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FOCUS ON ...

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STATE OVERSIGHT AND REGULATION OF PHYSICIANS

EDITOR'S NOTE: Concern over both the quality of health care and the rising incidence and cost of medical malpractice litigation is causing states to strengthen their oversight and regulation of physicians. In this issue of FOCUS ON ... Rhona S. Fisher, senior research associate at IHPP, examines the more than 100 laws relating to physician competence and discipline that were enacted by the state legislatures in 1987 and 1988. In addition to an analysis of trends, the report includes a map showing the distribution of laws and a state-by-state summary of the laws. 'Anne T. Robinson, an intern at IHPP, provided research assistance. Research for this project was made possible, in part, by support from the Health Resources and Services Administration.

States, showing increasing concern with the quality of medical care, are starting to zero in on problems involving the country's 500,000 licensed and practicing physicians. Since 1987, 44 state legislatures have enacted more than 100 laws to help assure quality medical care by strengthening their oversight and monitoring of physician behavior.

Quality problems in the services doctors deliver can stem from any number of deficiencies -- from poor practice habits to inadequate training to physical or mental impairments. According to a recent Office of Technology Assessment report on quality,[1] the general grounds for physician discipline are unprofessional conduct or professional incompetence. Most often, such conduct involves fraud, illegal acts or the inability to render medical care safely. The specific grounds that are the basis for disciplinary actions against licensees are set by state medical practice acts. Many states in recent years have seen fit to expand the types of conduct for which doctors can be disciplined.

Authority to license or restrict medical licensure also lies with the states. By expanding the powers of state medical boards, stepping up physician licensure requirements, adding protections for peer reviewers and toughening requirements for hospital reporting, states hope to rid their systems of bad medical care and reduce malpractice problems. (See Exhibit 1 for distribution of state laws and Exhibit 2 for state-by-state summaries of 1987 and 1988 laws.)

Comprehensive Reforms

FLORIDA, MARYLAND and ILLINOIS are good examples of how states are adding teeth to their physician licensure and quality assurance regulations. Through a series of broad tort reforms enacted in February and again in late

June, FLORIDA has taken a tough stand on physician competence.[2] A newly established Division of Medical Quality Assurance within the Department of Professional Regulation is empowered to use whatever resources and make whatever efforts are necessary to investigate and discipline physicians guilty of unprofessional conduct... "in order to take forceful corrective measures to assure quality medical care throughout the state." To do this, eleven professional boards were created within the new division and given broad authority to train investigators, conduct investigations, require reporting on malpractice and disciplinary actions from licensed health facilities and discipline physicians. A total of 89 new positions in the division will be supported by $3.4 million, derived mainly from a trust fund generated from licensure fees collected by the state.

The new FLORIDA law allows the division of medical quality assurance to enter into agreements with the state professional society of physicians to reviews complaints referred to the division and prepare confidential reports of its findings. However, the division must rule on the basis of its own independently prepared evidence and supporting expert opinions.

Disciplinary actions available in FLORIDA include denying, revoking or suspending a doctor's license, imposing administrative fines, issuing reprimands or imposing probation with requirements for further professional training, supervision or treatment. In what may be a trend to crack "the brotherhood of silence" -- professionals who look the other way when mishaps and/or incompetence occur -- the state will require nurses to report physician misconduct to the division or risk disciplinary actions similar to physician sanctions.

MARYLAND has also reorganized its licensure responsibilities this year through the creation of a new state board to license and discipline doctors. To be known as the Board of Physician Quality Assurance, the new entity will replace the part-time system of physician discipline that had primarily used volunteer physicians from the state medical society. Under the new law, unethical or incompetent doctors would be investigated more thoroughly, quickly and aggressively. In 1987, the existing medical licensing commission received 800 complaints but only disciplined five doctors. It also had a backlog last year of more than 700 cases.

Claiming that the 11-member commission was overworked and understaffed, MARYLAND Governor Schaefer sponsored the plan. The new law provides for hiring full-time investigators and hearing officers to handle complaints. The state medical society will continue to offer expert opinion but will no longer conduct investigations. Funds for the new MARYLAND law for FY 1989 will total $446,633. Projections for the next two fiscal years include budget increases of approximately $200,000 per year, though the increases are subject to review by the legislature to see if the new quality assurance board is doing its job. With this in mind, the law requires annual legislative reports on board actions and also stipulates disposition of all claims within one year or a report giving reasons for the delay. MARYLAND has also beefed up physician sanctions. The new law will automatically suspend doctors convicted of crimes of immorality and allows for permanently revoking a physician's license.

Last year ILLINOIS replaced a 1923 law with the Medical Practice Act of 1987. The new statute updates licensure requirements to practice medicine in the state and creates two separate boards to oversee physician activities. A new 9-member board will handle physician discipline while a second 7-member board will continue to regulate licensure. The law identifies increased reporting requirements of disciplinary actions to the appropriate board and also increases postgraduate clinical training requirements from 12 to 24 months. It also adds

requirements for physicians to self-report any disciplinary actions, including voluntarily surrendering medical practice privileges. Finally, the law allows civil fines of up to $5,000 for physician misconduct.

Health Care Quality Improvement Act of 1986

The actions taken in FLORIDA, ILLINOIS and MARYLAND are in part a response to a recent federal law involving physician competency and discipline. The measure (PL 99-660) provides two major tools in support of the peer review process: immunity protections for appropriate reviews and the creation of a national clearinghouse on physician data.

The clearinghouse, known officially as the Practitioner Adverse Credentialing Data Bank, will collect data on malpractice payments, professional disciplinary actions, professional society membership revocations and adverse actions on clinical privileges. Insurance companies, boards of medical examiners and peer review groups will be required to report the information, under penalty of fines. (CALIFORNIA enacted provisions for a similar state-run physician data bank last year. A few other states (e.g., ALASKA) have mandated review of physician applicant records maintained in the nationwide data bank of the Federation of State Medical Boards.)

Once the new federally mandated clearinghouse is operative, licensed hospitals, peer review groups and state licensing boards will have access to the information. In the past, there has been little to keep doctors whose licenses have been revoked or hospital privileges suspended from relocating their practices in another state. The new system, which will legally bind hospitals to check on physicians' professional backgrounds, is designed to prevent doctors with histories of being disciplined from continuing to jump from state to state.

The President's FY 88 budget sought a $2.8 million appropriation to support the clearinghouse; this was also the amount included in a recent House-Senate budget agreement. Cost estimates for the proposed data bank have run as high as $10-$20 million. Target start-up dates range from early 1989 to early 1990. The American Medical Association, which had been actively pursuing the role of data bank administrator, has dropped out of the running. The AMA says there are too many unknowns about the potential cost of managing the bank.

The second part of the federal mandate extends protection to people who provide information to a professional review board regarding the competence of physicians, if they are acting in good faith. Also protected are professionals and others who perform the peer review activities. Seen as a "shield" law to protect physicians from retaliatory suits by angry colleagues unhappy with the peer review process, the federal protection will extend to state courts in 1989.

The immunity issues addressed by the federal quality assurance mandate grew out of a case brought by an OREGON physician, who had charged that members of a local clinic who challenged his professional competence were acting to reduce competition in the small town rather than give an unbiased peer review of his professional skills. The case reached the U.S. Supreme Court, which upheld an earlier ruling in the plaintiff's favor that the clinic's doctors were using the peer review process to limit competition, in violation of anti-trust laws. Also, although OREGON mandates peer review, the Court found that the state at the time was not sufficiently regulating the process to warrant the immunity from liability that the clinic's doctors claimed due them in their actions as peer reviewers, e.g., as quasi-state officials.

Peer Review Initiatives

States have until October 1989 to either accept the federal peer review provisions or reject them in lieu of their own peer review statutes. Last year, WYOMING, TEXAS, NORTH CAROLINA and INDIANA opted for early acceptance of the federal standards; this year KENTUCKY, COLORADO and LOUISIANA did so, and HAWAII is studying whether or not to adopt the federal peer review provisions. In CALIFORNIA, on the other hand, pending legislation (SB 2565) spells out detailed state peer review requirements.

As one of the three states so far this year to specifically adopt the 1986 federal immunity provisions, KENTUCKY mandated that four requirements be met for the federal protections to be effective: 1) the activities must be performed with the reasonable belief that quality care is being promoted; 2) reasonable efforts must be taken in the investigation; 3) adequate notice must be afforded the physician involved; and 4) any actions taken must be supported by reasonable beliefs that the facts support them.

Over the last two years, many states have chosen to amend their existing peer review laws. ALABAMA, FLORIDA, MAINE, TENNESSEE, UTAH, ARIZONA, CALIFORNIA, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, MISSOURI, NORTH CAROLINA, OKLAHOMA, OREGON, WYOMING and VIRGINIA all provide immunity for participants in the peer review process and, in most cases, extend immunity to peer review informants as well.

State Medical Board Initiatives

Licensure of physicians, done under state authority, has historically been based on a written and oral examinations process. In most states, the same body that grants licenses also has the authority to discipline doctors it deems unfit to practice, though a few -- ILLINOIS, for example -- have separate entities. With the advent of a nationally standardized licensing exam for physicians, medical boards no longer find so much of their time taken up with revising and administering licensure exams. This, coupled with increased consumer concerns and the dramatic rise in the number of licensed physicians, has caused many states to reevaluate how to best use the resources of the boards.

Recommendations by Health and Human Services Secretary Otis R. Bowen on changes states can make to reduce the frequency of malpractice actions say that "state licensing boards should be properly staffed, funded and authorized to operate effective disciplinary programs."[3] In this regard, VERMONT has appropriated $40,000 and NEBRASKA $47,000 to support studies of staffing, management and revenue needs of its licensing boards. And as seen earlier, both FLORIDA and MARYLAND legislatures have made substantial monetary commitments to improving the operations of their respective disciplinary boards.

In addition, a number of states have expanded medical board functions to include provisions for more comprehensive investigations. Last year, for instance, GEORGIA enacted requirements for mandatory investigation of licensees who have had a medical malpractice judgement of more than $100,000 as well as in cases where two or more judgments against or settlements have occurred. Similarly, the TEXAS medical board must investigate any physician who has three or more malpractice claims within a five-year period. So far in 1988, ALABAMA, FLORIDA and RHODE ISLAND have beefed up requirements that certain investigations be initiated by their medical boards or its appointed representatives.

Reorganization Many states have redefined the duties and composition of

their state medical boards. For example, under the new **FLORIDA** statute described earlier, board members must receive special training in investigatory procedures. In **VIRGINIA**, medical board membership will consist of one medical physician from each congressional district, four other professional members and two citizen members. **ARIZONA's** 12-member medical board also will include two public members as well as a nurse and nine practicing physicians from at least three counties in the state. **MARYLAND'S** new medical board will be made up of primarily physician members appointed by the Governor. **RHODE ISLAND** reduced the number of board members needed to make up a hearing committee from seven to five.

Impaired Physicians **ALABAMA** splintered the functions of its medical board by adding a special committee, to function under the supervision of the state board for the purpose of identifying, treating and rehabilitating impaired physicians. This later move by **ALABAMA** to establish a specific approach to dealing with impaired physicians reflects a growing concern by states of how to best handle physicians who appear to be in trouble. Rather than take a punitive approach, states are uniformly looking for strategies to rehabilitate and manage physicians suffering from alcohol or drug abuse, mental illness or, in some cases, physical deterioration due to disease or age.

For the most part, states promise confidentiality for physicians willing to undergo approved treatment programs and/or voluntarily restrict medical practice until the state deems their rehabilitation successful. For example, **FLORIDA** enacted rules this year for a recently established impaired practitioners committee that incorporate the aforementioned approach. Physicians are not considered disciplined if they "voluntarily" suspend practice until the state-appointed consultant deems them competent to resume practice. Collusion between a consultant and a physician and/or a treatment provider is a felony charge in this southern state.

ALASKA and **NEW MEXICO** will contract privately for their impaired physician rehabilitation programs. Other states that have recently established impaired physician programs include **ARIZONA, MONTANA** and **NORTH CAROLINA; ILLINOIS, NEVADA, TEXAS, VIRGINIA** and **WASHINGTON**, meanwhile, have revised their sanctioning authority of impaired physicians. For example, **WASHINGTON** allows doctors to choose drug treatment rather than face disciplinary action for drug abuse. Confidentiality is extended to the physician and immunities are provided to those who report practitioners to the program. In another example of stepped up oversight, **VIRGINIA** requires doctors who provide assistance to an impaired physician to report the action to the state licensing board.

Sanctions One of the busier avenues of reform has been in increasing the disciplinary sanction authority of state medical boards. Although all state medical boards have the authority to revoke or suspend a physician's license, the percentage of those who are actually disciplined is, by all accounts, small compared to the number of doctors believed to be professionally incompetent to practice. States vary in their willingness to discipline and in the types of actions they take, largely because of differences in their laws and regulations.

More than a dozen states have strengthened the authority of medical boards to sanction physicians. For example, in **INDIANA**, the state's medical licensing board may impose new disciplinary sanctions. Grounds for sanctioning include: obtaining a license through deceit; engaging in fraud in the course of professional duties; advertising services falsely; being convicted of a crime relating to professional competence; knowingly violat-ing any state or federal statutes relevant to the medical profession; and continuing to practice although unfit

because of incompetence, out-of-date skills, and/or physical or mental disability. Physicians who engage in immoral conduct in the course of services, mishandle drugs or have been disciplined in another jurisdiction may also be disciplined.

The INDIANA law gives discretionary authority to the licensing board to grant probationary licenses that limit areas of practice and require provision of community service, regular reports on the licensee's progress, and/or continuing professional education. In VIRGINIA, a new law will enable a board-appointed audit committee to review practices of disciplined licensees to see if their practice conforms to conditions placed on the physician by the board. PENNSYLVANIA added a civil penalty of up to $1,000 for failure of a physician to disclose financial interest in a facility or service prior to offering it to a patient. ALABAMA and FLORIDA enacted provisions allowing for the immediate suspension or revocation of a physician's license when the public health and safety requires it.

MINNESOTA added fee splitting, kick-backs and other financial advantages as reasons for denial of a license or sanctions. Also, health-related licensing boards in the state are directed to investigate all communications that indicate sexual contact with a patient. A disciplinary conference must be held if there is sufficient evidence to warrant sanctions or other actions. All mandatory reporting by the licensing board must include legislative summaries of each individual case involving sexual misconduct.

Professional Licensure

Another approach to physician oversight has been to tighten licensure regulations, specifically in the areas of renewal, out-of-state applicants and investigations. During the licensure renewal process, states such as COLORADO and ARIZONA will now require physicians to self-report any activity that violates the state's medical practice standards or related disciplinary action.

One area that states are continuing to change is reciprocity of licensure between states. Once a professional courtesy between states, reciprocal licensure is no longer automatic. For example, SOUTH CAROLINA will endorse previous licensure in another state only when certain examination requirements have been met. IOWA, MICHIGAN and WEST VIRGINIA require transfer applicants to be investigated for past disciplinary actions while three other states -- FLORIDA, INDIANA and KANSAS -- tightened restrictions for out-of-state applicants.

States continue to amend the definition of professional conduct in efforts to expand the criteria for sanctions. ARIZONA, for example, has redefined professional misconduct to include unwillingness to submit requested documents to the medical board and making false or misleading statements to the board.

Hospital Regulations

Hospitals are under increasing pressure to improve their scrutiny of medical staffs, in large measure because of new accreditation standards from the Joint Commission on Accreditation of Healthcare Organizations.[4] The regulations, which become effective next year, will require hospitals to set up risk management programs as well as to improve investigations of physicians applying for new or renewed privileges. New standards will require such physicians to report any voluntary relinquishment or reduction of privileges or licenses. This will help close a longstanding loophole that had allowed physicians under the gun to "voluntarily" discipline themselves, skirting requirements to self-report any past disciplinary sanctions.

A number of states, such as VIRGINIA, MICHIGAN, and CALIFORNIA, have included reporting of voluntary resignations or other medical practice limits in recent statutes. The VIRGINIA law also requires hospital staff to report suspected substance abuse or mental illness in a physician as well as any disciplinary actions to the medical board. COLORADO will also require hospitals to report any disciplinary action to suspend, revoke "or otherwise limit" a physician to the medical board. MINNESOTA has taken that a step further, requiring hospital reports to medical boards to include detailed information such as the specific patient record and reasons for the action.

Consumer Rights

Consumers of health care services are beginning to be mandated participants in some states' physician oversight systems. There are two main approaches. The first involves a citizen member serving on the medical board, as seen in VIRGINIA'S reorganization statute. And the second -- adopted by states such as TEXAS, MISSOURI and RHODE ISLAND -- supports public access to information about disciplinary actions. For example, TEXAS requires summaries of disciplinary orders to be made available to the general public and public libraries. Impaired physicians who voluntarily participate in approved rehabilitation programs are excluded from publicly released information. Such is also the case in MISSOURI, which distributes quarterly lists of physicians given license restrictions. RHODE ISLAND also requires public reports on physician discipline actions when the actions result in changes in the physician privileges related to patient quality of care. Clearly, some states recognize consumers' right to know what actions the state deems necessary to take to restrict physicians, in order to select physicians and make other informed health decisions.

Further Comments

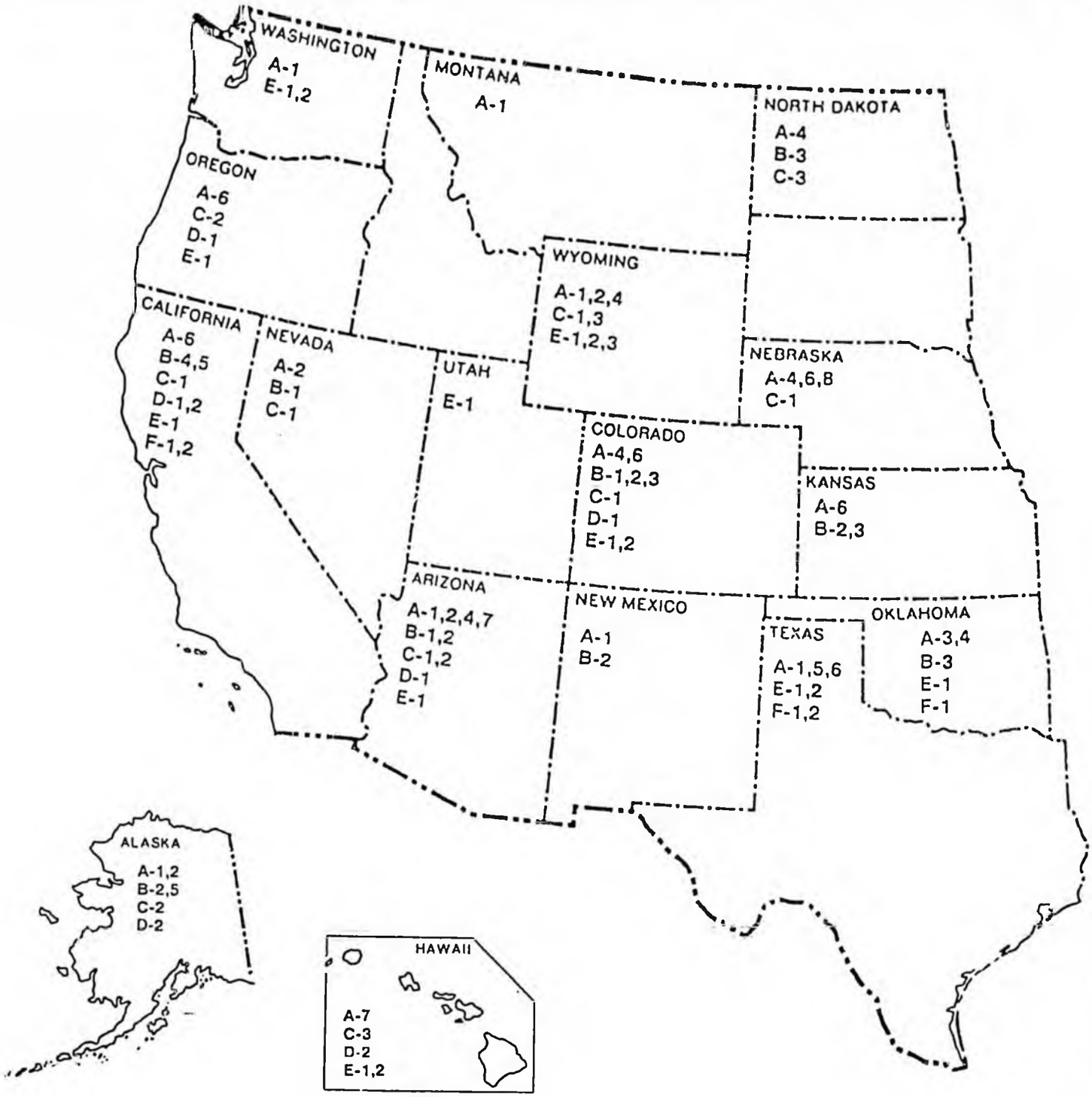
Problems still plaguing state medical boards include the overwhelming administrative backlog of cases to be investigated and reported. The number of complaints continues to rise, and more complex criteria are being utilized in the review process. Although investigative procedures that consume additional resources are being mandated, most boards are being given only marginal increases in funds.

