SUNSET REVIEW

OF

THE BOARD OF MEDICAL EXAMINERS

Submitted by
The Colorado Department of Regulatory Agencies
Office of Policy & Research

June 1994

June 30, 1994

The Honorable Vickie Agler, Chair
Joint Sunrise/Sunset Review Committee
State Capitol Building
Denver, CO 80203

Dear Representative Agler:

The Colorado Department of Regulatory Agencies has completed the evaluation of the Colorado Board of Medical Examiners. We are pleased to submit this written report, which will be the basis for my office's oral testimony before the Joint Legislative Sunrise/Sunset Review Committee. The report is submitted pursuant to Section 24-34-104 (8)(a), of the Colorado Revised Statutes, which states in part:

> *"The Department of Regulatory Agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...*
>
> *The Department of Regulatory Agencies shall submit a report and such supporting materials as may be requested, to the Sunrise and Sunset Review Committee created by joint rule of the Senate and House of Representatives, no later than July 1 of the year preceding the date established for termination..."*

The report discusses the question of whether there is a need for the regulation provided under article 36 of title 12, C.R.S. The report also discusses the effectiveness of the division and staff in carrying out the intention of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Joseph A. Garcia
Executive Director

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EXECUTIVE SUMMARY

The Department of Regulatory Agencies has concluded its sunset review of the Board of Medical Examiners and recommends continuation of the Board and the regulation of the practice of medicine. Patients are exposed to significant risk on a daily basis. Furthermore, it is not reasonable to expect that most members of the general public have the knowledge or information that is needed to choose between qualified and unqualified physicians. All of this justifies continued regulation.

This report will make numerous recommendations to improve the Medical Practice Act and enhance the public protection role of the Board. For instance, a requirement prohibiting physicians from engaging in sexual relations with a patient for a period of six months following termination of the physician-patient relationship is included because of the significant risk of patient exploitation in such relationships. This sunset review also recommends repeal of a statutory requirement that a physician commit two or more acts or omissions which fail to meet generally accepted standards of medical practice before the Board may discipline the practitioner. This review found that any act or omission should be actionable dependent on the seriousness of the infraction and the degree of harm to the patient caused by the licensee.

This review concludes its recommendations with miscellaneous statutory revisions that will improve the administration of the article and enhance the Board's effectiveness in pursuing it's public protection mandate.

BACKGROUND

A. The Sunset Process

Article 36 of Title 12 of the Colorado Revised Statutes will be repealed, and the licensing functions of the Colorado State Board of Medical Examiners (BME) will be terminated, on July 1, 1995, unless continued by the General Assembly pursuant to the Sunset Act. The purpose of this report is to assess the efficacy of the Colorado State Board of Medical Examiners from 1985 to the present within the context of the sunset criteria as mandated by the Colorado General Assembly.

In 1976, the legislature concluded:

> . . . state government actions have produced a substantial increase in numbers of agencies, growth of programs, and proliferation of rules and regulations and that the whole process developed without sufficient legislative oversight, regulatory accountability, or a system of checks and balances. The General Assembly further finds that, by establishing a system for the termination, continuation, or reestablishment of such agencies and by providing for the analysis and evaluation of such agencies to determine the least restrictive regulation consistent with the public interest, it will be in a better position to evaluate the need for the continued existence of existing and future regulatory bodies.

This concept of regulatory accountability developed into the Colorado sunset law, which establishes a schedule whereby regulatory bodies are subject to evaluation, and possible termination. This report evaluates the licensing functions and performance of the BME based on nine evaluation criteria, including two primary features:

1) Whether regulation by the agency is necessary to protect the public health, safety, and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less, or the same degree of regulation.

2) If regulation by the agency is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms, and whether agency rules enhance the public interest and are within the scope of legislative intent.

[The entire list of sunset criteria are attached as Appendix A.] After evaluating the BME based upon the sunset criteria, DORA has concluded that the continuation of the BME is necessary to protect the interests of Colorado citizens. Consequently, the balance of this review seeks to determine whether significant changes are necessary to improve agency operations and to enhance the public interest.

