our original proposal we called for annual renewal so we could adjust fees in such manner as necessary to meet expenses.

What might work would be to change the expiration date of licenses now in force to 12/31/87, collect the renewals in Nov/Dec '87 and thus have the funds to function in 1988. Thereafter we would advise renewal be annual or at the most every two years. To do this we probably need authority in law.

Again thanks for all your help and support in the effort and good luck this session. I suspect we are either going to get it together as a state this year and emerge with much greater maturity or we are going to be in a world of hurt. I'm particularly pleased by the idea of getting a statement of minimum funding by joint resolution sometime in March. It should let local governments and school districts budget more rationally and force the issue of what we are going to be willing to pay for locally.

Sincierly,

Thomas L. Conley, M.D.

TLC/mm

P.S. Dave Johnson here and George Brenneman of our board from Anchorage feel the first sentence of AS08.01.065 (d) should start "An amount at least equal to ...". The argument is that it forstalls quibblers who want to cause difficulties due to minor mismatches of funds and permits a fall back position if the economy goes completely gunny-sack and the board has to be run at some minimal level during times of financial disaster.

Amend AS0864.336 (b) to add a new line at line 28, to wit:

27 ...refusing to grant hospital privileges. Additionally a person licensed to practice medicine or surgery or osteopathy in this state who resigns his/her hospital staff privileges while under investigation by a hospital or committee thereof shall be reported to the board. A report is required...

Amend 08.64.338 to add new language at line 16, to wit:

15 ...examining physician or practitioner. If a licensee fail to submit to an examination when properly directed to do so by the board the board may enter a final order of license revocation upon proper notice, hearing, and proof of refusal.

(In other words, failure to submit to an exam under such circumstances is cause for license revocation)

Add new section:

AS 08.64.335 Actions reported. All actions taken under AS 08.64.331, AS 08.64.332 and AS 08.64.334 above and denials of licensure under AS08.64.240 shall be expeditiously reported to the Federation of State Medical Boards for inclusion in the nationwide Disciplinary Data Bank.

(We have to this point interpreted our mandate as permitting this as such knowledge is in the public domain after the board acts. However sending the material to other agencies unsolicited could be interpreted as actively "publishing" such information. It could perhaps be argued as grounds for a claim against the state. Paranoid of me no doubt. The more important reason for adding the section is actually simple statement of intent.)

Finally as we discussed, there should be some sanction placed on failure to report as required under AS 08.64.336. Clearly we have authority in this regard vis-a-vis physicians via licensing action. We have no jurisdiction over hospitals so writing a sanction into AS08.64 for hospitals that fail to report seems neither proper nor practical. What this should consist of (misdemeanor, civil fine, etc.) and where in the state code it should be placed I would leave to your good offices and that of legislative affairs. I do think it is an important matter as hospitals may decide it more expeditious to risk noncompliance with a law without sanctions than the entanglements of reporting.

The previous recommendations for amendments to AS 08.01 are hereby also appended for completeness. Notice our additional line on AS 08.01.065 (d). Note also the division requests we substitute the designation executive secretary for executive director.

AS 08.01.065 (c) should be renumbered AS 08. 01. 065 (d) and should be rephrased to read:

d) An amount equal to the amount of fees collected for applications, licenses, and permits under AS08.64 during the previous calender year shall be allocated each year by the department for services provided to or on behalf of the State Medical Board by the Division of Occupational Licensing. These feels shall be set by the State Medical Board consistent with its statutory obligations.

AS 08.64.101 is Amended by adding two new subsections to read:

6) In consultation with and under the existing rules of the Division of Occupational Licensing to hire an Executive Secretary for the board and provide such administrative, secretarial, and investigative staff as shall prove necessary to ensure effective functioning of the activity. Financial support for the necessary positions shall derive from fees set by the board under AS 08.01.65 (d).

7) The board shall have the authority to enter into contractual arrangements with existing private professional organizations to set up an effective Impaired Professionals program to deal with physicians and members of other regulated groups displaying problems with abuse of addictive substances.

Delete AS 08.64.260 (b), (c), and (d). AS 08.64.260 (a) should remain unchanged.

AS08.01.065 (e) should be renumbered AS08.01.065 (d) and should be rephrased to read:

(d) An amount equal to the amount of fees collected for applications, licenses, and permits under AS08.64 during the previous calender year shall be allocated each year by the department for services provided to or on behalf of the State Medical Board by the Division of Occupational Licensing. These fees shall be set by the State Medical Board consistent with its statutory obligations.

AS08.64.101 is Amended by adding two new subsections to read:

6) In consultation with and under the existing rules of the Division of Occupational Licensing to hire an Executive Director for the board and provide such administrative, secretarial, and investigative staff as shall prove necessary to ensure effective functioning of the activity. Financial support for the necessary positions shall derive from fees set by the board under AS08.01.65 (d).

7) The board shall have the authority to enter into contractual arrangements with existing private professional organizations to set up an effective Impaired Professionals program to deal with physicians and members of other regulated groups displaying problems with abuse of addictive substances.

Delete As08.64.260 (b), (c) and (d) .

AS08.64.260 (a) should remain unchanged.

ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
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