Between 1982 and 1984, the boards saw a 45 percent increase in the number of disciplinary actions taken, although many of these were in the form of "soft sanctions" such as reprimands and censures. These actions may be a practical response to the limited funds and staffing resources of the boards. Certainly, states will continue to reevaluate their licensure and physician oversight practices, particularly in light of new federal requirements to improve reporting and oversight of disciplinary actions.

Will state initiatives on physician competence and discipline have the desired effect of reducing the incidence of physician incompetence and misconduct and, ultimately, eliminating bad doctors? The answer is yes, but only to the extent that states continue to actively support oversight responsibilities through increased funding and beefed up sanction authority.

In addition, medical boards must be willing to exercise sanction authority and to monitor and report on the success of their efforts. Legislatures can continue to pass laws spelling out new grounds for physician discipline but unless everyone involved in delivering health care complies with reporting and review requirements, physician discipline systems will not be able consistently to assure the quality of medical care.

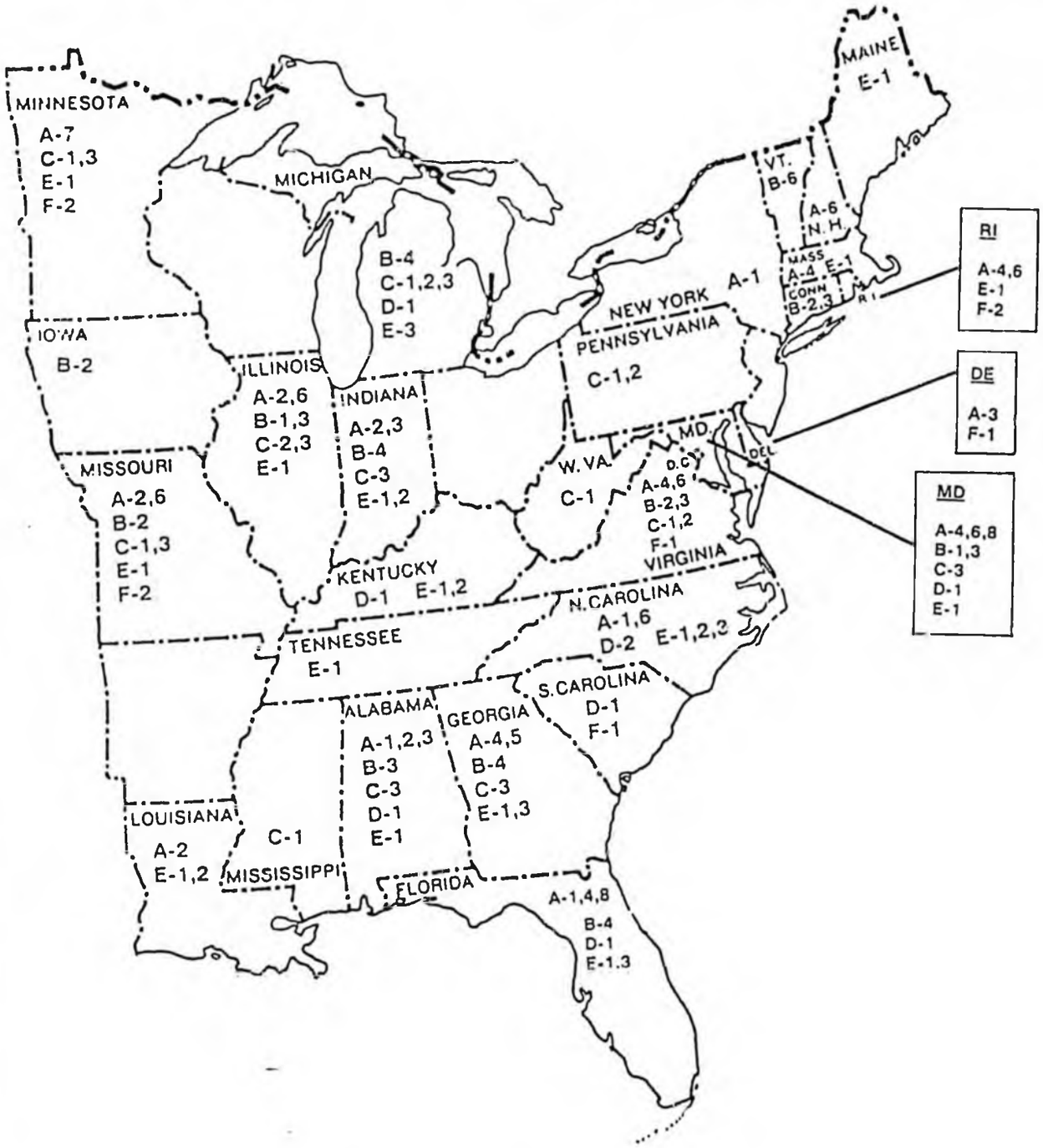
EXHIBIT 1. 1987-1988



A. MEDICAL BOARDS
1. Impaired Physicians
2. Examination Authority
3. Immediate Action
4. Reorganization
5. Mandatory Investigation
6. Reporting
7. Information Exchange
8. Increased Appropriations

B. LICENSURE
1. Self-Reporting
2. Resident Permits
3. Foreign Medical Graduates
4. Reciprocity
5. Data Bank
6. Other

ENACTMENT FEATURES



C. SANCTIONS
1. Unprofessional Conduct
2. Civil Fines
3. Sanctions Redefined

D. REPORTING
1. Medical Boards
2. Data Banks

E. PEER REVIEW
1. Immunity
2. HCQIA of 1986
3. Mandated Review

F. INDIVIDUAL RIGHTS
1. Physicians
2. Consumers

ALABAMA -- HB 163, Act 87-389, 1987 Laws Authorizes the board of medical examiners to suspend or revoke a license when another state licensing board has taken disciplinary action against the licensee.

HB 164, Act 87-775, 1987 Laws Grants authority to the board to evaluate off-shore medical schools and approve only those with substantially equivalent education to that of U.S. schools. The board may then reject or not accept diplomas for licensure from those schools.

HB 283, Act 88-536, 1988 Laws Creates an Impaired Physicians Committee under the supervision of the board. Impaired physicians are defined as those unable to practice medicine with reasonable skill and safety by reason of illness, substance or alcohol abuse or any other physical or mental condition. The committee, to be comprised of physicians, is responsible for the identification, intervention, treatment and rehabilitation of impaired physicians and has the authority to compel a physician to be evaluated. It may contract with providers of treatment programs and must make annual reports to the state board. Immunity is provided to persons who provide information to the committee. Findings of the committee are confidential and not available for discovery or subpoena.

SB 132, Act 88-86, 1988 Laws Allows immediate suspension or revocation of a license by the Medical Licensure Commission. Strengthens the commission's authority to discipline physicians. Prevents judicial stays of disciplinary actions, including licensure suspension or revocation, except if the commission is found to have acted outside of its statutory authority, performed in an arbitrary or capricious manner or acted with gross abuse of its discretion.

ALASKA -- HB 70, Ch.87, 1987 Laws Requires primary financing of the state medical board through licensure fees and allows a one-time assessment on such fees to cover costs of the new positions of investigator and executive secretary. Mandates establishment of an impaired physicians program through private contract to treat practitioners suffering from substance abuse. Mandates review of physician applicants records in the nationwide disciplinary data bank with the Federation of State Medical Boards (FSMB). Offers one year temporary permits to physician residents or interns. Adds civil fines up to $10,000 to the list of sanctions available to the board. Requires the board (also physicians and hospitals) to report all disciplinary action to the FSMB. Authorizes the board to require physicians under investigation to take mental or physical exams, including drug testing, at the board's expense.

ARIZONA -- HB 2014, Ch.135, 1987 Laws Defines the primary duty of the board of medical examiners as protecting the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners through licensure, regulation and rehabilitation. Permits physical and mental exams. Requires CEO, medical director or chief of staff to inform the board when privileges are denied, revoked, suspended or limited or when a physician resigns.

HB 2015, Ch.102, 1987 Laws Provides for the board to establish a program for the treatment and rehabilitation of physicians who are impaired by alcohol or drug abuse. The program will include education, intervention, treatment and post-treatment monitoring and support and may provide services through a contract arrangement with other organizations. A physician identified in need of treatment must agree to certain stipulations or risk probation or other actions by the board.

HB 2085, Ch.117, 1988 Laws Exempts from licensure requirements physicians interns or residents participating in a health care institution's training or approved fellowship program and when proper supervision exists.

HB 2200, Ch.190, 1988 Laws Expands the definition of unprofessional conduct to include failure to provide the medical board with documents on one's medical practice or related activities and making misleading statements on medical board forms or written

correspondence with the board. Requires the board to engage in a full exchange of information with boards of other states. Directs the board to prepare and circulate educational materials that it determines are helpful and proper for licensees. Defines duties of the executive director of the board. Exempts short-term residency participants from licensure, but requires registration. Requires persons renewing licensure to report disciplinary actions or restrictions on licensure by another state or foreign government.

HB 2309, Ch.105, 1988 Laws Amends existing law prescribing disciplinary grounds and sanctions for osteopathic physicians. New grounds for unprofessional conduct include: failure to appear for an informal interview requested by the board unless formally continued; failure to make medical or practice records available; failure to report to the board an osteopathic physician who may be guilty of unprofessional conduct or incompetence; and failure to disclose financial interest in a diagnostic or treatment facility when referring a patient. Allows civil fines up to $500 each for violations. Mandates physical/ mental examination of physicians when required by the board. Stipulates that the examining board may send a "letter of concern" to notify a physician that while insufficient evidence exists to support direct action, there is sufficient evidence for concern. The letter becomes a public document and may be used in future disciplinary actions against the physician. Identifies a decree of censure as an official action against a doctor's license. Allows the board to appoint hearing officers and employ special consultants or other agents to make investigations, gather information, review complaints, prepare reports and undertake other activities. Exempts from licensure requirements osteopathic interns and residents. Changes licensure renewal from yearly to every two years and requires evidence of 20 hours of completed continuing education. Requires institutions to report to the board any evidence of physician misconduct or impairment or risk sanctions by the licensing board. Also requires the board to report all disciplinary actions to facilities where the physician has privileges.

SB 1090, Ch.121, 1988 Laws Renames state peer review statutes to health care quality assurance provisions. Grants immunity for persons who participate in the quality assurance process without malice and makes this a standard to be determined by the court. Exceptions are made in state confidentiality provisions to protect both providers and others involved.

CALIFORNIA -- **AB 782, Ch.1368, 1987 Laws** Grants the division of licensing authority to substitute postgraduate education and training to remedy deficiencies in an applicant's education and training. Requires certification of training by the medical education director.

AB 1956, Ch.1336, 1987 Laws Provides for the imprisonment of any person pretending to be a practicing professional without a certificate or license and who creates circumstances causing or creating risk of great bodily harm to another. Also permits the medical board to issue sole source contracts for the services of medical consultants to assist in its program.

AB 2249, Ch.721, 1987 Laws Creates a central file within the Department of Consumer Affairs of disciplinary actions, public complaints, malpractice awards and criminal convictions for health care licensees. Requires reports on disciplinary actions by medical institutions or societies to be made available to other medical institutions unless the board finds the report is without merit or is more than 3 years old.

SB 231, Ch.1341, 1987 Laws Creates reciprocity for licensed physicians from other states who have graduated from accredited medical schools and meet certain other requirements. Revokes a requirement for taking the written state clinical competency exam.

SB 1620, Ch.1044, 1987 Laws Tightens provisions requiring certain health care providers and peer review bodies to report physician privilege denials or sanctions. Also includes mandatory reporting of any voluntary resignations. Expands on details required in such reports, known as 805 reports, and gives 30 days after the date the sanction takes effect for it to be submitted to the licensing authority. The physician must be given a copy of the complaint and a notice of rights in submitting additional information. An updated report is required when a physician has met any terms of compliance required by the sanctions. Immunities are extended both to those reporting under this chapter and to reviewers.

COLORADO -- HB 1066, 1987 Laws Amends the definition of unprofessional conduct to include two or more acts or omissions that fail to meet accepted standards of practice that may occur in more than one patient or more than one act.

HB 1037, 1988 Laws Provides immunity to participants in peer review functions conducted by facilities licensed or certified by the Department of Health.

HB 1340, 1988 Laws Staggers length of service for medical board membership. Grants the board authority to require foreign medical school graduates to serve three years of postgraduate clinical training, rather than two. Identifies unprofessional conduct as the use or distribution of controlled substances and failure to report any disciplinary action to the board when renewing or seeking reinstatement of a license. Members of the board are granted immunities from civil litigation. The board is required to report annually to the general assembly concerning its activities and progress. The board must report any final disciplinary action within 30 days to hospitals where the disciplined physician has privileges. Supervisors of interns or residents must report any actions that would constitute licensure violations or failure to progress on the part of the physician in training. Requires hospitals to report actions that "otherwise limit" physicians to the medical board and requires physicians to complete a self-reporting questionnaire when renewing licenses. The State Medical Board will be responsible for establishing rules to meet the requirements of the Health Care Quality Improvement Act of 1986 (HCQIA), upon its implementation.

CONNECTICUT -- HB 5001, PA.88-362, 1988 Laws Requires residents or interns to receive a permit to practice in the state, based on recommendation of the hospital administrator. The administrator must certify that the intern or resident has received a degree from an accredited medical school or has been approved by the American medical school liaison committee to participate in clinical programs in the U.S.

DELAWARE -- HB 18, Ch.2, 1987 Laws Permits the medical board to temporarily suspend a license when allegations present a clear and immediate danger to the public health. The physician must receive written notice and be afforded a hearing on the matter.

FLORIDA -- HB 1221, Ch.87-296, 1987 Laws Establishes reciprocity criteria for licensure of faculty-appointed physicians, employed by not-for-profit corporations only. Provides for the incorporation of certain entities for not-for-profit provision of health service, so long as the corporation is not an HMO.

HB 1626, Ch.88-392, 1988 Laws Amends Section 455.26 on the establishment of an Impaired Practitioners Committee comprised of representatives of licensed providers and further defines its treatment and oversight responsibilities. Impairment is defined as substance abuse or mental conditions that affect the physician's ability to practice. Allows the department to designate approved treatment programs and to retain consultants to assist in the identification of impaired physicians. Practitioners who voluntarily submit to treatment and are without other formal complaints of their medical practices are not considered "disciplined" as long as they voluntarily limit their practices and share records with the board. If a physician agrees to withdraw from practice until the consultant determines his satisfactory completion of an approved treatment program, the board will not become further involved in the case. Suspension from a hospital staff is not considered a complaint. Warns against collaboration between consultants, physicians or other providers and makes such actions a felony charge.

SB 6-E and HB 819, Ch.1, 1988 Laws Enacts major tort reforms in the wake of a special legislative session as well as a Governor's commission to study medical malpractice problems. Those provisions that address physician competence and discipline include: 1) establishing a Division of Medical Quality Assurance within the Department of Professional Regulation; 2) providing for regular training of DMQA staff to promote adequate and appropriate medical quality assurance; 3) establishing 11 different professional boards within DMQA, including the Board of Medicine; 4) limiting immunity for good faith participants

in the state-mandated peer review process; 5) mandating that licensed health facilities must provide physician peer review; 6) requiring reporting of final disciplinary actions within 10 days to the DMQA; and 7) mandating quarterly reports by hospital risk management programs to the Department of Professional Regulation on malpractice actions taken against hospital physicians. Applicants for licensure who are under disciplinary investigation in another jurisdiction may not be licensed until the investigation is completed. Grants authority to the DMQA to review actions against physicians and to discipline them, including stopping a physician who is perceived as a danger to patients from practicing medicine until he can demonstrate his ability to practice with reasonable skill and safety. The legislature appropriated $3.4 million for implementation of DMQA provisions.

GEORGIA -- HB 707, Act 795, 1987 Laws Requires hospitals and ambulatory surgical centers to conduct peer review activities. Provides immunities for participants in peer review.

SB 286, Act 545, 1987 Laws Designates a special teaching license for out-of-state physicians to teach at an approved medical school. Mandates board investigations of any physician who has had a) a malpractice award in excess of $100,000 or b) two or more previous judgments or settlements relating to medical practice. Every licensee must report any settlement in excess of $20,000 to the state examining board.

SR 332, 1988 Laws Creates the Senate Health Related Professions Study Committee to analyze conditions, needs and problems of state examining boards and to see if merging Georgia's 16 boards into a single licensing and regulatory body would work better.

SB 367, Act 1365, 1988 Laws Amends the Georgia Code to provide for disciplinary sanctions in cases where a physician fails to properly obtain informed consent for procedures or treatments to be performed.

HAWAII -- Senate Resolution 48, 1987 Laws Requests a study to review peer review laws and procedures, for the purpose of making recommendations for meeting the HCQIA requirements. Recommends that the state opt for early compliance with the federal mandate.

SB 442, Act 67, 1987 Laws Requires the licensure board to cooperate with any federal, state and county agency seeking information about physician licensure and sanctions. All disciplinary actions by the board, including denials, as well as voluntary actions must be reported to central national data banks, state associations and, on request, to health facilities.

HB 3068, Act 325, 1988 Laws Extends immunity from civil liability to participants in peer review programs.

SB 2794, Act 110, 1988 Laws Amends provisions for disciplinary actions to include a) actions taken by a federal agency and b) actions that limit medical privilege.

ILLINOIS -- SB 243, PA.85-0004, 1987 Laws Creates the Medical Practice Act of 1987; repeals the law enacted in 1923. Updates licensure requirements to practice medicine and provides immunity from liability for participants in internal quality control. Creates a 9-member disciplinary board and a 7-member licensure board. Identifies entities required to report disciplinary actions. Stipulates conditions under which professionals may advertise. Permits physical or mental examination of license applicants. Increases postgraduate clinical training requirements from 12 to 24 months and grants visiting professor permits. Applicants must voluntarily report all disciplinary actions, including surrender of privileges. Impaired physicians may have a license suspended immediately, pending a hearing within 15 days of the suspension. Allows civil fines up to $5,000.

INDIANA -- HB 1702, 1987 Laws Provides for the immunity of persons providing information to peer review committees. Where the peer review activities meet the standards of the HCQIA of 1986, the protections of that act are extended to participants.

SB 516, 1987 Laws Grants the licensure bureau a 90 day period in which to investigate applicants for renewal of licensure. Allows limitations on probationary licenses, so that disciplinary actions taken are appropriate. The medical licensing board may consider renewal of a license that had previously been surrendered voluntarily. Identifies criteria for consideration of probationary licensure, including disciplinary actions in another state.

SB 2, PA.88-152, 1988 Laws Applies a new chapter to medical licensing and licensure of other health professionals. Licensing boards may conduct disciplinary hearings and order a practitioner to submit to physical or mental exams. The boards may permanently revoke or suspend a practitioner's license, or censure, reprimand or place the professional on probation. They may also suspend a license for 90 days during the review process under threat of clear and immediate danger to public health and safety. A revoked license may not be reinstated for seven years. Subject of disciplinary action may be responsible for costs. Applicants for licensure, certification or registration through reciprocity may be subject to examination.

IOWA -- HB 346, 1987 Laws Limits time period for temporary licenses to one year and makes them nonrenewable.

KANSAS -- HB 2643, 1988 Laws Prohibits using information obtained through peer review in any judicial or administrative hearing other than certain licensing and disciplinary actions taken by the state. Makes employees of institutions for the mentally ill and mentally retarded responsible for complying with the state's existing requirement to report incidents of substandard care to the appropriate licensing agency.

HB 3034, 1988 Laws Reviews provisions for temporary licenses to out-of-state applicants coming to complete education and training programs. Such licenses are valid up to one year, are not renewable and are subject to other restrictions. Foreign medical school graduate applicants must have passed the exam required by the educational commission.

KENTUCKY -- HB 551, 1988 Laws Enacts major tort reform with sections specific to physicians. Application for licensure implies a waiver of any claims for damages arising out of information furnished to a peer review board or committee. Proceedings and recommendations of peer review committees are confidential and not subject to discovery or subpoena. Immunity provisions of the HCQIA are included as part of the state law. Specifies reporting requirements for county boards of health. Grants counties the right to inspect physician offices and issue restraint orders where violations are found.

LOUISIANA -- HB 1712, Act 884, 1987 Laws Allows the medical licensing board to require physical or mental examinations as a condition for licensure and may require disciplined physicians to pay board costs as a condition of probation. Redefines criteria for review of disciplinary actions by the board. Provides protections from civil liability in the case of review of medical practice and disciplinary actions.

HB 1115, Act 689, 1988 Laws Makes activities of peer review committees, including by HMOs, PPOs and other health facilities, confidential and not subject to court subpoena.