Research for this report began in January of 1994. Interviews were conducted with Director of the Division of Registrations, the BME Program Administrator, the President of the BME, athletic trainers, physician assistants, and the Assistant Attorney General charged with representation of the Board. Input was received from professional medical associations, industry representatives, and officials from other states who regulate physicians. Board meetings were attended and various Board documents, including rules, regulations, and complaint and disciplinary files, were reviewed. Legislation from other states was studied to determine whether additional means exist to protect the public from substandard or otherwise deficient medical care. The enabling statute was analyzed and legal and medical literature reviews were also performed. The author is grateful to all individuals who gave their time and assistance during the preparation of this report.

B. History of Regulation

The Colorado State Board of Medical Examiners was created five years after Colorado achieved statehood in an effort to protect the citizens of Colorado from unqualified medical practitioners. To this end the Board is empowered with licensure and disciplinary authority to insure that only qualified persons be permitted to practice the healing arts within the State of Colorado.

After the Revolutionary War, medical practice was regulated by state medical societies. This system produced less than satisfactory results due to the lack of a standardized program of medical education. In 1847, the American Medical Society was formed and in 1881 the Colorado General Assembly passed the Medical Examiners Act. This legislation represents the state's initial effort to regulate medical practice in Colorado. The original nine-member state Medical Board established educational standards by the development of a state medical examination, and for almost 100 years the Board served the public interest primarily by setting and enforcing these standards. Now, however, the Board no longer develops and constructs its own licensure examination, but instead relies upon the nationally developed and universally accepted examinations.

The modern Colorado State Board of Medical Examiners has experienced a dramatic shift in its function, and its new focus has evolved into protection of the public health, safety and welfare by enforcing a minimum level of quality in the delivery of health care services by physicians. The Board seeks to achieve this goal by setting and enforcing a basic standard of minimal competence, below which practice will not be tolerated. The modern Board's primary mission is to review complaints and information and, after investigatory and adjudication processes, to discipline practitioners when appropriate.

The last sunset review of the BME was conducted in 1984, after which the General Assembly voted to continue the regulatory program. That report itemized four major issues within Board jurisdiction, including the expanding role of allied health care providers, the regulation of podiatrists by the Board, the problems inherent in the licensure of graduates of international medical schools (IMGs), and the steep increase in the number of disciplinary cases since the 1978 sunset review. With the exception of podiatry regulation which, since 1984, has been turned over to a separate board, the BME continues to confront regulatory challenges regarding the other three issues. In addition, the Board's regulatory umbrella has been extended to the certification of physician assistants, to defining the scope of practice for qualified athletic trainers, to prescribing minimum competencies for unlicensed x-ray technicians who work in medical facilities, and to the promulgation of rules defining the duties and responsibilities of emergency medical services physician advisors and their emergency medical technicians.

Other significant developments that occurred after 1984 include the formation of and collaboration with professional review committees regarding the investigation and disciplinary actions of licensees, statutory creation of a fund for a physicians peer assistance program to identify, evaluate, and monitor the treatment of health-impaired physicians, the expansion of the definition of unprofessional conduct to include, among other things, sexual misconduct with patients and the specific prohibition of itemized advertising methods. Concomitant with the Board's increased jurisdiction is the fact that its disciplinary caseload continues to increase while its resources with which to undertake these functions diminish.

In spite of this difficulty, the public and health care professionals continue to demand the Board's increased involvement in the regulation of physicians and health care providers. And, when reduced simply to the number or licensees requiring regulation, the need for the Board's continuing regulation is evidenced as the number of licensees continues to grow. As of January, 1994, the Medical Board regulated the following number of <u>active</u> physicians and physician assistants:

total physicians (M.D or D.O.)	13,405
physicians with Colorado addresses	8,600
physician assistants	375

SUMMARY OF STATUTE AND RULES

The Colorado State Board of Medical Examiners (BME) is responsible for the regulation of physicians and physician assistants under the Medical Practice Act (MPA). It is also statutorily obligated to define the minimum competencies and proper scopes of practice for athletic trainers, emergency medical technicians, and unlicensed x-ray technicians.

The Colorado Medical Practice Act, Section 12-36-101 et seq., C.R.S., codifies the practice of medicine in Colorado. Besides defining the practice of medicine and outlining the requirements for medical licensure and physician assistant certification, the statute outlines what constitutes unprofessional conduct (Section 12-36-117, C.R.S.) and establishes the procedure the Board must follow in disciplinary matters (Section 12-36-118, C.R.S.). Board members are granted immunity from civil or criminal liability arising from their official conduct, including disciplinary acts, so long as it is performed in good faith (Section 12-36-103(5), C.R.S.). Other sections outline minimum competencies that licensees must satisfy to practice medicine in Colorado, and obligations they must fulfill to continue practicing.