HB 1116, Act 690, 1988 Laws Opts for early adoption of Health Care Quality Improvement Act immunity provisions for professional review actions, effective July 1988.

MAINE -- SB 952, Ch.646, 1988 Laws Grants broad immunity from civil liability for physicians serving on ACAH-required peer review committees, utilization review boards or certain other disciplinary committees. Grants immunity to informants acting without malice.

MARYLAND -- HB 179, Ch.660, 1987 Laws Redefines requirements for applicants for licensure, including alternate criteria for graduates of certain foreign medical schools.

SB 1041, Ch.653, 1987 Laws Protects the records of a peer review committee when requested by the Department of Health for review. Records are not subject to judicial discovery or subpoena.

HB 27, Ch.160; SB 305, Ch.138, 1988 Laws Amends health claims arbitration panel law to provide that any actions to nullify or reject an award must be reported to the Maryland Commission on Medical Discipline. SB 305 requires all claims filed with the Health Claims Arbitration Office to be reported to the commission.

SB 508, Ch.109, 1988 Laws Major reorganization of state medical licensure responsibilities. Creates the Board of Physician Quality Assurance to license and discipline doctors. Eliminates the previous, mostly volunteer, physician oversight system. The new disciplinary body will receive a projected $850,000 budget over the next three fiscal years if the board meets the legislature's performance expectations. Requires disposition of complaints to be completed within one year an explanation to the legislature of reasons for delay. Board activities must be reported in detail to the legislature. New positions, which will have increased sanction authority, include assistant attorneys general, investigators and hearing officers. The Governor will appoint the 15-member board: 11 physicians, 3 consumer members and one recommended by the Health and Mental Hygiene Department.

SB 602, Ch.153, 1988 Laws Revises terms and renewal of professional licenses. Stipulates that licenses may not be issued for more than 3 years. Requires each renewal notice to include a blank panel data sheet from the Health Claims Arbitration Office.

MASSACHUSETTS -- HB 2519, Ch.467, 1987 Laws Provides protections for the documents and proceedings of peer review committees.

HB 5930, Ch.579, 1987 Laws Redefines functions of medical peer review: to evaluate or improve the quality of health care rendered; to determine compliance with applicable standards of care and reasonableness of costs of care; to determine whether particular actions call a provider into question; and to assist impaired health care providers. Provides records of the peer review committees with protections from discovery or subpoena.

MICHIGAN -- HB 4337, Act 178, 1987 Laws Enumerates grounds for sanctions against licensed physicians and identifies which violations warrant which sanctions to be taken. Authorizes medical board to impose fines up to $250,000. Mandates reporting of any disciplinary actions taken by HMOs and hospitals (including voluntary resignation). Makes owners, operators and governing bodies of licensed hospitals responsible for the quality of care rendered, for granting privileges only to licensed practitioners consistent with their training, and for conducting internal review of professional practice.

HB 4771, PA.81, 1988 Laws Amends licensure for out-of-state health professionals applying for Michigan licensure. Applicants must be able to: 1) meet the requirements promulgated by Michigan's appropriate professional board; 2) not have any related disciplinary proceeding pending against them; 3) not have any sanctions resulting from another state's disciplinary action in force at the time of application; 4) have met substantially equivalent licensure standards in the other state; and 5) appear for a personal interview upon the board's request. The board is also charged with making an independent inquiry into the applicant's professional status in the other state. An applicant who has been licensed, registered or specialty certified in any profession by another jurisdiction must disclose that fact and must also submit documents from the appropriate state professional licensing board or national association as to his current status.

MINNESOTA -- HB 285, Ch.152, 1987 Laws Provides immunities for professional organizations participating in peer review activities.

SB 737, Ch.86, 1987 Laws Allows person making a complaint to the medical board to receive a full report on the action taken, including the nature of the misconduct.

SB 1904, Ch.557, 1988 Laws Provides additional basis for refusals to grant privileges or impose disciplinary actions. Includes a new section making fee splitting fee splitting, kickbacks and other financial advantages as grounds for denial or sanctions. Also provides sanctions when a physician misuses devices or referral services when not medically indicated, e.g., when physician has a financial investment in the product. Grants discretion to the board to share information with other state boards or agencies regarding disciplinary actions against physicians or licensees.

MISSISSIPPI -- HB 774, 1987 Laws Provides additional grounds for disciplinary actions against a licensee, to include requiring a certified copy of a conviction, order or judgment regarding violation of narcotics laws, misdemeanors or felonies. Disciplinary actions in another state against licensees are prima facie evidence. Failure to furnish the medical board with any necessary information regarding licensure is also grounds for disciplinary action.

HB 778, Ch.386, 1987 Laws Grants the board authority to deny licensure to an applicant who has been disciplined by a professional medical association or society, whose privileges have been suspended or revoked by a hospital or voluntarily surrendered and/or who is found to be professionally incompetent.

HB 982, 1987 Laws Exempts records sought by the medical board from the Public Records Act. Waives the physician's privilege of confidentiality of patient information, where information is used only for the purposes of the review.

MISSOURI -- HB 667, 852 & 809, 1987 Laws Establishes detailed grounds for physician discipline, including failure to properly guard against infectious diseases, and enumerates sanctions. Allows temporary licenses for residents/interns and requires evidence of completion of postgraduate training for permanent license applicants. The medical board may require a physician to undergo mental or physical exams. Provides immunity for persons providing information to the board. Requires the board to distribute to the public a quarterly list of all physicians whose licenses have been restricted. Doctors voluntarily submitting to rehabilitation treatment will not be included in the public disclosure reports.

MONTANA -- HB 555. Ch.283, 1987 Laws Authorizes the Board of Medical Examiners to establish a program to rehabilitate licensed physicians who are impaired by alcohol, narcotics or other substances.

NEBRASKA -- LB 473, 1987 Laws Revisions to Chapter 44 apply to the membership and length of terms of the Commission on Medical Qualifications. Expands grounds for sanctioning to include gross negligence. Charges the Department of Health with establishing protocols in the case of conflict of interest for members of the board, to remove incompetent board members and to adopt rules for the development and administration of exams for licensure. Appropriates $47,000 to implement these provisions.

LB 384, 1988 Laws Establishes criteria to evaluate the need for more stringent regulation of health professions. Creates oversight of health profession boards, requiring criteria to be met for changes in scope of practice or credentialing. Establishes a fund from application fees to support the activities.

NEW HAMPSHIRE -- HB 852, 1988 Laws Provides for legislative oversight of claims arising from clinical operation of the state's mental hospital.

NEW MEXICO -- SB 309, Ch.204, 1987 Laws Creates the Impaired Physician Act, granting the medical board authority to contract with nonprofit organizations for the purpose of implementing detection, intervention and treatment programs for impaired physicians.

SB 54, Ch.11, 1988 Laws Provides for temporary licenses, for up to three months, for out-of-state physicians to assist in teaching, research or performing special diagnostic and treatment procedures.

NEW YORK -- Senate Int.6322, Ch.811, 1987 Laws Provides immunity to persons serving on boards charged with identifying and referring licensees for substance abuse.

NEVADA -- SB 77, Ch.111, 1987 Laws Defines the required course of study for persons desiring to practice medicine in the state. Lists licensure criteria, to include passing the national medical licensing exam given by specialty boards. Adds new criteria to grounds for denying licensure, including filing a report that the applicant knows to be false, failure to report discipline by other agencies or states or failure to be found competent to practice medicine under Nevada law. Adds substance abuse as grounds for denying licensure. Allows the medical board to require physical or mental exams of physicians under investigation. Waives licensure requirements for out-of-state physicians coming for additional training.

SB 397, Ch.696, 1987 Laws Waives certain licensure requirements for physicians serving in counties where the population is less than 18,000, provided they have graduated from an accredited medical school and completed at least one year of residency training.

NORTH CAROLINA -- SB 240, Ch.859, 1987 Laws Permits the Board of Medical Examiners to contract with medical societies to perform peer review functions. Each entity that contracts must maintain a program for impaired physicians. Mandates reporting to the board when a physician constitutes an imminent danger to the public or himself or when he refuses to participate in the rehabilitation program or presents the basis for other disciplinary action. Establishes immunity for members of peer review and designates peer review as a state action for the purposes of antitrust laws. Requires hospitals to maintain a risk management program for licensure. Opts for early adoption of HCQIA provisions.

NORTH DAKOTA -- HB 1563, 1987 Laws Requires the board to keep applications for licensure on file for at least six years. Redefines qualifications for application and eligibility for licensure for foreign medical graduates. Expands available disciplinary actions to habitual use of alcohol and drugs and physical and mental disability affecting practice.

OKLAHOMA -- HB 1478, 1987 Laws Provides for inquiry into an applicant's medical education credentials and lists criteria for eligibility to take the licensure examination. Foreign medical graduates may be required to meet higher standards. Changes the name of the State Medical Board to the Board of Medical Licensure and Supervision. Allows the board to require defendants to pay for investigation and prosecution of their case as a condition of probation or suspension and to contract with agencies to conduct the investigations.

SB 183, 1987 Laws Defines professional review bodies and the actions taken by such entities. Provides immunity to reporting persons and members of peer review boards. Physicians under review must have the opportunity for a timely hearing. Immediate action may be taken without a hearing if imminent danger is perceived but the opportunity for a hearing must occur within 3 days of such action.

OREGON -- HB 2372, Ch.850, 1987 Laws Establishes requirements for medical staff bylaws and practice including hospital oversight responsibilities and peer review activities. Allows the Board of Medical Examiners to appoint physicians to conduct peer review for a health facility upon special request. Deems such appointees agents of the board and grants immunity to participants in peer review. Grants antitrust immunity to peer reviewers.

SB 323, Ch.774, 1987 Laws Requires insurers to report to the licensing board any claims of malpractice, settlements, dismissals or judgments within 30 days. A permanent

record of such reports must be kept by the commissioner and provided to licensed health facilities. Civil penalties up to $10,000 for those failing to report under the law's criteria.

PENNSYLVANIA -- SB 803, Act 66, 1988 Laws Requires licensees to disclose financial relationships with another provider when making patient referrals. Grants the licensing board enforcement authority for this and allows fines of up to $1,000 for violations.

RHODE ISLAND -- HB 5885, Ch.87-522, 1987 Laws Amends immunity from liability provisions to include directors, officers and trustees of nonprofit corporations in their activities, when they act in good faith. Requires the board to publicly report changes in privileges when the change is related to quality of patient care.

SB 761, 1987 Laws Redefines the peer review law to include liability protection for boards of trustees or directors of professional associations or societies, licensed health care facilities, medical care foundations, HMOs and hospital or medical service corporations, where they review the proceedings, records or recommendations of other peer review boards.

HB 8011, Ch.88-572, 1988 Laws Grants immunity from civil liability for peer review members and participants who act in good faith. Requires hospitals to take actions based upon adverse information received about one of its physicians. Hospitals must make a formal inquiry to see if further action is required.

SB 3074, Ch.88-385, 1988 Laws Requires at least four votes on the medical review board to find a licensee guilty of unprofessional conduct.

SOUTH CAROLINA -- HB 2080, Ratification No.85, 1987 Laws Provides that applicants who have not passed the state examination after three attempts are not permitted to retake the exam. Any further exam scores will be considered only upon special permission.

HB 3577, Ratification No.466, 1988 Laws Requires all medical malpractice insurance carriers to file all final judgments, settlements, agreements and awards against a licensee with the appropriate professional or occupational licensing board.

SB 703, Ratification No.326, 1988 Laws Grants physicians, surgeons and osteopaths the right to judicial review of suspension or revocation of a license or any other disciplinary action. Appeals must be filed with the circuit court within 30 days of the medical board's judgment and must be heard by the courts within 30 days if the board ruled to restrict a license for more than six months. Any license restriction handed down by the board remains in effect, pending the outcome of the judicial review. All board decisions to discipline must be by majority vote of the entire board membership.

TENNESSEE -- HB 146, Ch.315, 1987 Laws Extends immunities to peer review activities in preferred provider organizations and individual practice associations.

SB 1435, Ch.808, 1988 Laws Exempts interns, residents and medical fellows of osteopathic medicine from licensure. Requires supervisors to report to the medical board any termination or completion of the applicant's participation in training programs.

SB 2166, Ch.609, 1988 Laws Strengthens immunity for medical review committee members and for witnesses or informants for committee proceedings. Liability remains in cases of persons who knowingly give false information.

TEXAS -- HB 2560, 1987 Laws Amends the Medical Practice Act to redefine peer review activities. Provides that the state medical board must meet at least four times a year and appoint its own executive director. Requires the board to disseminate at least twice yearly information significant to physicians, including summaries of disciplinary orders. The

information must be available to physicians, health care entities, members of health committees in the legislature, members of the general public and public libraries throughout the state. Additional information regarding complaints against specific physicians may be released upon special request from the legislature. Establishes the process of investigation and review for licensure that the board must follow. Identifies when the board must immediately report actions taken against physicians. Requires the board to investigate any physician who has three or more malpractice claims within a five year period. Implements the provisions of the HCQIA in regard to professional review actions. Requires reporting by peer review committees and protects such communications from disclosure. Provides immunity from civil liability to participants in peer review activities. Exempts from certain reporting rules impaired physicians undergoing treatment in board-approved programs.

UTAH -- SB 13, 1988 Laws Protects any person, health care facility or organization from incurring liability in providing information to the state, the state medical association, peer review organizations, professional societies or health providers when the information is used to advance medical research or for professional association discipline.

VERMONT -- SB 321, Act 236, 1988 Laws Mandates 20 hours of continuing education as condition of biennial licensure renewal. Allows the board discretion in identifying specific areas of study to meet the requirement.

VIRGINIA -- HB 1078, Ch.874, 1988 Laws Makes physicians liable for civil fines up to $1,000 for nondisclosure of interest in referral facilities.

SB 238, Ch.29, 1988 Laws Provides for biennial renewal of professional licenses. Requires hospitals to report any disciplinary actions to the state medical board, with immunity protections. Requires physicians to report any assistance given to another physician for certain disorders (mental, emotional, personal, drug addiction or chronic alcoholism). Requires medical associations to report to the state any disciplinary actions taken and provides immunity for informants. Malpractice judgments must be reported to the state. Insurers are required to report certain claims information. Confidentiality provisions protect the information collected from disclosure and subpoena. Establishes membership and protocols for the board of medicine, including the available sanctions and procedures for investigation and review and the development of certain committees within the board. Enumerates standards for unprofessional conduct. Allows a medical practices audit committee to monitor disciplined physicians. Allows physician under review notice and an opportunity to be heard. Addresses temporary licensure for out-of-state applicants and intern/residents and reciprocity for applicants from states without formal agreements with Virginia.

SB 424, Ch.132, 1988 Laws Requires supplemental training of up to three years of postgraduate training in an approved hospital for licensure applicants from unrecognized schools, such as certain foreign medical schools.

SB 425, Ch.904, 1988 Laws Makes it unprofessional conduct for a physician to sell drugs except under special designated circumstances or to sell medical devices or appliance to patients not under his care or for personal gain.

WASHINGTON -- HB 699, Ch.129, 1987 Laws Provides for limited license for physicians who serve as teaching-research members of the University of Washington or are enrolled in a fellowship program. Applicants must comply with all other licensure requirements.

SB 5972, Ch.269, 1987 Laws Provides for actions taken by a peer review body not based on professional conduct or competence to be limited to appropriate injunctive relief and damages for lost earnings directly related to the peer review activity. Immunities protecting reporting and review activities continue. Nothing in state statutes are meant to limit immunities conferred under federal law. Information under review or evaluation by hospital risk management programs is not subject to discovery or introduction into evidence.

SB 6470, Ch.247, 1988 Laws Provides alternatives to disciplinary actions for impaired physicians. Allows referrals to drug treatment centers without the consent of the license holder. Failure to complete treatment may be grounds for sanctions. Voluntary participation does not subject the licensee to disciplinary action. Confidentiality is protected. Employers of doctors referred by the board are not limited by that decision in refusing to employ the impaired physician. Immunity provided to those reporting practitioners to the program.

WEST VIRGINIA -- SB 166, 1987 Laws Redefines the provisions regarding requirements for licensure. Establishes criteria for temporary licensure, renewal and inactive licensure.

SB 574, 1988 Laws Repeals a previous law allowing resident physicians holding temporary certificates to obtain permanent licenses.

WYOMING -- HB 146, Ch.193, 1987 Laws Adopts the HCQIA immunity provisions.

HB 158, Ch.182, 1987 Laws Requires hospitals to maintain peer review activities as a condition of licensure.

SB 105, Ch.79, 1987 Laws Enacts the Medical Practice Act of 1987, which establishes a new system of licensing and regulation for physicians. Identifies the board of medical examiners and defines the duties of the board. Provides protections from civil liability. Requires health facilities to report to the board disciplinary actions, including voluntary surrender by a physician of clinical privileges. Creates new grounds for disciplinary actions as well as new santions, including civil fines and imprisonment for practicing without a license. Reorganizes existing law on impaired physicians, without significant change. Physicians may still be required to undergo physical and mental examination. Three practicing physicians from the community will be appointed to a committee to investigate the allegations and report findings to the board within 30 days. A physician may voluntarily surrender his license, in which case the investigation ends.

ENDNOTES

1. Office of Technology Assessment, "The Quality of Medical Care," June 1988.

2. See State Health Notes, March 1988, for a discussion of Florida SB 6-1, parts of which were reenacted in June in HB 819.

3. "Report of the Task Force on Medical Liability and Malpractice," Office of the Secretary, Department of Health and Human Services, August 1987.

4. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed tougher standards that will not allow hospitals to rubber-stamp applications for renewal of privileges and will require them to devote adequate resources to risk management and quality assurance. Hospitals that do not comply with the demand for greater scrutiny of their medical staffs could lose accreditation. The new regulations will take effect in January 1989. Beginning in the 1990s, the JCAHO will collect data on the quality of clinical care provided by hospitals.

FOCUS ON...

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ATTACHMENT B

"Physician Discipline Emerges as a State Priority," State Health Notes, July/August 1988 and "Doctor Discipline or Doctor Bashing?" Medicine and Health Perspectives, May 2, 1988

SHN July/Aug 1988 Physician Discipline

Physician Discipline Emerges as a State Priority

The states, showing increasing concern with the quality of medical care, are starting to zero in on problems involving the country's 500,000 licensed and practicing physicians. With many legislatures having already adjourned for the year, more than half have enacted measures to regulate the quality of care by strengthening their oversight and monitoring of physician behavior.

Quality problems in the services doctors deliver can stem from any number of deficiencies, from poor practice habits to inadequate training to physical or mental impairment. According to a recent Office of Technology Assessment report on quality, the general grounds for physician discipline are unprofessional conduct or professional incompetence.

Authority to license or restrict medical licensure lies with the states. By expanding the powers of state medical boards, stepping up physician licensure requirements, adding protections for peer reviewers and toughening requirements for hospital reporting, states hope to rid their systems of bad medical care and reduce malpractice problems. (See table on p.4-5 for state-by-state enactments.)

Comprehensive Reforms

FLORIDA and **MARYLAND** are two good examples of how states are adding teeth to their physician licensure and quality assurance regulatic s. Through a series of broad tort reforms enacted in February (SB 6-E, detailed in SHN March 1988) and again in late June (HB 819), **FLORIDA** has taken a tough stand on physician competence. A newly established Division of Medical Quality Assurance within the Department of Professional Regulation is empowered to use whatever resources and make whatever efforts are necessary to investigate and discipline physicians guilty of unprofessional conduct... "in order to take forceful corrective measures to assure quality medical care throughout the state." To do this, eleven professional boards were created within the new division and given broad authority to train investigators, conduct investigations, require reporting on malpractice and disciplinary actions from licensed health facilities and discipline physicians. Eighty-nine new positions in the quality assurance division will be supported by $3.4 million, derived mainly from a trust fund generated from licensure fees collected by the state.

The new **FLORIDA** law allows the division of medical quality assurance to enter into agreements with the state professional society of physicians to conduct reviews of complaints referred to the division and prepare confidential reports of its findings. However, the division must rule on the basis of its own independently prepared evidence and supporting expert opinions.

Disciplinary actions available in **FLORIDA** include denying, revoking or suspending a doctor's license, imposing an administrative fine, issuing a reprimand or imposing probation with requirements for further professional training, supervision or treatment. In what may be a trend to crack "the brotherhood of silence" -- professionals who look the other way when mishaps and/or incompetence occur -- the state also will require nurses to report physician misconduct to the division or risk disciplinary actions similar in range to physician sanctions.

MARYLAND has also reorganized its licensure responsibilities and created a new state board that will license and discipline doctors. To be known as the Board of Physician Quality Assurance, the new entity will replace the part-time system of physician discipline that had been primarily conducted using volunteer physicians from the state medical society. Under the new law, unethical or incompetent doctors would be investigated more thoroughly and quickly and with more aggressive action. In 1987, the existing medical licensing commission received 800 complaints but only disciplined five doctors. The commission had a backlog last year of more than 700 cases.

Claiming the 11-member commission was overworked and understaffed, MARYLAND Governor Schaefer sponsored the new plan, which passed the Senate unanimously. The new law will provide for the hiring of full-time investigators and hearing officers to handle complaints. The state medical society will continue to offer expert opinion but will no longer conduct investigations.

Funds for the new MARYLAND law for FY 1989 will total $446,633. Projections for the next two fiscal years include budget increases of approximately $200,000 per year, although the increases are subject to review by the legislature to see if the new quality assurance board is doing its job. With this in mind, the new law stipulates requirements for annual legislative reports on board actions.

MARYLAND has also beefed up physician sanctions. The new law will automatically suspend doctors convicted of crimes of immorality and can allow for permanently revoking a physician's license.

Health Care Quality Improvement Act of 1986

The legislation enacted in FLORIDA and MARYLAND is in part a response to a recent federal law involving physician competency and discipline. The measure (PL 99-660) provides two major tools in support of the peer review process: immunity protections for appropriate reviews and the creation of a national clearinghouse on physician data.

The clearinghouse, known officially as the Practitioner Adverse Credentialing Data Bank, will collect data on malpractice payments, professional disciplinary actions, professional society membership, revocations and adverse actions on clinical privileges. Insurance companies, boards of medical examiners, and peer review groups will be required, under penalty of fines, to report information.

Once the new clearinghouse is operative, licensed hospitals, peer review groups and state licensing boards will have access to the information. In the past, there has been little to keep doctors whose licenses have been revoked or hospital privileges suspended from relocating their practices in another state. The new system, which will legally bind hospitals to check on physicians' professional backgrounds, is designed to prevent doctors with histories of disciplinary actions from continuing to jump from state to state.

The President's FY 88 budget requested a $2.8 million appropriation. Cost estimates for the proposed data bank have run as high as $10-$20 million. Target start-up dates range from early 1989 to early 1990.

The second part of the federal mandate extends protection to people who provide information to a professional review board regarding the competence of physicians, if they are acting in good faith. Also protected are professionals and others who perform the peer review activities. Seen as a "shield" law to protect physicians from retaliatory suits by angry colleagues having met unhappy outcomes from the peer review process, the federal protection will extend to state courts in 1989.

The immunity issues addressed by the federal quality assurance mandate grew out of a case brought by an OREGON physician, who had charged that members of a local medical clinic who challenged his professional competence were acting to reduce competition in the small town rather than give an unbiased peer review of his professional skills. The case reached the U.S. Supreme Court, which upheld an earlier ruling in the plaintiff's favor that the clinic's doctors were using the peer review process to limit competition, in violation of anti-trust laws. Also, although OREGON mandates peer review, the Court found that the state was not sufficiently regulating the process to warrant the immunity from liability that the clinic's doctors claimed due them in their actions as peer reviewers, e.g., as quasi-state officials.

Peer Review Initiatives

States have until October 1989 to either accept the federal peer review provisions or reject them in lieu of their own peer review

statutes. Last year, for example, WYOMING opted for early acceptance of the federal standards; in CALIFORNIA, on the other hand, pending legislation (SB 2565) spells out detailed state requirements and protections for the peer review process.

Several other states have enacted legislation this year addressing the immunity concerns raised by the OREGON case and by the federal mandate. KENTUCKY is one of two states in 1988 to specifically adopt the immunity provisions as established by the 1986 federal law. In this regard, four requirements must be met for the federally enacted immunity provisions to be effective: 1) the activities must be performed with the reasonable belief that quality health care is being promoted; 2) reasonable efforts must be taken in investigation; 3) adequate notice must be afforded the physicians involved; and 4) any actions taken must be supported by reasonable beliefs that the facts support such actions. COLORADO will also follow these immunity provisions.

Some states have chosen to amend existing peer review laws. ALABAMA, FLORIDA, MAINE, TENNESSEE, UTAH, ARIZONA and VIRGINIA provide immunity for participants in the review process. ALABAMA, MAINE, TENNESSEE and UTAH also extended the immunity to informants in peer review.

State Medical Board Initiatives

Licensure of physicians, done under state authority, has historically focused on a written and oral examinations process. In most states, the same body that grants physician licenses also has the authority to discipline doctors it deems unfit to practice. With the advent of a nationally standardized exam for physicians, medical boards no longer find so much of their time absorbed by revisions and administration of licensure exams. This, coupled with increased consumer concerns and the dramatic rise in the number of licensed physicians, has caused many states to reevaluate how to best use the resources of the boards.

Recommendations by HHS Secretary Otis R. Bowen on changes states can make to reduce the frequency of malpractice actions say that "state licensing boards should be properly staffed, funded and authorized to operate effective disciplinary programs." In this regard, VERMONT has appropriated $40,000 to support a study of staffing, management and revenue needs of its licensing boards and commissions.

In addition, a number of states have expanded medical board functions to include provisions for more comprehensive investigations. Last year, for instance, GEORGIA enacted requirements for mandatory investigation of licensees who have had a medical malpractice judgement more than $100,000, or in cases where two or more judgments against or settlements have occurred. So far in 1988, ALABAMA, FLORIDA and RHODE ISLAND have beefed up requirements that certain investigations be initiated by their medical boards or its appointed representatives.

ALABAMA, ARIZONA, COLORADO, FLORIDA, MARYLAND, KANSAS, RHODE ISLAND, VERMONT and VIRGINIA have redefined the duties and composition of their state medical boards. For example, under the new FLORIDA statute described earlier, board members must receive special training in investigatory procedures. In VIRGINIA, medical board membership will consist of one medical physician from each congressional district, four other professional members and two citizen members. ARIZONA's 12-member medical board also will include two public members as well as a nurse and nine practicing physicians from at least three counties in the state. MARYLAND'S new medical board will be made up of primarily physician members appointed by the Governor. RHODE ISLAND reduced the number of board members needed to make up a hearing committee from seven to five. ALABAMA splintered the functions of its medical board by adding a special committee, to function under the supervision of the state board for the purpose of identifying, treating and rehabilitating impaired physicians.

One of the busier avenues of reform this year has been in increasing the disciplinary sanction authority of state medical boards. Although all state medical boards have the authority to revoke or suspend a physician's license, the percentage of those who are actually disciplined is, by all accounts, small compared to the number of doctors believed to be professionally incompetent to practice. States vary in their willingness to discipline and in the types of actions they take, largely because of differences in state laws and regulations.

So far this year, a dozen states have strengthened the authority of medical boards to sanction physicians. For example, in INDIANA, the state's medical licensing board may impose new disciplinary sanctions. Grounds for sanctioning include: obtaining a license

PHYSICIAN COMPETENCE AND DISCIPLINE
1988 ENACTMENTS

	PEER REVIEW						MEDICAL BOARDS			LICENSURE					HOSPITALS			REPORTING	
	Opts for Federal Statute	Mandated Review	Immunities/Informers	Immunities/Reviewers	Expanded Activities	Reorganization	Further Training	Mandatory Investigation	Sanction Authority	Renewal Requirements	Out-of-State Applicants	Transfer Applicants	Physical/Mental Exams	Redefine Standards	Physician Appeal	Reporting of Actions	Reporting of Malpractice	Interstate	General Assembly	Licensing Body
ALABAMA																				
SB 132									x					x						
HB 283			x	x		x		x	x				x							
ARIZONA																				
SB 1090			x	x																
HB 2200					x	x			x					x						
COLORADO																				
HB 1340	x		x	x		x			x					x		x			x	
HB 1037			x	x																
CONNECTICUT																				
HB 5001														x						
FLORIDA																				
SB 6-E and HB 819		x	x	x	x	x	x		x		x					x	x			x
INDIANA																				
SB 2									x		x			x						
KANSAS																				
HB 2643				x	x															
HB 3034											x			x						
KENTUCKY																				
HB 551	x		x	x					x											
MAINE																				
SB 952			x	x																
MARYLAND																				
HB 27																				x
SB 508						x			x					x					x	
SB 305																				x
SB 602		—							x											

through deceit; engaging in fraud in the course of professional duties; advertising services falsely; being convicted of a crime relating to professional competence; knowingly violating any state or federal statutes relevant to the medical profession; and continuing to practice although unfit because of incompetence, out-of-date skills, and/or physical or mental disability. Physicians who engage in immoral conduct in the course of services, mishandle drugs or have been disciplined in another jurisdiction may also expect to be disciplined.

The INDIANA law gives discretionary authority to the licensing board to grant probation[illegible]y licenses which limit areas of practice, require provision of community service and regular reports on the licensee's progress, and/or continue professional education. In VIRGINIA, a new law will enable a board-appointed audit committee to review practices of disciplined licensees to see if his practice conforms to conditions placed on the physician by the board. PENNSYLVANIA added a civil penalty of up to $1,000 for failure of a physician to disclose financial interest in a facility or service prior to offering it to a patient. ALABAMA and FLORIDA enacted provisions allowing for immediate suspension or revoca-

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MICHIGAN HB 4771											x	x				x				
MINNESOTA SB 1904								x	x					x		x			x	
NEBRASKA LB 384									x											
NEW HAMPSHIRE AB 852																			x	
PENNSYLVANIA SB 803						x			x					x						
RHODE ISLAND SB 2074						x								x						
SOUTH CAROLINA HB 3577 SB 703 SB 1226										x					x					x
TENNESSEE SB 2166			x	x																
UTAH SB 13			x	x																
VERMONT SB 321						x				x										
VIRGINIA SB 425 SB 424 SB 238				x		x			x x	x	x		x x x	x x	x	x	x			
WASHINGTON SB 6470									x		x		x							
WEST VIRGINIA SB 574			—							x										

tion of a physician's license when the public health and safety requires it.

MINNESOTA added fee splitting, kick-backs and other financial advantages as reasons for denial or sanction in licensure. Also, health-related licensing boards in the state are directed to investigate all communications which indicate sexual contact with a patient. A disciplinary conference must be held if there is sufficient evidence to warrant sanctions or other actions. Further, all mandatory reporting by the licensing board must include legislative summaries of each individual case involving sexual misconduct.

Finally, a WASHINGTON law provides alternatives to disciplinary actions where impaired physicians are identified and allows for referrals to drug treatment centers without consent of the license holder. This type of remedial rather than disciplinary response on the part of state medical boards is similar to the intent of the ALABAMA law mentioned earlier.

Professional Licensure

Another approach to physician oversight has been to tighten licensure regulations, specifically in the areas of renewal, out-of-state applicants and investigations as part of

the licensure process. During the renewal process, states such as COLORADO and ARIZONA will now require physicians to self-report any activity that violates the state's medical practice standards or related disciplinary action.

One area that states are continuing to change is reciprocity of medical licensure between states. Once a professional courtesy between states, reciprocal licensure is no longer automatic. For example, SOUTH CAROLINA will endorse previous licensure in another state only when certain examination requirements have been met. IOWA, MICHIGAN and WEST VIRGINIA require transfer applicants to be investigated for past disciplinary actions while three other states -- FLORIDA, INDIANA and KANSAS -- tightened restrictions for out-of-state applicants. New laws in ALABAMA, VIRGINIA and WASHINGTON enable medical boards to require physical and mental exams for physicians applying for licensure or under investigation.

State legislatures continue to amend the definition of professional conduct in efforts to expand the criteria for sanctions. ARIZONA, for example, has redefined professional misconduct to include unwillingness to submit requested documentation to the medical board and making false or misleading statements to the board.

Hospital Regulations

Hospitals are under increasing pressure to improve their scrutiny of medical staffs, in large measure because of new accreditation standards from the Joint Commission on Accreditation of Healthcare Organizations. The regulations, which become effective next year, will require hospitals to set up risk management programs as well as to improve investigations of physicians applying for new or renewed privileges. New standards will require such physicians to report any voluntary relinquishment or reduction of privileges or licenses. This will help close a longstanding loophole that had allowed physicians under the gun to "voluntarily" discipline themselves, skirting requirements to self-report any past disciplinary sanctions.

VIRGINIA has included reporting of voluntary resignations in its recent statute. The law also requires hospital staff to report suspected substance abuse or mental illness in a physician and disciplinary actions to the medical board. COLORADO will also require hospitals to report any disciplinary action to suspend, revoke "or otherwise limit" a physician to the medical board. MINNESOTA has taken that a step further, requiring that hospital reports to medical boards must include detailed information such as the specific patient record and reasons for the action.

Other Reporting Requirements

COLORADO's board of medical examiners must give an annual report to the General Assembly, to include the number of active cases, complaints or reports received and status of actions taken as well as an analysis of results. Additional provisions in COLORADO require the board to report any disciplinary actions to hospitals where the disciplined physician may have privileges. Supervisors of interns or residents must also report any actions that would constitute licensure violations or failure of the resident to progress.

MINNESOTA, SOUTH CAROLINA and VERMONT also enacted reporting requirements. MINNESOTA, for example, gave its medical board discretionary power to share information on disciplinary actions with other states. SOUTH CAROLINA mandated that all malpractice insurance carriers report final judgments, agreements and awards to the appropriate licensure board. VERMONT will study staffing, management and revenue needs of its licensing boards and commissions and report to the General Assembly.

A Final Word

Problems that still plague the state medical boards include the overwhelming administrative backlog of cases to be investigated and reported. The number of complaints continues to rise, and more complex criteria are being utilized in review. Investigative procedures that consume additional resources are being mandated, yet most boards are being given only marginal increases in funds.

Between 1982 and 1984, the boards saw a 45 percent increase in the number of disciplinary actions taken, although many of these were in the form of "soft sanctions" such as reprimands and censures. These actions may be a practical response to the limited funding and staffing resources of the boards. Certainly, states will continue to reevaluate their licensure and physician oversight practices, particularly in light of new federal requirements to improve reporting and oversight of disciplinary actions. -- Rhona S. Fisher

Medicine & Health

5/2/88

• Physicians Discipline

• PERSPECTIVES

May 2, 1988

DOCTOR DISCIPLINE OR DOCTOR BASHING?

Once Americans expected too much of their doctors -- and American doctors loved it. The interplay of unreasonable expectation and expansive self-image left both patients and physicians ripe for a rude awakening. Amid horror stories ranging from sexual misconduct to substance abuse, doctors are being revealed as all too human. The disclosures have come, according to doctors, none too politely, but according to public interest groups, none too soon.

Pointing to massive increases in the frequency with which Americans sue their doctors for malpractice, public interest groups claim states have done a poor job of protecting patients from impaired or incompetent physicians. Activists are marshalling public support for far stronger doctor-discipline laws and surveillance systems that would snare grossly negligent practitioners before they can inflict injury.

Doctors complain they're being badmouthed for no good reason. They admit to the existence of a few incompetent or impaired practitioners, but maintain that most American doctors do blue-ribbon work. American Medical Assn. officials voice eagerness to get rid of impaired physicians, but also stress the impact of unrealistic patient expectations and the absence of definitive measures of quality of care. AMA says incompetent doctors and those with substance abuse problems need counseling, not harsh, subjectively derived penalties.

Of more than 552,000 U.S. doctors, 3-to-16 percent are impaired -- unable to practice at the peak of their powers because of substance abuse, mental illness, senility, or a disabling physical condition. According to the experts, another 10 percent are incompetent -- lacking the knowledge, skills, or judgment demanded for first-rate care. In other words, as many as 138,000 doctors may need help to deliver quality care.

Some experts suggest doctors are at higher risk of chemical addiction. From their first days as interns, doctors routinely operate in stressful situations; their easy access to mood-altering drugs may lead them to habitual reliance on amphetamines, sleeping pills, and alcohol, as well as less well-known substances.

Incompetent doctors may be older physicians who have failed to keep up with advances in medical knowledge. Or they may be younger physicians who did poorly in medical school and never improved. Some experts suggest medical school deans should more actively net inept medical students before they graduate. Others stress continuing education programs and recredentialing proposals that force older doctors to keep up with changes in clinical practice.

The medical system's 100-hour work week "brutalizes" doctors-in-training, says Lowell Levin, chairman of the People's Medical Society, an Emmaus PA-based consumer group. "Residents take pills to stay awake, they take pills to sleep," Levin says. "Before long it's a habit."

Levin and PMS President Charles Inlander are campaigning for reform. "When you get the members checking on themselves . . . you've got problems," says Levin, noting that America relies

McGraw Hill Kathy A. Fackelmann, Editor

on doctors to police their own ranks via state medical boards, set up by state lawmakers and staffed primarily with volunteer physicians and a few public members.

The system works this way: Each state has a medical board made up of doctors -- often named by the state's medical society -- and public members. Chartered under state medical practice law, boards have two functions: They control doctors' entry into practice and mete out discipline against practicing physicians. Boards' power over the marketplace comes from the licensing process; their disciplinary authority lets them revoke, suspend, or limit licenses or bring intermediate sanctions.

Critics call this arrangement a meld of logrolling and favor-swapping that renders medical boards incapable of the aggressive activism needed to root out incompetence. "They're really not there to protect the public," Inlander says. "They're there to protect the medical profession." In a cross-country roadshow targeted at consumers and legislators, Levin and Inlander rail at doctor-dominated review. Levin and Inlander take an extreme stance on the topic, but they aren't alone in their board-bashing. All around the U.S., critics are attacking medical boards for letting unfit, impaired, or negligent doctors to practice untrammeled.

STATE MEDICAL BOARDS

March 1988 Health Research Group data bolster the complaints, showing that state boards took 17 percent more serious disciplinary actions against physicians in 1986 than in 1985. But that increase pales in comparison with the 46 percent improvement in state crackdowns recorded between 1984 and 1985, says Washington-based HRG.

State boards have a lax attitude toward errant physicians, says HRG; board now impose 2.4 serious disciplinary actions per 1,000 physicians. "This rather small amount of discipline falls far short of capturing most of the doctors who are practicing substandard medicine in this country," says HRG director Sidney Wolfe, MD, adding that this poor performance has exacerbated the nation's malpractice problem.

"At the heart of the so-called medical malpractice crisis is actual malpractice, patients being injured or killed by negligent physician behavior," he says. HRG estimates that more than 100,000 Americans are injured or killed annually by incompetent or impaired physicians.

Not all of HRG's news is bad. The group praised New York for an increased statewide commitment to crack down on incompetent physicians, singling out New York City Council President Andrew Stein and Gov. Mario Cuomo for their efforts. Stein held hearings that focused on the state's poor track record in removing substandard physicians; Cuomo has backed several reforms, including a drive to force doctors to undergo periodic recertification to keep their licenses. Disciplinary actions by New York against physicians nearly tripled between 1985 and 1986, from 60 to 167. Other states deemed praiseworthy by HRG: West Virginia, Hawaii, New York, and Wisconsin -- all three were in the top 20 most aggressive states, doubling their penalty actions from 1985 to 1986.

HRG was less kindly disposed toward Arizona, Arkansas, Kansas, Louisiana, Rhode Island, Washington, and Pennsylvania -- and particularly hard on California. Once a model for doctor discipline, California "has fallen on hard times with disciplinary actions about half of what they were in the early 1980s," Wolfe says, tracing California's laggard performance to lack of commitment on the part of Gov. George Deukmejian.

Medical boards are getting a bad rap, says Bryant Galusha, MD. Galusha, Federation of State Medical Boards Executive Vice President, terms HRG's report "misleading" because it concentrates on serious disciplinary actions -- license suspension, revocation, probation -- but ignores boards' oft-used informal or intermediate actions. Boards often counsel or reprimand a physician, rather than taking the harsh step of yanking a license, Galusha says.

Most boards act informally and get good results; Galusha recounts his experience as a member of North Carolina's board in 1968. At that time, many doctors were inappropriately prescribing long-term amphetamine use for obese patients. Those referred to the state board were questioned and counseled. Most stopped prescribing uppers after that brush with the board, says Galusha; those that didn't faced further penalties such as a limit on their license.

But HRG isn't alone in criticizing medical boards. A February 1987 report by the HHS Office of the Inspector General found most boards ill-financed and understaffed. Most have backloads of cases numbering in the hundreds, with active investigations totaling 60 to 70 cases, says IG Richard Kusserow, noting that "severe budgetary constraints are precluding boards from enhancing the number or quality of investigators."

Since then most legislatures have voted enough money to let boards hire secretarial and support staff, but some boards still are struggling with shoestring budgets, Galusha says. He notes that Delaware's board can't afford to hire a secretary or outside investigators.

STATES: GET-TOUGH LAWS

Some states have been dropkicked into action by publicity about their boards' ineffectuality. This was the case in Maryland, the subject of newspaper reports about doctors convicted of serious crimes who nonetheless continued to practice. One case involved a gynecologist convicted of rape and hit with a five-year suspended sentence and community service work. The Maryland medical board suggested that instead of losing his license, the gyn be allowed to practice as long as he was "chaperoned" while conducting a physical exam.

These articles so incensed Maryland lawmakers that they boosted the Maryland medical board's budget; for the first time the board will be able to hire investigators, rather than relying solely on volunteer help. In the same law, the legislature stipulated license revocation for doctors convicted of certain crimes.