Board Composition, Powers and Duties

The Colorado State Board of Medical Examiners is a Type I policy-autonomous Board that is composed of eleven members appointed by the Governor. By statute, seven members must hold a M.D. degree, two members must be D.O.'s (Doctors of Osteopathy) and two members must be from the public-at-large. Members serve four-year terms. Medical members must have been licensed and actively engaged in practice in Colorado for three years prior to their appointment and residents for at least five years. There are no statutory restrictions on the term of service for Board members, but members may be removed by the Governor for neglect of duty, incompetence or unprofessional or dishonorable conduct (Section 12-36-103(3), C.R.S.)

Under Section 12-36-104, C.R.S., the Board is empowered to adopt and promulgate all necessary rules and regulations to carry out its statutory responsibilities, make investigations, hold hearings, issue subpoenas and compel the testimony of witnesses in matters relating to medical practice, adopt a seal to be affixed to licenses issued by the Board, aid state district attorneys in enforcement and prepare an annual report for the Governor and the General Assembly.

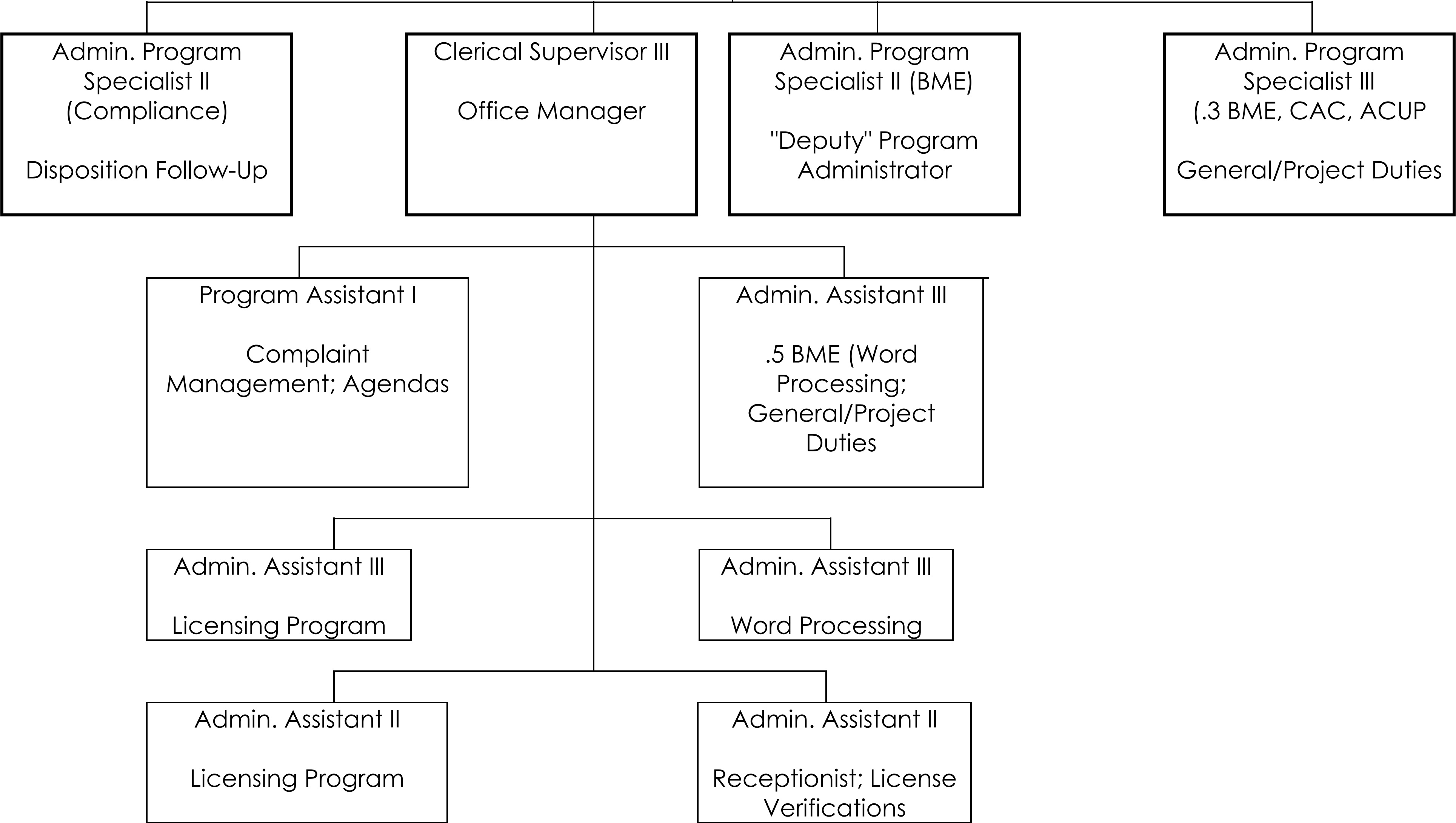
Because the act exempts several health-related occupations and certain practices of religious worship from adhering to requirements attaching to the practice of medicine, the Board has no regulatory authority over chiropractors, dentists, optometrists, podiatrists, or nurses. However, it does have jurisdiction over physician assistants, and it possesses the authority to define the scope of practice and minimum competencies of other health care providers such as qualified athletic trainers and unlicensed x-ray technicians. The Board must also approve rules promulgated in the Department of Health by the state advisory council on emergency medical services concerning the duties and functions of emergency medical technicians and paramedics. (Section 25-3.5-203, C.R.S.)

Administration

Passage of the Administrative Organization Act of 1968 transferred the Colorado State Board of Medical Examiners to the Department of Regulatory Agencies under the Division of Registrations as a type 1 transfer. This transfer allows the Executive Director of DORA and the Director of the Division of Registrations to exercise administrative authority over the Board, while allowing the Board to maintain broad policy-making authority independent of the department (24-1-105, C.R.S.). This policy-making authority includes the power to adopt rules, make investigations, hold hearings, administer oaths and issue subpoenas.

The Board is funded as a cash funded agency pursuant to Section 24-34-105, C.R.S. As a cash funded board in an executive agency, it must adjust its fees to approximate the spending authority authorized by the General Assembly so that the revenue generated from incoming fees does not exceed such authority. This revenue is credited to the Division of Registrations' cash fund and is appropriated to the Board by the General Assembly for use in conducting Board business and operations. The license renewal fee for the current biannual cycle is $175 per license. In addition, each licensee is assessed $30 that goes into a dedicated fund that the Board disburses to a qualified peer assistance program.

Decisions of the Board are implemented by staff. For fiscal year 93-94, the division was assigned 9.5 FTEs to assist the Board. Investigative support is provided to the Board by the Department of Regulatory Agency's complaint and investigation staff. The Board occasionally utilizes the services of physician-consultants in the interpretation of investigatory reports on a per diem basis, and it contracts out for legal services with the Office of the Attorney General. The attached chart illustrates the organizational composition of the BME administrative staff.


PROGRAM ADMINISTRATOR II - .9 BME
Admin. Program Specialist II (Compliance)
Disposition Follow-Up
Clerical Supervisor III
Office Manager
Admin. Program Specialist II (BME)
"Deputy" Program Administrator
Admin. Program Specialist III (.3 BME, CAC, ACUP
General/Project Duties
Program Assistant I
Complaint Management; Agendas
Admin. Assistant III
.5 BME (Word Processing; General/Project Duties
Admin. Assistant III
Licensing Program
Admin. Assistant III
Word Processing
Admin. Assistant II
Licensing Program
Admin. Assistant II
Receptionist; License Verifications

Licensing and Examination

Physicians. The Board no longer administers licensure examinations for physicians; instead, it accepts passing scores achieved on Board-approved national tests, typically administered by the National Board of Medical Examiners or the Federation of State Medical Boards. The MPA outlines licensure requirements and gives the Board the authority to issue licenses to practice medicine in Colorado. To be licensed, an applicant must be twenty-one years of age, of good moral character, a graduate of a Board-approved medical school and certify passage of a Board-approved licensing examination. The applicant who has graduated from a U.S. or Canadian medical school must also have completed an internship or post-graduate training of at least one year, while international medical graduates must complete up to three years of postgraduate training. Reciprocal licensing may be granted, at the Board's discretion, provided the licensure requirements in the licensee's state are equivalent to those in Colorado. There are no continuing education requirements to maintain a valid physician's license in Colorado. There are 13,405 licensed physicians in the state of which over 800 were new licensees during the last fiscal year.