Doctors and hospitals backed the stiffening of Maryland's medical discipline mechanism. Maryland Hospital Assn. spokesman Rick Wade says the state's disciplinary board had been slow and somewhat ineffective. The new law "puts the heat on the doctor community," he says, adding the bill had the backing of his group and Maryland's Medical & Chirurgical Faculty of Maryland. Med-Chi, as it is commonly known, is the state's medical society.

Other legislatures are considering bills aimed at shielding patients from inept or impaired doctors. New Jersey's legislature took up reform proposals after the State Commission of Investigation reported problems in that state. "The overwhelming majority of New Jersey's 28,766 licensed physicians are honorable, competent and caring professionals," the report says, terming the impaired and incompetent a "lethal minority." The commission, a nonpartisan panel, reports to the legislature and the governor. Its study spurred hearings; no bill has been introduced.

While praising New Jersey's medical board for its tough discipline, the commission noted that the board can't take action without complaints -- which are discouraged by the guildsmanship that envelops medical societies, hospitals, physicians, and other health professionals. "Failure to promote a voluntary reporting system among medical peers has been a primary reason why a number of incompetent or impaired doctors have been able to continue life-threatening medical practice from hospital to hospital and from state to state," says the Commission

Physician inertia persisted despite a 1983 New Jersey law granting immunity from lawsuit to any person who in good faith tells the state board of physician misconduct. New Jersey passed the law to allay health professionals' fears of suits by angry colleagues.

The liability issue may be a "red herring," thrown up by doctors to disguise the real reason they won't inform on one another, the report says. The tribal nature of medical practice bands

health professionals together, even in the face of gross negligence. Many are reluctant to speak out about incompetent or impaired colleagues because of the task's essential unpleasantness, says Robert Clark, deputy director of the New Jersey Commission of Investigation. Most professionals don't want to "get involved" -- even when patients are at risk.

New Jersey investigators chronicled numerous examples of widely-known misconduct that were hushed up. In one instance, a cardiac surgeon notorious for his sexual misconduct and substance abuse -- in addition to blacking out often, he repeatedly exposed himself in the operating room -- never was reported to the board.

The Commission urged a mandatory reporting requirement for all health professionals. Professionals aware of an impaired or incompetent physician would have to report the situation or risk a monetary penalty or loss of license, under the proposal. "There should be a clear statement made by the legislature that it is not acceptable to know about problem professionals and not make sure the appropriate disciplinary bodies are aware of it," the commission said.

CONGRESSIONAL ACTION

Physician incompetence and/or impairment has been feeding into concern about the malpractice crisis. Last year Congress passed the Health Care Quality Improvement Act, a creation of Rep. Ron Wyden (D-OR) that would set up a national registry for malpractice and disciplinary data. Wyden says some 18,000 U.S. physicians regularly commit malpractice but escape penalties by moving to another state.

Wyden's registry, to be run by outside groups, will collect and disseminate data on malpractice claims, loss of hospital privileges, and disciplinary action taken by state boards -- even voluntary resignation from a medical staff. Insurers, hospitals, and medical boards must report physician-data to the registry -- or face a $10,000 fine.

Critics say Wyden's mechanism is too lax -- hospitals unwilling to endure the anger of staff doctors still can get around the reporting requirement, as happens in New Jersey, which has mandated reporting since 1983. Hospitals there make up fanciful names for disciplinary actions to avoid having to report them to the medical board; doctors in trouble often take "vacations" or extended leaves from their clinical duties.

The leading bidder for the clearinghouse contract is the American Medical Assn., in tandem with the Federation of State Medical Boards. AMA would record hospital actions and malpractice lawsuits; the Federation would track state penalty actions. Critics deride the AMA-Federation plan as an insiders' scheme to discourage deservedly harsh penalties. After a false start, HHS plans to start the bidding process soon. The data bank probably won't be in operation until mid-1989 -- at the earliest.

For the near term, medical boards will continue to police doctors. The Federation's Galusha believes more state lawmakers are waking up to the need for more money to run these panels. That cause should be helped by consumer activists' attacks on the lack of get-tough board activity. The People's Medical Society would go even further, by evicting all MDs from medical boards and replacing them with consumers. That point of view is not universal -- most experts believe medicine is so complex that doctors must be involved in peer review. The future seems sure to hold tighter state disciplinary laws -- but doctors are likely to have less control over the process in the future.

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State Health Legislation Report May 1978

o Physicians Licensure Discipline

MEDICAL LICENSURE AND DISCIPLINE

Alabama has passed a law providing that the imposition of the penalty of suspension or revocation of a license to practice medicine shall create a presumption that the continuation in practice of the physician constitutes an immediate danger to the public health, safety, and welfare. Pending judicial review of the medical board decision, there is to be no stay of the decision to suspend or revoke the decision unless a reviewing court finds that the board acted without statutory authority, was arbitrary or capricious, or acted in gross abuse of its discretion. (S.B. 132; Ala. Code §34-24-367)

Florida has passed legislation expanding reporting requirements and creating a Division of Medical Quality Assurance. Under the new provisions, all final disciplinary actions taken by peer review panels must be reported to the Division of Medical Quality Assurance within ten working days. The Division is to determine whether the conduct involved in each report is subject to disciplinary action. In addition, physicians, chiropractors, podiatrists, nurses, pharmacists, and dentists must report to the Division any physician who the health care provider knows has violated the physician discipline statute. A health care provider who fails to report such a physician is subject to penalties. Another new reporting provision requires physicians, podiatrists, and dentists to report to the Department of Professional Regulation the final disposition of all claims against them personally. (S.B. 6-xxxxx)

Indiana has added a provision to its medical licensing law providing that the medical licensing board may issue a probationary license where it determines that an applicant for licensure has committed an act that would have subjected the applicant to disciplinary action if he had been licensed at the time of the act. As a condition for issuance of a probationary license, the board may require the licensee to perform any of the following acts: 1) regularly report to the board concerning matters that are the basis of probation; 2) limit practice to the areas prescribed by the board; 3) continue or renew professional education; 4) perform acts, or refrain from performing acts, as deemed appropriate by the board; or 5) engage in community service without compensation as specified by the board. (S.B. 2; Ind. Code §25-22.5-5-2.5)

Indiana has passed legislation establishing "health professions standards of practice," which provides that state health regulatory boards may impose sanctions upon a health practitioner where the practitioner has: 1) engaged in fraudulent conduct; 2) been convicted of a crime that has direct bearing on the practitioner's ability to practice competently; 3) knowingly violated a state or federal law regulating the profession; 4) continued to practice

although he has become unfit to practice due to professional incompetence, failure to keep up with current professional practice, or impairment due to drugs or alcohol; 5) engaged in lewd or immoral conduct in connection with the delivery of professional services; or 6) allowed his name or license to be used by another. (S.B. 2; Ind. Code §25-1-9)

PROFESSIONAL LIABILITY

Florida has passed comprehensive professional liability legislation addressing numerous aspects of medical negligence claims. The medical negligence claims components include a requirement that, prior to initiating litigation or rejecting a claim, parties must conduct an investigation and submit a verified written medical expert opinion corraborating grounds to initiate medical negligence litigation or grounds for rejecting the claim of medical negligence.

A second medical negligence claim component provides that the parties may elect to have damages determined through voluntary, binding arbitration. Under the arbitration scheme: 1) economic damages are offset by collateral source payments; 2) noneconomic damages are limited to $250,000; 3) future economic damages are to be paid in periodic payments; 4) punitive damages awards are prohibited; 5) the defendant pays the claimant's attorney fees (not to exceed 15% of the award) and the costs of the arbitration proceeding; and 6) each defendant who submits to arbitration is to be jointly and severally liable for all damages. If a defendant refuses a claimant's offer to arbitrate, at any subsequent trial where the claimant prevails, there is no limitation on damages and the claimant is entitled to recover prejudgment interest and attorney fees of up to 25% of the award. If a claimant rejects a defendant's offer to arbitrate, noneconomic damages are limited to $350,000, future economic damages are to be paid in periodic payments, and there is an offset of future collateral source payments.

Another medical negligence claim component of the new law creates a no-fault compensation system for birth related neurological injuries. Under "The Florida Birth-Related Neurological Injury Compensation Plan," lawsuits against participating physicians for birth-related neurological injuries are prohibited. Each claim is to be reviewed by a medical advisory panel as to whether the injury is a birth-related neurological injury. The deputy commissioner of the Division of Workers' Compensation is to determine whether a birth-related neurological injury occurred, whether obstetrical services were delivered by a participating physician, and how much compensation is awardable. A "participating physician" is a physician who performs obstetrical services and who pays an annual assessment of $5,000 to the

"Birth-Related Neurological Injury Compensation Trust Fund." The Fund is also financed through an annual assessment on hospitals of $50 per infant delivered and an annual assessment of $250 on all other licensed physicians. (S.B. 6-xxxxx)

Florida also amended its Good Samaritan law to provide that any hospital, hospital employee, or physician who provides emergency room medical care shall not be held liable for damages resulting from such medical treatment, unless the circumstances demonstrate "reckless disregard" for the life or health of the patient. Another provision of the new Florida legislation, however, provides that physicians may not engage in a concerted effort to refuse to render services to emergency room patients. In addition, the new law provides that a hospital may not terminate or substantially reduce the availability of emergency or trauma services without first obtaining a certificate of need for such termination. A certificate of need for termination of services will not be approved unless it is shown that there is no need in the area for continuing the emergency or trauma services (S.B. 6-xxxxx; Fla. Stat. §768.13)

Massachusetts has amended its consumer protection law to provide for regulation of listing services that compile plaintiff personal injury listings for distribution to subscribers. The law provides that no plaintiff personal injury listing may be sold or distributed unless it includes clear and accurate information as to the names and addresses of the parties, the claim of the plaintiff, and the current status or disposition of the matter listed. Every listing service must disclose to all persons named in a plaintiff personal injury listing, the fact that such a listing exists, the information contained therein, and identity of all subscribers. All persons listed also shall be furnished with a disclosure statement notifying them of their right to review the information and to dispute the completeness or accuracy of the information. The law also provides that it is an "unfair and deceptive act or practice" to retaliate against personal injury plaintiffs by refusing to provide health care services to a person or his family because he is named in a plaintiff personal injury listing. There is a presumption of retaliation where a plaintiff's name appeared in a listing and a health care provider subscriber refused to provide services. The presumption may be rebutted by a showing by the health care provider by a preponderance of the evidence that the plaintiff was refused health care services for a valid business reason and not in whole or in part due to the appearance of the plaintiff's name in the listing. (H.B. 2328; Mass. Gen. Laws Ann. ch. 93, §§95-100)

ATTACHMENT C
Information on the National Practitioner Data Bank,
Professional Licensing Report, January 1989

and before he was suspended, Bambic stole $300,000 from more than a dozen other clients.

Unfair and unresponsive process

HALT criticizes the discouraging tone of most disciplinary agencies' informational brochures, many of which advise clients not to complain about disagreements, mistakes, failures of communication, or simple neglect because these do not usually constitute unethical conduct. Others warn consumers that filing could "drastically affect the lawyer's ability to earn a living as well as his personal standing in the community." Moreover, fifteen agencies do not provide complainants with immunity from being sued for libel or slander based on information they provide the discipline agency.

Lack of public participation Although a number of states since 1970 have begun to allow nonlawyers as members on disciplinary hearing panels (11 agencies report requiring one nonlawyer among the three members on hearing panels), HALT found the processes continue to be controlled by lawyers and strongly influenced by state bar associations. "As the profession's trade association, state bar associations advance the profession's public relations and economic interests. These interests conflict with uncovering attorney misconduct," the report maintains. Most complaints do not involve sophisticated allegations that nonlawyers would not understand; rather they involve allegations of theft, inordinate delay, substance abuse, and the like.

Recommendations The report calls for a great variety of reforms including public audits of each state's system, nonlawyer control over disciplinary governing boards, improved complaint handling, more responsive investigative and hearing processes, and stronger penalties including permanent disbarment for some offenses. But HALT strongly indicts the basic premises of the system of attorney discipline and calls for discipline to be conducted by a publicly accountable body It maintains, quoting Stanford law professor Deborah Rhode: "No matter how well intentioned . . . no vocational group is well situated to pass judgment on matters that directly implicate its economic interests, social status, and self-image." The report predicts: ". . . as long as consumers' interests are secondary, discontent with lawyers and legal services will mount as will pressure for consumer reforms."

Questions and Answers on the National Practitioner Data Bank

On December 30, 1988, the Department of Health and Human Services announced it had awarded a $15.9 million five-year contract to establish and operate the National Practitioner Data Bank to Unisys, an information systems company with corporate headquarters in Blue Bell, Pennsylvania. Because of the significance of the project to licensing boards, this section of PLR is devoted to questions and answers on the data bank.

What is the purpose of the data bank?

The data bank was initially authorized to restrict the ability of physicians and dentists to move their practices from one state to another with little likelihood of discovery of previous substandard professional performance. It has since been expanded to include a range of health practitioners. It will be the first nationwide repository of information on payments of malpractice claims and disciplinary actions taken by state licensing authorities and health care entities against licensed health practitioners

How soon will the data bank be operational?

While originally slated to commence operation sometime in the summer, the data bank is now expected later this year to start collecting information on physicians and dentists. No information is to be reported to the data bank until the date of the beginning of its operation is announced in the *Federal Register.*

What regulations govern the data bank?

A confusing aspect of the National Practitioner Data Bank has been the fact that at least two separate statutes dictate its structure and operation. Title IV of the Health Care Quality Improvement Act of 1986 (Public Law 99-660) mandated the establishment of the data bank for physicians and dentists. Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) expanded the data bank operation to include other licensed health professionals.

Only the rules for Title IV have been proposed so far. They were published in the March 21, 1988 Federal Register, followed by a period of public comment. The final regulations are expected to be published early in 1989. The rules for Section 5 are still under development.

Where will the data come from?

Under Title IV, four types of data must be reported to the data bank:

Malpractice data Any entity such as an insurance company or self-insured hospital that makes a malpractice payment on behalf of any licensed health practitioner as the result of a court judgment or out-of-court settlement must report requisite data to the data bank and to the appropriate licensing board.

Disciplinary licensure data State medical and dental boards must report the disciplinary action they execute against the license of a physician or dentist to the data bank.

Adverse clinical privilege data Health care entities must report an adverse action taken against a physician's or dentists' clinical privileges, when such action will last more than 30 days. They may, if they choose to do so, report such actions on other health practitioners.

All hospitals and other health care entities, such as health maintenance organizations and group medical practices, report when they have used peer review (due process) and when they are assessing practitioner competency or professional conduct.

Adverse membership data Professional societies must report their adverse actions taken against the membership of a physician or dentist when they have reached that action through peer review (due process) and when they have been assessing practitioner competency and/or professional conduct.

Professional societies of other health fields may, if they so choose, report adverse actions taken against the membership of a practitioner when they have reached that action through peer review (due process) and when they have been assessing practitioner competency or professional conduct.

The health care entities and professional societies submit their reports to the appropriate state medical or dental board in duplicate for physicians and dentists and in triplicate for other practitioners. Thus, the board retains one copy for its own use, sends one to the data bank, and if the action is on other than a physician or dentist, sends the third copy to the appropriate other licensing board.

Under Section 5, state boards of all licensed health practitioner fields must submit requisite data to the data bank on the disciplinary actions taken against their practitioners. In addition, state and local governments which take disciplinary actions on the licenses of health care entities under their authority must report requisite data to the data bank.

Will practitioners other than physicians and dentists be phased in later?

According to project officer Margaret Wilson, contrary to reports, there was never any intention to phase in practitioner groups at different times under the request for proposals or the contract. The only thing preventing the immediate inclusion of groups other than physicians and dentists as mandated under Section 5 is that regulations for Section 5 are still under development.

Will actions taken before the data bank becomes operational have to be reported?

No retroactive reporting of data will be required. According to Margaret Wilson, this decision was made by the Office of General Counsel of the Department of Health and Human Services.

Who will have access to the data?

All hospitals must query the data bank every two years regarding those on their medical staff or holding clinical privileges. Hospitals also must query the data bank when negotiating to bring individuals onto their medical staff or grant them privileges. Hospitals may query at other times as they wish and may query regarding health practitioners other than physicians and dentists.

State licensing boards for any health field may query the data bank regarding an individual when they need information to achieve their mission.

Other health care entities may query the data bank when they are negotiating to bring an individual onto their staff. The law requires these entities to use peer review (due process) when they are taking adverse actions regarding the competency or professional conduct of one of their practitioners.

When a lawsuit is filed against a hospital and one of its practitioners, a plaintiff or a plaintiff's attorney may access the data bank regarding a given practitioner, if the plaintiff or plaintiff's attorney can prove the hospital has failed to query the data bank as required by law.

Individuals may query regarding their own records in the data bank. However, they will routinely receive from the data bank a copy of the data being entered about them each time such a report is received by the data bank.

Under Section 5, state licensing boards, hospitals, and health care entities can receive data. The details of the other entities which may obtain data have not been finalized.

Will the data bank charge fees for access to records?

Individuals may obtain their own record at no cost, while others who query the data bank must pay a user's fee.

How will the confidentiality of the information in the data bank be assured?

The law states that the data are to be used for professional review activity. While individuals may have access to their own records, civil money penalties may be levied against state licensing board members and employees, staff and employees of health care entity review boards, and employees of the contractor if they violate the confidentiality requirement of the law. Penalties of up to $10,000 per violation are provided for.

According to Margaret Wilson, the bank will use an identifier system to assure proper identification of each individual on whom information is banked, and to assure that those reporting to the data bank and those obtaining data from it are eligible to do so. There will also be comprehensive security to prevent manipulation of the data by unauthorized sources.

What about states with strong freedom of information laws?

The law states that nothing in its requirements "shall prevent the disclosure of the data by a party which is otherwise authorized, under applicable state law, to make such disclosures." In states with sunshine laws, this could mean that state boards which have obtained data bank information may have to release it.

Will information in the data bank be available for research purposes?

As part of the contract, Unisys is to provide a research service program through which aggregate data without identifying information will be available to interested parties. This will offer the opportunity for research which was previously almost impossible, says Margaret Wilson. "For example, it will be possible to conduct a study to learn if physicians whom state medical boards discipline in a certain manner for specific causes are those who also have a profile of certain types of malpractice claims of DEA [Drug Enforcement Administration] restrictions, or adverse clinical privilege actions."

What if boards fail to comply with the law?

When a board fails to report to the data bank the data required, it will receive a notice of noncompliance and an opportunity to comply. If it still fails to report, the secretary of Health and Human Services must designate another qualified entity to report. According to Margaret Wilson, this provision "may not be as innocuous as it seems."

What kind of advisory group will work with the contractor?

Fourteen private organizations and three federal agencies will be represented on the executive committee formed to provide advice to Unisys as it develops the national practitioner data bank. During the first year of the contract, the group is scheduled to meet quarterly, with the first meeting sometime in February. HHS Secretary Otis Bowen announced January 12 that, in addition to two citizen members, the organizations represented on the executive committee are:

American Academy of Medical Directors, Tampa, Florida

American Association of Dental Examiners, Chicago, Illinois

American College of Healthcare Executives, Chicago, Illinois

American College of Legal Medicine, Omaha, Nebraska

American Dental Association, Chicago, Illinois

American Health Care Association, Washington, D.C.

American Hospital Association, Chicago, Illinois

American Insurance Association, Washington, D.C.

American Medical Association, Chicago, Illinois

American Osteopathic Association, Chicago, Illinois

American Osteopathic Hospitals Association, Alexandria, Virginia

Federation of State Medical Boards, Fort Worth, Texas

Group Health Association of America, Washington, D.C.

National Council of State Boards of Nursing, Chicago, Illinois

U.S. Department of Defense, Washington, D.C.

Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C.

The U.S. Veterans Administration, Washington, D.C.

How will further information about the data bank be provided?

As part of its contract, Unisys will develop and provide a communication and educational program to assure all those whom the law requires or allows to participate in the data bank know in advance what they are to do. Educational materials and conferences will be part of this program.

For further information in the meantime, contact Margaret A. Wilson, Project Officer, National Practitioner Data Bank, Office of Quality Assurance, BHP/HRSA/DHHS, Parklawn Building, Room 8-15, 5600 Fishers Lane, Rockville, Maryland 20857 (301) 443-2300.