Physician assistants. The MPA requires physician assistants to be certified to practice. To be a Board certified physician assistant, the applicant must be at least 21 years of age, make an application to the Board and pay the required fee established pursuant to Section 24-34-105, C.R.S., successfully complete a Board approved educational program for physician assistants, and successfully complete the national certification of physician assistants or other Board-approved examination (Section 12-36-106(5)(c), C.R.S.). There are no requirements for certification renewal, nor is continuing education required. There are approximately 375 certified physician assistants statewide.

Scope of Practice

Physicians. The medical practice act defines the practice of medicine as:

1) Holding oneself out to the public as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, pain, injury, deformity, or physical or mental condition, whether by use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever.

2) Recommending, suggesting, prescribing, or administering treatment or operation for such condition for compensation.

3) Maintenance of an office for medical examinations or treatment, or using titles, such as M.D. or D.O., that induces the public to believe that one is licensed to practice medicine.

4) The performance of surgery, and

5) The practice of midwifery except for services rendered by a licensed nurse-midwife or by a properly registered direct-entry midwife.

Physician assistants. The medical practice act allows a physician, licensed in the state, to delegate to a physician assistant (PA) the authority to perform acts which constitute the practice of medicine to the extent authorized by Board rules, including the prescribing of non-controlled substances provided that protocols are followed. Physicians utilizing PAs are responsible for the actions of their PAs in the performance of delegated medical tasks, and the delegated tasks must be performed under the personal and responsible supervision of the physician unless otherwise specifically permitted by the Board. Likewise, no more than two PAs may be supervised by a single physician unless the Board has granted a waiver under particular circumstances.

Discipline

The MPA sets out specific conduct that is defined as unprofessional and meriting disciplinary measures in Section 12-36-117, C.R.S. This provision presents a laundry list of conduct that includes sexual misconduct with patients; conviction of a felony or pleading guilty or nolo contendere to a felony, including drug charges; habitual intemperance in the use of alcohol or drugs; aiding an unlicensed person in the practice of medicine; practicing while physically or mentally disabled; grossly negligent malpractice or two or more counts of substandard care; inappropriate use of prescriptive authority; false advertising; having a suspended or revoked license in another state; failure to fulfill one's reporting duties; and falsifying records.

The disciplinary function of the Medical Board is governed by Section 12-36-118, C.R.S. The disciplinary procedures embodied in this section apply to physicians and physician assistants, who fall within the purview of this section pursuant to Section 12-36-106(5)(f), C.R.S.

Written complaints against a practitioner can come before the Board from many sources. Physicians are required to report to the Board any colleague they suspect of having violated any portion of the unprofessional conduct provision of the statute (Section 12-36-118(3), C.R.S.) and any adverse action or surrender of license to practice medicine taken against the physician personally. Reports are also required from malpractice insurance carriers (Section 10-1-124, C.R.S.), and from hospitals that take action to suspend or revoke the privileges of a physician or allow a physician to resign from a hospital in lieu of such action (Section 12-36-118(4), C.R.S.). Professional review committees that take disciplinary action against a physician are also required to produce records of their actions to the Board if so requested. The Board also has the authority to take initiate complaints upon its own motion.

When disciplinary matters are undertaken, the Board divides into two panels of five members each, four of whom must be physician members. Each panel may act as a inquiry panel or hearing panel, but to avoid conflict and to protect the physician's right of due process, neither panel may act in both capacities in a given case. When a complaint comes before the Board the physician-respondent is notified of the complaint and given 20 days to respond to the allegation. Thereafter, the matter is referred to an inquiry panel for investigation. After reviewing the complaint, the response, and the results of further investigation, the panel may dismiss the complaint for lack of merit or for lack of reasonable cause to warrant further action. If the investigation discloses conduct which does not warrant formal disciplinary action but which indicates "possible errant conduct by the licensee that could lead to serious consequences if not corrected," the Board must send a confidential letter of concern to the physician. If, on the other hand, the investigation discloses an instance of unprofessional conduct that should not be dismissed as meritless but does not warrant formal action, it must send a letter of admonition to the physician. Finally, if the investigation discloses facts that warrant further proceedings, the Board refers the matter to the Attorney General's Office and a formal complaint seeking disciplinary action against the physician is filed with the Board.