UPCOMING MEETINGS

Federation of Associations of Regulatory Boards
(202) 783-6500

Annual Forum
Sheraton Waterfront Hotel
San Francisco, California
February 10-12, 1989

National Clearinghouse on Licensure, Enforcement & Regulation (CLEAR)
(606) 252-2291

Eastern Regional Conference
Sheraton-Charleston
Charleston, South Carolina
March 2-3, 1989

Western Regional Conference
Red Lion Inn Riverside
Boise, Idaho
March 31-April 1, 1989

1989 Annual Meeting
Westin Hotel
Indianapolis, Indiana
September 5-9, 1989

Federation of State Medical Boards
(817) 335-1141

1989 Annual Meeting
Westin Hotel
Chicago, Illinois
April 27-29, 1989

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ATTACHMENT D
Codes used by Alaska's Medical Board
when Disciplining Physicians

100 CODE/REVOCATION

100 LICENSE REVOKED
101 ALCOHOLISM
102 INCOMPETENCY/MALPRACTICE/NEGLIGENCE
- 102.1 Failed to provide emergency and/or timely treatment or abandoned patient
- 102.2 Performed improper or unnecessary surgery
- 102.3 Malpractice
- 102.4 Gross Negligence or incompetence
- 102.5 Other incompetency/malpractice or negligence

103 NARCOTIC VIOLATIONS
- 103.1 Intentionally/unlawfully dispensing in violation of the laws
- 103.2 Prescribing/distributing or selling to addicts
- 103.3 Prescribing without medical indication or examination
- 103.4 Excessive prescribing to detriment of patients
- 103.5 Prescribing drugs for sexual favors
- 103.6 Failing to keep records on substances dispensed/prescribed
- 103.7 Personal use or addiction
- 103.8 Other narcotic violations

104 FELONY
- 104.1 Assault
- 104.2 Abortion
- 104.3 Conviction of a crime
- 104.4 Petit Larceny
- 104.5 Grand Larceny
- 104.6 Murder
- 104.7 Homicide or manslaughter
- 104.8 Conviction of crimes not listed

105 FRAUD
- 105.1 Medicaid/Medicare/Medi-Cal or other insurance fraud
- 105.2 Using mails to defraud
- 105.3 Receiving/concealing stolen property
- 105.4 Income tax evasion
- 105.5 Obtaining license by fraud
- 105.6 Other fraud

110 UNPROFESSIONAL CONDUCT
- 110.1 Conviction of a crime
- 110.2 Moral turpitude
- 110.3 Criminal sexual conduct
- 110.4 Engaging in lewd conduct
- 110.5 Other unprofessional conduct

120 MENTAL REASONS
130 ALLOWING UNLICENSED PERSON TO PRACTICE
140 VOLUNTARY SURRENDER OF LICENSE
- 140.1 Intemperate use of alcohol
- 140.2 Narcotic violations/use
- 140.3 Pending disciplinary hearing
- 140.4 Due to health related problems
- 140.5 Other reasons for voluntary surrender of license

150 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
180 OTHER REASON LICENSE REVOKED - NOT CLASSIFIED

200 CODE/PROBATION

200 PROBATION FOR MEDICAL LICENSES (ALONE OR AFTER STAT OF REVOCATION)
201 ALCOHOLISM
202 INCOMPETENCY/MALPRACTICE/NEGLIGENCE
- 202.1 Failed to provide emergency and/or timely treatment or abandoned treatment
- 202.2 Performed improper or unnecessary surgery
- 202.3 Malpractice
- 202.4 Gross Negligence or incompetence
- 202.5 Other incompetency/malpractice or negligence

203 NARCOTIC VIOLATIONS
- 203.1 Intentionally/unlawfully dispensing in violation of the laws
- 203.2 Prescribing/distributing or selling to addicts
- 203.3 Prescribing without medical indication or examination
- 203.4 Excessive prescribing to detriment of patients
- 203.5 Prescribing drugs for sexual favors
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204 FELONY
- 204.1 Assault
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- 204.4 Petit Larceny
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- 204.6 Murder
- 204.7 Homicide or manslaughter
- 204.8 Conviction of a crime not listed

205 FRAUD
- 205.1 Medicaid/Medicare/Medi-Cal or other insurance fraud
- 205.2 Using mails to defraud
- 205.3 Receiving/concealing stolen property
- 205.4 Income tax evasion
- 205.5 Obtaining license by fraud
- 205.6 Other fraud

210 UNPROFESSIONAL CONDUCT
- 210.1 Conviction of a crime
- 210.2 Moral turpitude
- 210.3 Criminal sexual conduct
- 210.4 Engaging in lewd conduct
- 210.5 Other unprofessional conduct

220 MENTAL REASONS
230 ALLOWING UNLICENSED PERSON TO PRACTICE
250 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
260 PROBATION MODIFIED
270 VIOLATED PROBATION
280 OTHER REASON NOT CLASSIFIED

300 CODE/SUSPENSION

300 LICENSE SUSPENDED
301 ALCOHOLISM
302 INCOMPETENCY/MALPRACTICE/NEGLIGENCE
303 NARCOTIC VIOLATION
- 303.1 Intentionally/unlawfully dispensing in violation of the laws
- 303.2 Prescribing/distributing or selling to addicts
- 303.3 Prescribing without medical indication or examination
- 303.4 Excessive prescribing to detriment of patients
- 303.5 Prescribing drugs for sexual favors
- 303.6 Failing to keep records on substances dispensed/prescribed
- 303.7 Personal use or addiction
- 303.8 Other narcotic violations

304 FELONY
- 304.1 Assault
- 304.2 Abortion
- 304.3 Conviction of a crime

305 FRAUD
- 305.1 Medicaid/Medicare/Medi-Cal or other insurance fraud
- 305.2 Using mails to defraud
- 305.3 Receiving/concealing stolen property
- 305.4 Income tax evasion
- 305.5 Obtaining license by fraud
- 305.6 Other fraud

310 UNPROFESSIONAL CONDUCT
- 310.1 Conviction of a crime
- 310.2 Moral turpitude
- 310.3 Criminal sexual conduct
- 310.4 Engaging in lewd conduct
- 310.5 Other unprofessional conduct

320 MENTAL REASONS
330 ALLOWING UNLICENSED PERSON TO PRACTICE
350 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
380 OTHER REASON FOR SUSPENSION - NOT CLASSIFIED

400 CODE/MISCELLANEOUS

400 MISCELLANEOUS
401 LICENSE RESTORED OR REINSTATED
- 401.1 Probation terminated - issued unrestricted license to practice
- 401.6 Restored or reinstated but still on probation
- 401.7 Restored or reinstated but must limit practice to certain areas or institution
- 401.8 Other restoration/reinstatement, not listed

402 REINSTATEMENT DENIED
403 LICENSES BY RECIPROCITY DENIED
404 ADMITTANCE TO EXAMINATION DENIED
405 NARCOTIC PERMITS
- 405.1 Permission given to apply for permit
- 405.2 Directed not to apply for permit
- 405.3 Requested to and/or voluntarily surrendered permit
- 405.4 Permit no longer needed as per agreement with board
- 405.5 Permit denied
- 405.6 Permission given to apply for stated schedules

406 REPRIMAND OR ADMONISHED
407 DUPLICATE LICENSES ISSUED
- 407.1 Change of name
- 407.2 License stolen or lost

408 ACCUSATION DISMISSED
409 DENIED PERMANENT LICENSE - ISSUED TEMPORARY LICENSE
410 OTHER MISCELLANEOUS ACTION - NOT CLASSIFIED (stipulation or consent order)
411 ALLEGATIONS OF CHEATING
- 411.1 Exam taken but grades not given out
- 411.2 Ejected from Exam

412 LICENSURE DENIED
- 412.1 Fraudulent Credentials
- 412.2 Failed to submit acceptable evidence of post-graduate training
- 412.3 Falsified Application
- 412.4 Other not listed

414 REQUEST TERMINATION OF PROBATION DENIED
490 ACCUSATION FILED - CONTACT MEDICAL BOARD

REV.: 1985

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.
2630 West Freeway, Suite 138, Fort Worth, Texas 76102-7199
(817) 335-1141

DISCIPLINARY ACTION REPORT FORM

The following is a report of formal disciplinary action taken by the undersigned state medical board (or the appropriate disciplinary entity) which is a matter of public record.

****

A. PHYSICIAN AFFECTED:

1. Full Name: _____

   Other Names Used/Maiden Name: _____

2. Most Recent Address: _____

   _____

3. Date of Birth (month/day/year): _____ / _____ / _____ Social Sec. No.: ___ - ___ - ____

4. Medical License No.: _____ ECFMG No. (if any): _____

5. Medical Degree Held: _____ Year Degree Awarded: _____

6. Medical School Awarding Degree: _____

7. Please list the other state(s) in which this physician is licensed:

   _____

   _____

B. ACTION:

1. Using the disciplinary codes on the back of this form, enter below the most appropriate action code number and description. (Example: Code No.: 412.1 Description: Licensure denied-fraudulent credentials.)

   Code No.: _____ Description: _____

   _____

2. Date Disciplinary Action Taken (month/day/year): _____ / _____ / _____

3. Please enclose the applicable board order and any written findings of fact which were made. Check here if enclosed: _____

   If no findings of fact are enclosed, please briefly state the facts of the case:

   _____

   _____

   _____

   _____

4. Please enclose any other related information from the public record you believe is appropriate. Check here if enclosed: _____

****

The undersigned certifies the information above is correct.

_____ _____

Name of Board (or appropriate entity) Submitted by (name)

Date Submitted: _____ / _____ / _____ _____

Title

Federation Reports

Codes	name	date of action	
403	Stewart, Donald J	1983	denied lic based on revocation in CA
412	Ogley, Helen	1985	lic denied
412.3	Spriggel, Ronald	1984	lic denied - fraudulent app
406	Merrick, Michael	84	censured + restricted [illegible]
101	Davenport, Wayne	83	revoked - ETOH
412	Strand, Ronald	83	lic denied based on action in other
505	Brax, Charles	87	suspended - [illegible] violation
300	Temple, Michael	86	suspended [illegible] API
102, 105, 110	Sobun, Martin DPM	87	revoked fraud, incompetency, unprof. conduct
260	Merrick, Michael	86	probation modified
103 104	Salgado, Fernando	85	revoked narcotic violation felony
102	Storrs, Henry	81	revoked incompetent
203	Pine, Charles	87	probation - narcotic violation
201	[illegible], Ray	87	probation ETOH
103 & 103.3	[illegible], John	87	criminal sale dangerous drugs
412.3	Lopez, Arthur	88	falsified app
201	Davenport, Wayne	88	probation ETOH
401	Price, John	88	reprimand
1405	[illegible], Harold	88	violating [illegible]
203.7	[illegible], Doug	89	probation - [illegible]
201	Sullivan, Paul	89	probation ETOH [illegible]
410	Lewis, Clement J	89	stipulated agreement - [illegible]

ELEMENTS OF A MODERN STATE MEDICAL BOARD

A PROPOSAL

6

THE FEDERATION OF
STATE MEDICAL BOARDS
OF THE UNITED STATES

2630 WEST FREEWAY
SUITE 138
FORT WORTH, TEXAS
76102-7199

817 335-1141
FAX 817 332-1909

DATE: August 15, 1989

TO: Distinguished State Officials and Legislators

FROM: Melvin E. Sigel, MD, Chairman, Federation Project Work Panel

ABOUT: Enclosed *Elements of a Modern State Medical Board: A Proposal*

Enclosed for your consideration is a copy of a document recently completed by a special task force of the Federation of State Medical Boards of the United States. Called the Project Work Panel, the task force has spent over a year developing the *Elements of a Modern State Medical Board: A Proposal* under a federal contract awarded by the Health Resources and Services Administration of the US Department of Health and Human Services. The document was first introduced during a meeting of the National Conference of State Legislatures' Health Committee at the NCSL's annual meeting in Tulsa on August 7. Its preparation and purpose are discussed succinctly in its preface and introduction, which I hope you will read before reviewing the full document. Let me point out here, however, that **the *Elements* is not a policy or position statement by the Federation of State Medical Boards.** It is the result of the Project Work Panel's study and discussion under the federal contract and will be evaluated as carefully by the Federation as by others interested in enhancing the effectiveness of state medical boards.

My colleagues and I on the Project Work Panel would be pleased to receive your comments on our effort, and we hope you will find it useful as you evaluate your own medical board. The *Elements* will achieve its purpose if it stimulates constructive discussion concerning the structure and function of state medical boards in this country.

Should you have any comments or should you like to have additional copies of the *Elements*, please write to me care of Mr Dale G Breaden, Associate Executive Vice President, Federation of State Medical Boards, 2630 West Freeway, Suite 138, Fort Worth, Texas 76102-7199.

Thank you for your time.

MES:lm

CONTENTS

PREFACE

To be of value, an idea must be challenging enough to concern us a bit. Certainly, the idea of attempting to specify the elements fundamental to the structure and function of a modern state medical board meets that criterion, given the diversity of the states and the differences among the medical boards now in place. Needless to say, in undertaking preparation of the document you hold in your hand, the Federation of State Medical Boards of the United States was more than aware it faced a challenging idea, but one with which it had to deal.

In early 1988, the Division of Medicine of the Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services, requested proposals for the development of a document on board structure and function to be a complementary companion to the fifth edition of the Federation's *Guide to the Essentials of a Modern Medical Practice Act.* It was clear the Federation must respond: no other organization had the knowledge, experience, and resources required for the task. And no other could offer as responsible and informed an effort. If the project was to be undertaken at all, and it surely was, the Federation had to do it. The Federation's proposal was accepted and the organization was awarded HRSA Contract Number 240-88-0040 to develop the document and make it available for consideration by the public, the states, the state medical boards, medical organizations, and others.

The result is the *Elements of a Modern State Medical Board: A Proposal.* It is the product of over a year of research, inquiry, meetings, consultation, drafting, and redrafting by a special Federation task force called the Project Work Panel (PWP). The *Elements* is **not** a detailed model for a complete state medical practice act; it is focused only on the structure and function of a modern state medical board and on the powers, duties, and protections basic to that structure and function. In that context, it reflects the study, concepts, opinions, knowledge, and experience of the members and consultants of the PWP as officers, members, attorneys, and staff of state medical boards and as Federation leaders. It is **not** intended to be, and is **not**, a policy or position statement by the Federation of State Medical Boards. Though the outgrowth of a federally funded project conducted under the auspices of the Federation, it will be reviewed and evaluated by the Federation's Board of Directors and membership as carefully and critically as it should be by a wide range of interested and involved agencies, organizations, and individuals. Far from perfect, the *Elements* is simply the best effort of the PWP to develop a proposal for the structure and function of a modern state medical board consistent with the principles expressed in the Federation's formally approved *Guide to the Essentials of a Modern Medical Practice Act.* It is offered as a stimulus for discussion of a number of issues vital to improving the regulation of the medical profession in this country.

During the past year, the PWP carefully studied the basic structural and functional outlines of sixty-five medical boards, contacted fifty-six boards in telephone surveys on several specific issues, reviewed in detail the medical statutes of thirty-eight states, and analyzed the potential impact of the *Elements* if implemented in eighteen widely differing state settings. While developing the document, the PWP benefited greatly from the advice, insight, and counsel of twenty-six state medical board members, eighteen of whom were board presidents, and twenty-three state medical board

executives. They deserve much of the credit for what you may find agreeable in the *Elements* and none of the blame for what you may find disagreeable. They certainly earned the PWP's warmest thanks for their kind cooperation and thoughtful assistance.

The *Elements* is the responsibility of the members and consultants of the PWP, acting at the behest of the Federation to fulfill its federal contract. Whether the project achieved its true purpose or not, only you and time can judge. The idea, however, was worth the trying.

The Federation Project Work Panel

Melvin E. Sigel, MD, Chairman
Minnesota Board of Medical Examiners
Gerald J. Bechamps, MD
Virginia Board of Medicine
Leroy B. Buckler, MD
Delaware Board of Medical Practice
Thomas L. Conley, MD
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Susan M. Spaulding
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Counsel, West Virginia Board of Medicine

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Charlotte, North Carolina
Stephen S. Seeling, JD
Exec. Dir., South Carolina Board of Medical Examiners

Project Director

Dale G Breaden
Associate Executive Vice President, Federation of State Medical Boards

INTRODUCTION

The organization and activities of each of the more than sixty medical regulatory boards (allopathic, osteopathic, and composite) within the United States are determined by a unique state statute, usually referred to as a *practice act.* The differences among these statutes are related to the general administrative structure of each jurisdiction and to the needs of the public as they are perceived by each responsible legislative body.

The *Elements of a Modern State Medical Board: A Proposal* is not intended to encourage movement toward total uniformity among these statutes. Given the diversity of administrative structures and the variations in perceived needs, that would be a futile exercise. In any case, such differences have a positive creative value, allowing the evolution and testing of a range of new approaches in a number of jurisdictions at once. In light of the concepts and principles it offers for consideration, the *Elements* is intended to nurture that creativity by encouraging the public, state legislators, medical boards, medical societies, and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers, and funding of medical boards. In doing this, however, the *Elements* does **not** address issues relating to standards for licensure, grounds for disciplinary action, or rules and regulations. It is **not** an effort to provide a pattern for a complete medical practice act. It includes only those portions of an act the authors believe focus most directly on the medical board itself.

It is axiomatic that state medical boards can most effectively discharge their important responsibilities to society only if they are properly organized and effectively empowered. The project that resulted in development of the *Elements* was conceived because of the growing realization that some medical practice acts remain inadequate to enable boards to respond to broad public needs. While not advocating total uniformity, which would have a stultifying effect, the Federation of State Medical Boards has, for over three decades, encouraged and facilitated the improvement of the various state medical practice acts through its official publication, *A Guide to the Essentials of a Modern Medical Practice Act.* Now in its fifth edition, *A Guide to the Essentials of a Modern Medical Practice Act* has served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes. The *Elements* builds on the foundation of *A Guide to the Essentials of a Modern Medical Practice Act* and is, in effect, an explication of the chapters in that publication relating to board structure and function. Unlike the broad recommendations of *A Guide to the Essentials of a Modern Medical Practice Act,* however, the *Elements of a Modern State Medical Board: A Proposal* is presented in language and detail readily adaptable to statutory formats.

The *Elements* reflects not only relevant characteristics of effective current practice acts but also a number of innovative concepts not yet widely implemented. The result is a document, eclectic in its content, that its authors believe is worthy of consideration for adaptation to the requirements of any jurisdiction. While it could hardly be expected that any one jurisdiction would accept the *Elements* in every particular, the principles of responsibility, empowerment, and accountability the proposal clearly affirms should lead each jurisdiction to assess its present board to

determine if it provides maximum potential for protection of the public interest. Though presented for consideration as an integrated whole, the *Elements* offers significant approaches to a variety of issues that concern and trouble many boards: issues involving funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public's right to know, among other things. Any one or a combination of these approaches could be extracted from the *Elements* and adapted to meet the needs of specific boards.

In some states, responsibility for licensing and disciplinary functions is divided between two separate boards. In others, boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few, the board is simply an advisory body. In most states, the board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective board funding. Clearly, the *Elements* proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others. But it is also a reflection of those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It can be drawn upon by both MD and DO boards, making appropriate adaptations in the area of board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations. The *Elements* includes significant material on a wide range of issues, much of which has the potential to benefit any administrative structure.

Recognizing the differences between and among jurisdictions, the authors have designed the *Elements* with the flexibility to accommodate as many of those differences as possible while maintaining the integrity of their overall concept. Specific flexible factors are designated in the text by bracketed, italicized segments and are footnoted. In addition, some sections empower a board to adopt alternatives of its choice provided they are in accord with other state statutes. Finally, some sections, such as that relating to board committees, are phrased permissively or in order to allow a board needed discretionary authority. In a sense, the *Elements* can be seen, not as one proposal, but as various proposals. Each is applicable, in one form or another, to a diversity of settings and all are aimed at increasing or refining the ability of state medical boards to protect the health, safety, and welfare of the public.

The Federation Project Work Panel

ELEMENTS OF A MODERN STATE MEDICAL BOARD

A PROPOSAL

I. LEGISLATIVE FINDINGS AND DECLARATION

As a matter of public policy, the practice of medicine is a privilege granted by the people of this State acting through their elected representatives. It is not a natural right of individuals. Therefore, in the interests of public health, safety, and welfare, and to protect the people from the unprofessional, improper, and incompetent practice of medicine, it is the responsibility of the Legislature to enact laws regulating the granting and subsequent use of the privilege to practice medicine and to ensure, as far as possible, that only qualified and fit persons hold that privilege. The fundamental purpose of this statute is to protect the public, and any license, certificate, or other practice authorization issued pursuant to this statute shall be a revocable privilege and no holder of such a privilege shall acquire thereby any irrevocable right.

II. DEFINITIONS

License: any license, certificate, or other practice authorization granted by the State Medical Board pursuant to this or any other applicable statute.

Licensee: the holder of any license, certificate, or other practice authorization granted by the State Medical Board.

Statute: this statute or any other statute applicable to the State Medical Board.

III. STATE MEDICAL BOARD

A. Board Created

There is hereby created the State Medical Board (hereafter referred to as the Board) to regulate the practice of medicine in this State in accord with this statute and to otherwise enforce this statute.

B. Delegation of Duty

The duty of determining a person's initial and continuing qualification and fitness for the practice of medicine, of proceeding against the unlawful and unlicensed practice of medicine, and of enforcing this statute is hereby delegated to the Board. That duty shall be discharged in accord with this statute.

C. Interpretation of Powers

It is necessary that the powers conferred on the Board by this statute be liberally construed to protect the health, safety, and welfare of the people of this State.

D. Board Membership

1. Number

The Board shall consist of *[from twelve (12) to twenty-four (24)]* members, twenty-five percent (25%) of whom must be public members *[and at least one (1) of whom must be a doctor of osteopathic medicine].*[1] The remaining members must be doctors of allopathic medicine. The membership of the Board shall be drawn from as many different regions of this State as possible.

2. *Qualifications*

a. Public members must reside in this State and be persons of integrity and good reputation who have lived in this State for at least five (5) years immediately preceding their appointments, have never been authorized to practice a healing art, and have never had a substantial personal, business, professional, or pecuniary connection with a healing art or with a medical education or health care facility, except as patients or potential patients.

b. Physician members must reside in this State and be persons of recognized professional ability, integrity, and good reputation who have lived and actively practiced medicine in this State with a full and unrestricted medical license granted by this State for at least five (5) years immediately preceding their appointments.

c. Members must be citizens of the United States who have attained the age of majority as defined in the statutes of this State.

d. Members must be selected without regard to sex, race, national or ethnic origin, creed, religion, or age above majority.

e. No member shall be a registered lobbyist.

f. No member shall be an officer, board member, or employee of a statewide or national organization established for the purpose of advocating

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[1] Flexible Factors: The size of a state's physician population should be considered in determining how many persons would be required, within this range (12-24), to accomplish the work of the Board as envisioned in this document. Similarly, should the Board regulate both MDs and DOs, DO representation should be required if the DO population is judged to be significant.

the interests of or conducting peer review of health care practitioners licensed under this statute.

3. Terms

The term of Board service shall be four (4) years. A person shall not serve as a member of the Board for more than two (2) consecutive full terms, but may be reappointed two (2) years after completion of such service. For the purpose of this paragraph, a person who serves more than two (2) years of an unexpired term shall be considered to have served a full term. Terms of service shall be staggered, one fourth of the Board's membership being appointed each year. The term[s] of no more than *[one (1)/two (2)]* public member*[s]* shall expire in any one year.[2]

4. Requirements

a. Before entering on the duties of office, each member of the Board shall take the constitutional oath or affirmation of office and shall swear or affirm he or she is qualified to serve under all applicable statutes.

b. The Board shall conduct and new members shall attend a training program designed to familiarize new members with their duties. A training program for new members shall be held annually.

5. Appointment of Members

a. The members of the Board shall be appointed by the Governor, who shall make each appointment at least thirty (30) calendar days prior to the beginning of the Board term being filled. The Governor shall fill an unexpired term within thirty (30) calendar days of the vacancy's occurrence. Should the Governor not act as required by this paragraph, the Board, by majority vote, shall select a qualified person to serve until such time as the Governor acts.

b. Any individual, organization, or group may suggest potential Board appointees to the Governor. Medical societies and associations in this State shall be specifically requested to recommend two or more potential physician appointees for each available physician Board seat.

6. Removal of Board Members

A Board member shall be automatically removed from the Board should he or she

a. cease to be qualified;

b. be found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;

c. be found guilty of malfeasance, misfeasance, or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;

d. be found mentally incompetent by a court of competent jurisdiction;

e. fail to attend three successive Board meetings without just cause as determined by the Board, or, if a new member, fail to attend the new members' training program without just cause as determined by the Board;

f. be found in violation of this statute.

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[2] Flexible Factor: One (1) per year should the Board have up to four public members, two (2) per year should the Board have more than four public members.

7. Board Compensation/Reimbursement

a. Compensation: Each Board member shall receive compensation equivalent to three-quarters (3/4) the daily rate paid the State Commissioner of Health *[or equivalent State officer]*[3] for each day or part of a day spent in Board or Board-related meetings. Other Board-related services shall be compensated at the same level on a pro-rata basis as determined by the Board.

b. Expenses: Each Board member's travel and expenses for active Board service shall be paid at the State's current approved rate.

c. Education/Training: Travel, expenses, and daily compensation shall also be paid for each Board member's attendance, in or out of State, at up to ten full days of education or training per year directly related to Board duties and approved by the Board, except that daily compensation shall not be paid to physicians eligible for continuing medical education credit for such education and training.

E. Board Structure

1. Officers

The Board shall elect annually from its members a president, a vice president, a secretary-treasurer, and those other officers it determines are necessary to conduct its business. The officers shall serve for a one (1) year term. No person shall serve more than two (2) years in the same Board office during a single four (4) year Board term.

2. Duties of Officers

a. The president shall preside at Board meetings, arrange the Board agenda, sign Board orders and other required documents, appoint Board committees and their chairmen, coordinate Board activities, represent the Board before legislative committees, and perform those other duties assigned by the Board and this statute.

b. The vice president shall assist the president in all that officer's duties as requested by the president and shall perform the duties of the president in that officer's absence.

c. The secretary-treasurer shall be responsible for the keeping of Board minutes and records, for development of the Board budget, and for authorizing the expenditure of Board funds as directed by the Board and this statute.

3. Committees

To effectively facilitate its work, fulfill its duties, and exercise its powers, the Board may establish standing committees, including, but not limited to, licensing, investigation, finance, administration, personnel, rules, legislative communications, and public information committees. Ad hoc committees may be named as required. Committees shall be comprised of Board members only; and, except as otherwise noted in this statute, the president shall appoint members and chairmen of committees, who shall serve one (1) year terms and

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[3]The highest ranking health official in the State's executive branch.

may be reappointed. In the absence of regular committee members and when necessary to provide a quorum for the conduct of committee business, the president may appoint from the Board temporary members to a committee. Changes in membership shall not be deemed to affect or hinder the continuing business or activity of any committee.

If established, committees of the Board shall conform with the following.

a. *A licensing committee* shall be comprised of at least one-quarter (1/4) of the Board's members and shall be responsible for reviewing or directing the review of the qualifications of applicants for licensure in accord with this statute and Board policy and rules. It shall recommend to the Board the issuance or denial of licenses to applicants. A licensing committee may also be responsible for recommending or preparing for the Board's consideration and approval those examinations to be used in meeting the examination requirements set by this statute for medical licensure, and for other evaluative purposes. It may also administer or direct administration of all examinations in keeping with this statute and Board policy and rules.

b. An investigation committee shall be comprised of at least three (3) members of the Board, one (1) of whom must be a public member. An investigation committee shall be responsible for reviewing any complaint or charge referred to it in accord with written Board policy, for conducting an investigation to determine if there is a reasonable basis for the complaint or charge, for determining if a hearing is required, and for referring the matter to the appropriate prosecuting authority for presentation to the Board or, if directed to do so by the Board, to a Board designated hearing officer. In performing its duties, it shall have all the powers granted the Board in this statute to compel cooperation and the provision of information by individuals and institutions. The Board shall act in the capacity of the hearing and adjudicatory body, and no member of an investigation committee shall sit with the Board to hear or adjudicate a matter considered by his or her investigation committee nor shall he or she be counted as part of the Board in determining a quorum for the conduct of business during such a hearing or adjudication. Should the volume of complaints and charges require it, more than one investigation committee may be named at the Board's discretion.

c. *A finance committee* shall be comprised of the secretary-treasurer, acting as chairman, the president and vice president, and one public member of the Board. It shall be responsible for gathering budget information and proposing a budget to the Board for its consideration. It shall also arrange for annual audit of the Board's accounts by the State Auditor's Office *[or equivalent State office]*[4]. Budgets shall be prepared and adopted sufficiently in advance of the fiscal year to allow reasonable notice for increases or decreases in the fees and charges set by the Board.

d. Other committees created by the Board shall have those responsibilities,

[4]That office or authority charged by law with primary responsibility for auditing the State's accounts.

consistent with this statute, delegated to them by the Board.

4. Advisory Councils

To assist the Board in the performance of its duty relating to the regulation of health care professionals other than physicians, the president, with advice and approval of the Board, shall appoint a separate Advisory Council for each of the health care fields for which the Board has responsibility under this statute. Each Advisory Council shall be chaired by a member of the Board appointed by the president and shall have four other members. Each of those four other members shall meet the same requirements and be subject to the same limitations and causes for removal as a physician member of the Board, the requirement for medical licensure being replaced by that for full and unrestricted authorization to practice in the particular health care field of the Advisory Council to which he or she is appointed. Terms and limitations of service on an Advisory Council shall be the same as for the Board. The chairman of an Advisory Council shall be compensated and reimbursed as a Board member. The other four members of an Advisory Council may be compensated at an appropriate and reasonable level as determined by the Board and shall be reimbursed for meeting-related travel and expenses at the State's current approved rate. Advisory Councils shall meet at least once each year to review the regulation of their health care fields and to advise the Board on policy and rules relating to that regulation. The Board may also consult them or their members for advice on particular issues or disciplinary matters. The Board shall determine the specific functions of the Advisory Councils in keeping with this statute.

F. Funding

1. Revenues

The Board shall be fully supported by the revenues generated from its activities, including fees, charges, and reimbursed costs. All such revenues, with the exception of fines, shall be deposited in the State Treasury to the credit of the State Medical Board Account, which is hereby established and which shall also receive all interest earned on the deposit of such revenues. Such funds are appropriated continuously and shall be used by the Board only for administration and enforcement of this statute. All fines levied by the Board shall be deposited in the State General Fund.

2. Budget

The Board shall develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues, and interest thereon, from each health care field regulated shall fully support Board regulation of that field. The budget shall include allocations for establishment and maintenance of a reasonable reserve fund.

3. Setting Fees and Charges

All Board fees and charges shall be set by the Board pursuant to its proposed budget needs. Reasonable notice shall be provided for all increases or decreases in fees and charges.

4. Fiscal Year

The Board shall operate on the same fiscal year as the State.

5. Secretary-Treasurer

The secretary-treasurer of the Board, at the direction of the Board, shall oversee the collection and disbursement of funds. That officer shall be bonded by the Board in an amount to be fixed by the Board.

6. Audit

The State Auditor's Office *[or equivalent State office]*[5] shall audit the financial records of the Board annually and report to the Board and the Legislature.

G. Board and Committee Meetings

1. Location

The Board and its several committees shall meet in the Board's offices or other appropriate facilities in the same city as those offices. At their discretion, however, they may meet from time to time in other areas of the State to facilitate their work or to enhance communication with the regulated professions.

2. Frequency; Duration

a. The Board shall meet at least bimonthly *[quarterly]*[6] for a period sufficient to complete the work before it at that time.

b. Committees shall meet as directed by the Board. However, each standing committee shall meet at least once per year to review its area of responsibility and to prepare a formal annual report for presentation to the Board.

3. Special Meetings; Conferences

a. Emergency meetings of the Board may be called at any time by the president or at the request of an officer and two (2) Board members if required to enforce this statute. The Board may establish procedures by which its committees may call emergency meetings.

b. Informal conferences of an investigation committee may be called by the chairman of the committee for the purpose of holding discussions with licensees, accused or otherwise, who seek or agree to such conferences. Any disciplinary action taken as a result of such a conference and agreed to in writing by the Board and licensee shall be binding and a matter of public record. The holding of an informal conference shall be at an investigation committee's discretion and shall not preclude formal disciplinary investigation, proceedings, or action.

c. A telephone or other telecommunication conference shall be an acceptable form of Board meeting for the purpose of taking emergency action to enforce this statute if the president alone or another officer and two (2) Board members believe the situation precludes another form of meeting. The Board may establish procedures by which its committees may meet by

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[5] That office or authority charged by law with primary responsibility for auditing the State's accounts.

[6] Flexible Factor: Bimonthly meetings may not be required in states with small physician population. One meeting per quarter may be sufficient in such cases.

telephone or other telecommunication conference to take emergency action.

4. *Notice*

a. The Board shall establish a system for giving all Board and committee members reasonable advance notice of all Board and committee meetings.

b. The Board shall establish a system for giving the public, including its regulated professions, reasonable advance notice of all open Board and committee meetings. Emergency meetings, including telephone or other telecommunication conference meetings, shall be exempt from this public notice requirement.

5. *Quorum*

a. A majority of members shall constitute a quorum for the transaction of business by the Board or any committee of the Board.

b. Notwithstanding any provision of law to the contrary, the business of the Board and its committees shall be conducted in accord with this statute and with rules of parliamentary procedure adopted by the Board.

6. *Conflict of Interest*

No member of the Board, acting in that capacity or as a member of any Board committee, shall participate in the making of any decision or the taking of any action affecting his or her own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate. With advice of legal counsel, the Board shall adopt and annually review a conflict of interest policy to enforce this section.

7. *Records*

Minutes of all Board and committee meetings and proceedings, and other Board and committee records, shall be prepared and kept in accord with the Board's adopted rules of parliamentary procedure and other applicable State statutes.

8. *Open Meetings; Confidentiality*

a. All meetings of the Board and its committees shall be open to the public, with the following exceptions:

(1) meetings or portions of meetings of the Board devoted to consideration of personnel and staff employment or evaluation issues, to consultation with legal counsel, to business or contract matters the premature public knowledge of which would adversely affect the financial interests of the Board or the State, and to matters the Board is required to keep confidential by contract or statute;

(2) meetings or portions of meetings of the Board, acting in its capacity as a hearing or adjudicatory body, held to receive testimony or evidence the public disclosure of which the Board determines would constitute an unreasonable invasion of personal privacy, to consult with legal counsel, to deliberate issues, and to arrive at disciplinary judgments;

(3) meetings of an investigation committee;

(4) meetings of a licensing committee.

Recommendations or decisions made in non-public meetings shall be ratified in public and shall be matters of public record.

b. The minutes and all records of non-public meetings are privileged and confidential and shall not be disclosed except to the Board or its designees

for the enforcement of this statute, except that all licensing decisions made by the Board and all disciplinary orders, with the associated findings of fact and conclusions of law, issued by the Board shall be matters of public record.

c. The following shall be privileged and confidential:

(1) application and reregistration forms and any evidence submitted in proof or support of an application to practice, except that the following items of information about each applicant or licensee included on such forms shall be matters of public record:

(a) full name;
(b) date and place of birth;
(c) name(s) and location(s) of professional schools attended;
(d) school awarding professional degree, date of award, and designation of degree;
(e) site(s) and date(s) of graduate professional training;
(f) Board recognized specialty certification(s) held and date(s) granted;
(g) specialty and professional society memberships;
(h) year of initial licensure in this State;
(i) other states in which licensed to practice in the same field; and
(j) current office address and telephone number;

(2) all investigations and records of investigations;

(3) any report from any source concerning the fitness of any person to receive or hold a license;

(4) any communication between or among the Board and/or its committees, staff, advisors, attorneys, employees, hearing officers, consultants, experts, investigators, and panels occurring outside public meetings;

(5) the identity of that individual or entity filing an initial complaint with the Board.

d. Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to other boards, agencies, or law enforcement bodies of this State, other states, other jurisdictions, or the United States upon written official request by such an entity.

e. Nothing herein shall be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's right of due process under the law.

H. Offices; Administration

1. Offices

The Board shall maintain offices it determines are adequate in size, staff, and equipment to effectively carry out the provisions of this statute. At its discretion, it may establish branch offices, staffed and equipped as it finds necessary, in as many areas of the State as it believes require such branch offices to facilitate the work of the Board.

2. Administration

The Board, in keeping with applicable State statutes, shall set out the function, operation, and administrative structure of its offices.

I. **Staff; Special Personnel**

1. Board Authority

The Board is hereby empowered to determine its staff needs and to employ, fix compensation for, evaluate, and remove its own full-time, part-time, and temporary staff in accord with the statutory requirements of this State. It shall define the duties of and qualifications for staff positions and shall bond those members of staff charged with the handling of funds. Staff benefits shall be provided in accord with the statutes of this State.

2. Staff Positions

The Board's staff may include, but need not be limited to, the following:

a. an executive director, who, among administrative and other delegated responsibilities, may assist, at the Board's discretion, in the discharge of the duties of the secretary-treasurer;

b. one or more assistant executive directors;

c. one or more medical consultants, who shall be licensed to practice medicine in this State without restriction;

d. office and clerical staff;

e. one or more attorneys, who may be full-time employees of the Board, or assigned from the Office of the State Attorney General by agreement between the Board and that office, or in private practice;

f. one or more hearing officers, who shall be trained to conduct hearings according to law and vested with full authority to do so on the Board's behalf and in its name, but whose decisions shall be reviewed and approved, modified, or disapproved by the Board;

g. one or more investigators, who shall be trained in and knowledgeable about the investigation of medical and related health care practice;

h. experts and consultants; and

i. special agents.

3. Special Support Personnel

The Board may, at its discretion, and in accord with the statutes of this State, enlist the services of experts, advisors, consultants, and others who are not part of its staff to assist it in more effectively enforcing this statute. Such persons may serve voluntarily, be reimbursed for expenses in accord with State law and policy, or be compensated at a level commensurate with services rendered in accord with State law and policy. When acting for or on behalf of the Board, such persons shall benefit from the same immunity and indemnification protections afforded by this statute to the members and staff of the Board.

J. **Immunity; Indemnity; Protected Communication**

1. Immunity

There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, or any other person serving or having served the Board, either as a part of the Board's operation or as an individual, as a result of any act, omission, proceeding, conduct, or decision related to his or her duties undertaken or performed in good faith and within the scope of

the function of the Board.

2. Indemnity

If a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, or any other person serving or having served the Board requests the State to defend him or her against any claim or action arising out of any act, omission, proceeding, conduct, or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board, and if such a request is made in writing at a reasonable time before trial, and if the person requesting defense cooperates in good faith in the defense of the claim or action, the State shall provide and pay for such defense and shall pay any resulting judgment, compromise, or settlement.

3. Protected Communication

a. Every communication made by or on behalf of any person, institution, agency, or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint, or statement, shall be privileged. No action or proceeding, civil or criminal, shall be permitted against any such person, institution, agency, or organization by whom or on whose behalf such a communication was made in good faith.

b. The protections afforded in this provision shall not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

K. Duties of the Board

In addition to any other duties placed on the Board by this statute, the Board, acting in accord with this statute, shall:

1. enforce the provisions of this statute;

2. adopt and enforce rules to carry into effect the provisions of this statute and to fulfill its duties thereunder;

3. develop and use application and other necessary forms and related procedures it finds appropriate for purposes of this statute;

4. prepare or select, conduct or direct the conduct of, set passing requirements for, and assure security of licensing and other required examinations;

5. acquire information about and evaluate the professional education and training of applicants;

6. issue or deny licenses;

7. accept or deny applications for license reregistration based on the evaluation of adverse information, if any, relating to applicant fitness, performance, or practice;

8. review and investigate complaints and adverse information about licensees;

9. establish by rule a mechanism, which, at the Board's discretion, may involve cooperation with and/or participation by one or more Board approved professional organizations, for the identification and monitored treatment of licensees who abuse or are dependent on or addicted to alcohol or other addictive chemical substances;

10. establish by rule a mechanism by which licensees who believe they abuse or are or may be dependent on or addicted to alcohol or other addictive chemical substances, and who have not been identified by the Board through other sources of information, will be encouraged to report themselves voluntarily to the Board and/or, at the Board's discretion, to a professional organization approved by the Board to seek assistance and monitored treatment;

11. conduct hearings in accord with this statute;

12. adjudicate those matters that come before it for judgment under this statute and issue final decisions on such matters;

13. discipline licensees;

14. report all final disciplinary actions, license denials, and voluntary license limitations or surrenders related to physicians, with any accompanying Board orders, findings of fact and conclusions of law, to the Board Action Data Bank of the Federation of State Medical Boards of the United States and to any other data repository required by law, and report all such actions, denials, and limitations or surrenders related to other licensees, with the same supporting documentation, to the appropriate national practitioner data repositories recognized by the Board or required by law;

15. act to halt the unlicensed or illegal practice of medicine and to seek penalties against those engaged in such practice;

16. institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions of this statute;

17. establish appropriate fees and charges to ensure active and effective pursuit of its responsibilities;

18. employ, direct, reimburse, evaluate, and dismiss staff in accord with State procedures;

19. establish policies for Board operations; and

20. recommend to the Legislature those changes in or amendments to this statute that it determines would benefit the health, safety, and welfare of the public.

L. Powers of the Board

In addition to any other powers provided the Board herein, the Board, when acting in accord with this statute, shall have those powers necessary to fulfill its duties under this statute. Those powers shall include, but not be limited to, the following:

1. to employ or contract with one or more organizations or agencies known to provide acceptable examinations for the preparation and scoring of required examinations, and to employ or contract with one or more organizations or agencies known to provide acceptable examination services for the administration of required examinations;

2. to prescribe the time, place, method, manner, scope, and subjects of examination;

3. to impose sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal penalties, or any combination of these, against those who violate or attempt to violate examination security, those who obtain or attempt to obtain licensure by fraud or deception, and those who knowingly assist in

such activities;
4. to determine which professional schools, colleges, universities, training institutions, and educational programs are acceptable in connection with licensure under this statute, and to accept the approval of such facilities and programs by Board recognized accrediting bodies in the United States;
5. to require supporting documentation or other acceptable verifying evidence of any information provided the Board by an applicant or licensee;
6. to require information on an applicant's or a licensee's fitness, qualifications, and previous professional record and performance from recognized data sources, including, but not limited to, the Federation of State Medical Boards' Board Action Data Bank, other national data repositories, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and law enforcement agencies;
7. to require the self-reporting by applicants or licensees of any information the Board determines may indicate possible deficiencies in practice, performance, fitness, or qualification;
8. to require all licensees to report to the Board information that appears to show another licensee is or may be professionally incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in licensed practice, and to report to the Board and/or to an agency designated by the Board a licensee's possible dependence on alcohol or other addictive chemical substances;
9. when deemed appropriate by the Board to do so, to require professional competency, physical, mental, or chemical dependency examination of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids;
10. in establishing mechanisms for dealing with licensees who abuse or are dependent on or addicted to alcohol or other addictive chemical substances, to conclude agreements, at its discretion, with professional organizations, whose relevant procedures and techniques it has evaluated and approved, for their cooperation and/or participation;
11. to issue cease and desist orders, and to obtain court orders and injunctions to halt unlicensed practice, violation of this statute, or the rules of the Board;
12. to act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in the name of the State, including subpoenas for patient records, hold hearings, institute court proceedings for contempt to compel testimony or obedience to its orders and subpoenas, take evidentiary depositions, and perform such other acts as are reasonably necessary under law to carry out its duties;
13. to use preponderance of the evidence as the standard of proof and to issue final decisions when acting as trier of fact in the performance of its adjudicatory duties;
14. to present to the proper authorities information it believes indicates an applicant or licensee may be subject to criminal prosecution;

15. to issue conditional, restricted, or otherwise circumscribed licenses as it determines necessary;

16. to take the following actions, alone or in combination, against those found in violation of this statute:

a. revoke, suspend, restrict, and/or otherwise circumscribe the license;

b. place the licensee on probation with conditions;

c. levy fines and/or assess the costs of proceedings against the licensee;

d. censure, reprimand, and/or otherwise chastise the licensee;

e. require the licensee to provide monetary redress to another party, and/or provide a period of free public or charitable service;

f. require the licensee to satisfactorily complete an educational, training, and/or treatment program or programs;

g. require the licensee to successfully complete an examination or examinations designated by the Board;

17. to summarily suspend a license if it has cause to believe such action is required to protect public health and safety prior to hearing and final adjudication, and no court shall act to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion;

18. to determine and direct Board operating, administrative, personnel, and budget policies and procedures in accord with applicable State statutes;

19. to set necessary fees and charges, employ, evaluate, and dismiss personnel, and otherwise administer or direct administration of the Board in accord with applicable State statutes.

M. Board Reports

1. Annual Report

The Board shall present to the Governor, the Legislature, and the public, at the end of each fiscal year, a formal report summarizing its licensing and disciplinary activity for that year. The report shall include, but need not be limited to, the following information about each of the Board's regulated professions:

a. the total number of persons fully licensed by this State and the number of those persons resident in this State;

b. the number of persons holding each form of limited license authorized by this statute;

c. the number of persons granted a full license by this State for the first time in the past year, the number of those persons resident in this State, and the number of full licenses denied in the past year;

d. the number of resident licensees about whom a complaint, a charge, or an adverse item of information required by law was received in the past year;

e. the number and the sources, by category, of complaints, charges, and adverse items of information required by law received about resident licensees in the past year, and the number of these found not to warrant action under this statute and the rules of the Board;

f. the number of disciplinary investigations conducted by the Board or its representatives concerning resident licensees in the past year;

g. the number of disciplinary actions, by category, taken by the Board in the past year against resident and non-resident licensees;
h. a ranking, by frequency, of primary causes for disciplinary action against resident and non-resident licensees in the past year;
i. the number of actions taken or instigated by the Board to halt the unlawful practice of medicine in the past year;
j. a review of disciplinary activity related to holders of limited forms of license in the past year;
k. a review of the operations of the Board's current mechanisms for dealing with licensees dependent on or addicted to alcohol or other addictive chemical substances;
l. a schedule of all current fees and charges;
m. a revenue and expenditure statement for the past year indicating the percentage of revenue from and expenditures for each regulated profession;
n. a summary of other Board activities and a schedule of days met by the Board and each of its committees during the year.

2. *Public Record; Action Reports*

Each of the Board's license denials and final disciplinary orders, including any associated findings of fact and conclusions of law, shall be matters of public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record. All such denials, orders, surrenders, and limitations shall be promptly reported by the Board to the public, all health care institutions in this State, appropriate State and federal agencies, related professional societies or associations in this State, and any data repository required by Board rules or policy, the laws of this State, or the laws of the United States.

3. *Required Response to Complainants and Others Providing Information*

Persons or entities reporting to the Board adverse information about licensees or instances of possible unlicensed practice shall receive prompt acknowledgment of their reports from the Board. The Board shall also inform them of the final disposition of the matters reported.

HB146

Commission investigating physicians

Times 10/10/88

MIAMI (AP) — The Federal Trade Commission is interviewing hundreds of Florida doctors and demanding minutes from medical societies' meetings in an investigation of emergency room boycotts last year, a newspaper reported.

"I don't see any smoking guns," said John Thrasher, general counsel for the Florida Medical Association. "My guess is had they had something, it would have developed by now and something would have been done about it."

The FTC is questioning doctors to determine if they acted as individuals or as a group when they began refusing emergency calls in response to a 33 percent to 42 percent hike in insurance premiums, The Miami Herald reported Sunday.

Federal antitrust laws prohibit businesses from acting together for financial gain.

"We're intimidated," said Dr. Charles Lipman, a thoracic surgeon in North Miami Beach. "It's kind of like you're up against the big boys and that's scary."

The FTC won't discuss the growing investigation, but Lipman and Dade County hospital officials said hundreds of doctors have been questioned, either voluntarily or after being subpoenaed.

Some doctors who canceled their insurance saw eliminating emergency room work as a way to reduce the risk of being sued. Their actions captured the attention of politicians who promised to do something about the cost of malpractice insurance in Florida.

Last spring, the Legislature passed a law making it harder to gain damages in lawsuits from doctors who deliver babies and work in emergency rooms. Injured people must now prove the doctor showed reckless disregard for their care, and all lawsuits involving brain-damaged babies are handled by a state compensation system instead of the courts.

The changes stabilized insurance premiums and brought some doctors back to emergency rooms.

But many more are refusing to return unless Florida voters approve Amendment 10 on the November ballot. The law would ease their malpractice insurance burden by capping non-economic damages or those a jury would give for pain and suffering at $100,000.

The FTC began last year to investigate whether doctors were legally trying to change the state malpractice law, or illegally trying to pad their wallets.

The agency has forced some medical societies to hand over minutes from meetings and all written communication between its members. That includes identical letters the Palm Beach obstetricians sent to hospitals announcing the boycott.

FTC spokeswoman Dee Ellison said the agency will try to make doctors found to have violated antitrust laws to agree to stop refusing emergency room care.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 146
PUBLISH DATE: HOUSE 2/3/89

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to interview requirements for applicants for medical licenses...
Sponsor: Rules Committee
Requestor: Governor

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

The bill provides the Executive Secretary of the State Medical Board with the authority to conduct interviews required of applicants who seek to obtain a permit to practice medicine in Alaska. New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Officer
Phone: 465-2144
Division: Occupational Licensing
Date: January 19, 1989

Approved by Commissioner: Larry Mercalieff
Date: 1/21/89
Agency: Commerce and Economic Development

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

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-24-89

PLACE: C#17

SUBJECT OF MEETING:

HB 146
HB 166
(Work session)

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Randall Burns	Dept of Commerce	P.O. Box O-UC Juneau AK 99811	99811		465-2535	(Y)	N	HB 146
Kim Smith	MICA	10301 Glacier Juneau AK	99801	789-0611	789-7910	(Y)	N	HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

HB

147

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 147
PUBLISH DATE: HOUSE 2/3/89

FISCAL NOTE

REQUEST:

Revision Date: January 13, 1989
Title: Unemployment Insurance

Agency Affected: Revenue
BRU: Income & Excise Audit

Sponsor: Rules Committee
Requestor: Governor

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95
OPERATING						
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
LANDS & 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)

Prepared By: Steven E. Kettel
Division: Income and Excise Audit
Phone: (907) 465-2320
Date: January 13, 1989

Approved by Commissioner: Hugh Malone for
Agency: Revenue
Date: January 13, 1989

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

HB 147
HOUSE 2/3/89

Prepared by: Steven E. Kettel
Income and Excise Audit Division
Department of Revenue
January 13, 1989

Fiscal Note Analysis

The uniform unclaimed property act (AS34.45) requires agencies, such as the Department of Labor(DOL), to report and pay over to the Department of Revenue (DOR), all funds which are represented by a valid claim, but where the claimant cannot be located. DOR then advertises the names of the missing claimants and takes other steps to reunite the owner with the funds. DOR holds the funds in trust for the missing owner forever.

This legislation exempts from the reporting requirements of AS34.45 overpayments of unemployment insurance. Employers occasionally overpay the state unemployment insurance contributions and are sent a refund check. If an employer has changed addresses and not notified DOR or the USPS, the check is returned and held by DOL in the unemployment compensation fund under AS23.20.130. This bill will continue DOL practice and remove these funds from the reporting requirements of AS34.45.

HOUSE COMMITTEE REPORT

(7)

Date Referred: February 3, 1989

FURTHER REFERRALS: JUDICIARY
FINANCE

Date of Committee Action: __________

The LABOR & COMMERCE Committee recommends that:

HOUSE BILL NO. 147 [UNEMPLOYMENT INSURANCE]
"An Act relating to unemployment insurance and unemployment insurance contribution overpayments; establishing a priority for payment; and providing for an effective date."

[ ] be replaced with ______________________ [ ] the same title
[ ] a new title

[ ] have 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

APPROVES PREVIOUS:

[ ] fiscal note(s) published: ______________

[ ] zero fiscal notes(s) published: ______________

SIGNING DO PASS:

Dave Donley

[illegible]

Mark Boyer

SIGNING OTHER THAN DO PASS:
(Do Not Pass, No Recommendation, Amend)

[illegible] No Rec

[illegible] NR

[illegible] no rec.

Dave Donley
Chairman's signature

SECTION-BY-SECTION ANALYSIS
House Bill 147

Section 1: [Sec. 1 of CS for HB 384 (L&C)]

The proposed amendment of AS 16.10.290(a) enhances the Department's ability to collect delinquent unemployment insurance contributions from fish processors and fish buyers. The Department's figures indicate that, as of December 1987, about 25 percent of all fish processors and buyers were delinquent in their contributions. Those delinquencies resulted in a loss to the unemployment trust fund of about $610,000 as of that date. Under the proposed amendment, the Department may assert claims for contributions against the fish processors' and buyers' surety bonds, such claims having next priority after claims for wages and payments for raw fish.

Section 2: [New section proposed for 1989 session]

The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 requires, as a condition of states receiving administrative grants under Title III of the Social Security Act, that states disclose certain information contained in employment security records, upon request, to HUD and representatives of a public housing agency. It also provides for reimbursement of costs and appropriate safeguards of the information. The proposed amendment to AS 23.20.110 would allow the Department of Labor to comply with these federal requirements. This is a federal conformity issue; as such, continued administrative funding for the Employment Security Division is contingent upon passage by September 30, 1989.

Section 3: [New section proposed for 1989 session]

This section provides for extension of the Reed Act for ten years. Title IX of the Social Security Act makes excess funds collected under the Federal Unemployment Tax Act (FUTA) available to pay benefits or for administration of the employment security programs. Federal law extended the time limits in which the funds may be used by ten years. Unless Congress increases the maximum allowable levels in these funds, we anticipate that there will be excess funds to distribute back to the states in the near future. Current statute does not permit the Employment Security Division to receive or use these funds. This proposal, by extending the Reed Act, would allow Alaska to accept our share of the funds.

Section 4: [Sec. 2 of CS for HB 384 (L&C)]

The amendment of AS 23.20.195(a) in this section provides that the ten percent penalty on delinquent employer reports and taxes may be discretionary instead of mandatory. It also increases the minimum penalty to $10 from $1. This provision is not presently enforced in cases for which it is not cost effective to do so. A discretionary penalty would conform the statute to current practice, and remove the requirement on the Department to assess and collect penalties regardless of whether the State actually loses money in doing so.

Sections 5, 6, 7 and 8: [Sections 3 and 4 of CS for HB 384 (L&C)]

The amendments to AS 23.20.205(c) and AS 23.20.220(a) in these sections clarify the procedures for the appeal by an employer of the Department's assessment against the employer for unemployment contributions. The Department may extend the 30-day appeal filing deadline for circumstances beyond the control of an employer. Also, the amendments clarify that if the employer files security with the appeal, the collection of the assessment will be stayed pending determination of the appeal.

In addition, extraneous language in AS 23.20.220 is being deleted.

Section 9: [New section proposed for 1989 session]

This amendment to AS 23.20.240 would allow the Department to use private collection agencies to collect outstanding employer contributions from employers. The Department is owed large amounts of contributions, expecially by out of state employers, that are difficult to collect. This would provide a means to collect these delinquent contributions. The amendment provides for adding the collection fee to the amount of the debt owed. Federal law prohibits the use of trust fund (or employer contributions) to pay a collection agency. This would have no impact on our current operations; it would provide us a means to collect delinquent contributions not currently available to us. Current staff levels for the department's collection efforts would not change.

Section 10: [Section 5 of CS for HB 384 (L&C)]

Under current law, an officer or employee of a corporation, or partner or employee of a partnership may be liable for delinquent unemployment taxes in a civil action if they have been determined to have the duty to pay the taxes. These individuals have no prior appeal rights regarding the determination of their duty to pay the taxes. This section provides a new section, AS 23.20.242, that allows these individuals to appeal, at an administrative level, the determination of "duty to pay," prior to civil action.

Sections 11, 12 and 13: [Sections 5, 7, and 8 of CS for HB 384 (L&C)]

Under current law, nonprofit organizations pay 50 percent of extended benefits (the state share) with the federal share being 50 percent. Under the Gramm-Rudman-Hollings Act (the Federal Balanced Budget and Emergency Deficit Control Act of 1985), the federal share of extended benefits payments may decrease because it is subject to sequestration. This action will increase the State share of extended benefits payments. To offset the anticipated loss of some portion of the federal money, nonprofit organizations that choose to reimburse the Department for benefits paid to their former employees, instead of paying contributions under AS 23.20.165, will, under the amendments to AS 23.20.277(b), (e) and (l), be required to reimburse the Department the full amount of the State's share of the benefits paid to their former employees. The amount charged government entities will not change because they currently reimburse 100 percent of extended benefits paid.

Section 14: [New Section proposed for 1989 session]

This section clarifies the intent of the law that the proviso for redetermining an initial claim applies only to the monetary determination. This redetermination will take place if the department finds that an error in computation or identity was made, additional wages for a claimant have become available or the initial determination resulted from the nondisclosure or misrepresentation of a material fact.

Section 15: [HB 287 from 1988 session]

This amendment provides for the payment of benefits to individuals who have been working full time while attending school and who are laid off from work. Under present law, a person who is taking ten (10) or more credit hours of classes in an academic program is not eligible for unemployment insurance benefits, with no exceptions. Current law unfairly penalizes individuals who have demonstrated that they can attend school without affecting their availability to work full time.

Section 16: [New section proposed for 1989 session]

This amendment would correct the language in AS 23.20.382 so the restrictions would apply only to claims under the Trade Act, as intended. Current language applies restrictions to all claimants that were only intended to apply to Trade Act claimants.

Section 17: [New section proposed for 1989 session]

Federal law precludes states from denying benefits to individuals because they are in training approved under Title III of the Job Training Partnership Act (JTPA). This amendment provides that all individuals who are attending training approved under JTPA will not be denied their unemployment insurance benefits. Currently, this provision is addressed in regulation; however, the regulation only provides for paying benefits while the individual is in vocational training. This conforming legislation is needed to pay benefits to those individuals, regardless of whether their training is academic or vocational.

Section 18: [New section proposed for 1989 session]

This provision disqualifies the week in which a fraudulent act occurs in addition to the period of disqualification currently imposed. Under current law, an individual can be paid for a week in which he commits fraud, because the disqualification begins the week the fraud decision is issued.

Section 19: [Section 10 of CS for HB 384 (L&C)]

Under proposed AS 23.20.390(f), individuals who fraudulently obtain benefits incur an additional monetary penalty of 50 percent of the amount improperly received, unless the Department waives the penalty, with any penalties collected to go to the general fund. Currently, under AS 23.20.387, a person who fraudulently receives benefits is disqualified from receiving benefits for a specified period of time, and, under AS 23.20.390(a), must repay the benefits fraudulently received (a situation similar to an interest-free loan). As a further disincentive for fraud, the 50 percent penalty is proposed.

Sections 20 and 21: [Sections 11 and 12 of CS for HB 384 (L&C)]

These amendments propose new AS 23.20.391, 23.20.393, and 23.20.394, which establish provisions for liens and attachment of property to facilitate the collection of overpayments that are caused by fraudulent receipt of benefits. The three proposed statutes are based on existing AS 23.20.200, 23.20.205 and 23.20.215, regarding liens on the property of an employer for failure to make the required contributions. Proposed AS 23.20.391(b), which tracks existing AS 23.20.200(b), refers to the lien being "constructive notice to creditors" and is intended to establish the priority of the state over unsecured and unrecorded creditors, whether prior or subsequent, as well as subsequent secured creditors.

Section 22: [Section 13 of CS for HB 384 (L&C)]

Under current law, an individual's eligibility for unemployment insurance benefits is based upon wages paid to the individual. Thus, if an individual works for an employer who files for bankruptcy and does not pay its employees, the individual does not qualify for unemployment benefits. The proposed amendment to AS 23.20.530(a) in this section rectifies this situation. This section expands the definition of "wages" to include earnings for work that an employee perfoms but is not paid for because the employer files for bankruptcy.

Section 23:

This provision allows the Department to participate in demonstration or pilot projects with the U.S. Department of Labor (USDOL) that test innovative ways to assist unemployed individuals to return to work. The Department may waive eligibility requirements if needed. Participation in these projects will be incumbent upon availability of administrative funds for operating the project.

Section 24: [New section proposed for 1989 session]

This amendment provides for employer overpayments of unemployment insurance contributions that are not claimed by the employer to remain in the unemployment insurance trust fund. The Unclaimed Property Act (AS 34.45) requires state agencies to transfer unclaimed property to the Department of Revenue. These overpayments should be exempted from the Unclaimed Property Act and remain in the Unemployment Trust Fund from which unemployment insurance benefits are paid. Expenditures from the trust fund are automatically replaced by employers in the state under the contribution formula; therefore, employers should receive the indirect benefit (through lower tax rates) of the unclaimed overpayments.

Section 25: [New section proposed for 1989 session]

This section modifies the provisions covering dependents' allowance payments. Currently, a dependent claimed by one parent cannot be claimed by another parent until the first person's benefit year has expired (even if the first parent is not claiming benefits or has no remaining benefits to receive). A portion of every parent's wages goes to support their children. UI is for temporary, partial wage replacement of every eligible claimant. It is, therefore, inequitable for any parent with children to support to be denied dependents' allowance. This proposal allows each unemployed parent in a family unit to claim dependent children. Three dependents would still be the most that could be claimed by any claimant. It also repeals outdated subsections of AS 23.20.175.

Sections 26, 27 and 28 provide for effective dates.

SECTION-BY-SECTION ANALYSIS
House Bill 147

Section 1:

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Sections 26, 27 and 28 provide for effective dates.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 147
PUBLISH DATE: HOUSE 2/3/89

FISCAL NOTE

REQUEST:

Revision Date:
Agency Affected: Labor
Title: " An Act relatiug to unemployment insurance..."
BRU: Employment Security
Sponsor: Rules Committee
Components: Unemployment Insurance
Requestor: Governor

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0.0	44.0	44.0	44.0	44.0	44.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND&STRUCTURES						
GRANTS,CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	44.0	44.0	44.0	44.0	44.0
CAPITAL						
REVENUE	0.0	150.0	150.0	150.0	150.0	150.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	30.8	30.8	30.8	30.8	30.8
FEDERAL FUNDS						
OTHER	0.0	13.2	13.2	13.2	13.2	13.2
TOTAL	0.0	44.0	44.0	44.0	44.0	44.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See Attached

Prepared by: Judy Knight, Deputy Director
Phone: 465-2712
Division: Employment Security Division
Date: 1/13/89

Approved by Commissioner: Jim Sampson
Date: 1/13/89
Agency: Department of Labor

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