When a formal complaint is filed, the Board is required to send a copy of the complaint to the practitioner, who is obligated to respond to the charges within twenty days. When the inquiry panel determines to file a formal complaint against a licensee, it may exercise the option of referring the case to the hearing panel or to assign it to an administrative law judge, who may preside over the hearing alone or with a Board member who has been appointed by the Board to act as an adviser. At the end of the hearing, the panel or ALJ must make findings and conclusions regarding the charges of unprofessional conduct. If the charges are not dismissed as unfounded, then the extent of discipline to be imposed must be established and an order is entered. The range of discipline that can be imposed includes:

1) a letter of admonition;
2) public censure;
3) suspension for a definite or indefinite period; and
4) revocation of a license to practice medicine.

Further, the Board has the latitude in all situations other than revocation to allow a physician to continue to practice by placing him on probation or by otherwise subjecting her to conditions as the panel deems appropriate, including physical or mental examinations, therapy, education or training, periodic review, or supervised or restricted practice. When making its disciplinary order, the Board may take the physician's prior disciplinary record into account.

Once a final order is entered, the parties may petition the Board to review and reconsider its order; however, this reconsideration is entirely discretionary. Either side possesses the right of appeal, review of which lies with the Colorado Court of Appeals.

Other Pertinent Regulation

In addition to the licensing and disciplinary functions imposed on the Board by the MPA, the statute defines other areas requiring Board regulation or decisionmaking. For instance, the General Assembly has established the physician peer health assistance fund from which the Board is required to make grants to one or more peer assistance programs annually. This program is intended to deal with physicians with substance abuse, mental or alcohol impairments. The program's role is to assess, educate, intervene, identify and diagnose the practitioner's problems, and then to refer the patient for appropriate treatment and follow-up with monitoring, counseling, and other support services.

The BME also has the authority to apply for injunctive relief in situations in which misleading, deceptive, or false advertising is propounded by a physician or any independent advertising or marketing agent, or to enjoin individuals from committing acts that are prohibited by the MPA.

Finally, the Board is mandated to utilize and allow professional review committees and governing boards of health care providers to assist it in reviewing and evaluating the professional conduct of licensees, including the quality and appropriateness of patient care rendered by physicians. By statute, the Board extends its licensing and disciplinary authority to these committees which, in turn, must exercise the disciplinary function after investigatory, hearing, and appellate procedures are followed. The Board is entitled to be informed of the findings, recommendations, and actions taken by such committees under certain circumstances so that it may proceed with disciplinary action if appropriate.

Board Rules

There are currently ten sets of rules in effect that have been promulgated and/or approved by the Colorado State Board of Medical Examiners. The general authority for the promulgation of these rules is set forth in Section 12-36-104, C.R.S.

The rules establish guidelines for: the duties and responsibilities of emergency medical services physicians and acts performed by emergency medical technicians; the licensing of foreign medical graduates; the certification of and practice by physician assistants; the education and training standards for unlicensed personnel exposing ionizing radiation; defining further unprofessional conduct; concerning financial responsibility standards; administering step 3 of the U.S. Medical Licensing exam; designating professional liability insurers; designating component medical societies; and establishing criteria for designation in advertising as an acceptable specialty board.

SUNSET ANALYSIS

The General Assembly has mandated that the primary mission of the Colorado Board of Examiners is to regulate the practice of medicine "to the end that the people shall be properly protected against unauthorized, unqualified, and improper practice of the healing arts in this state." Consequently, the BME concentrates on ensuring that only competent individuals are licensed to practice their profession, to take actions against licensees in violation of state laws and regulations, and overall, to protect the public health, safety and welfare.

This review attempts to determine to what degree the Board has satisfied its mission of protecting citizens of Colorado.

1. Necessity of Regulation

Colorado has developed its regulatory structure of physicians and health care professional, in part, to control a health care delivery system that has become enormously complex. the state is now faced with serious issues about how to obtain the best possible health care for consumers in urban and rural areas at a reasonable financial cost. Expanded access to medical services, practitioner competency, health care ethics, educational and training requirements, rapidly expanding technology, and quality of care are just a few of the issues currently confronting the state. The more complex health care becomes the more important effective regulation becomes.

Physicians are allowed to make decisions and to execute technical procedures that can result in the life or death, or the well or ill health of persons entrusted to their care. The state has an obligation to ensure that practitioners allowed to provide medical services have met established standards and are subject to enforcement sanctions should the quality of care they deliver diminish. Because practitioners are required to make greater numbers of critical decisions than ever before, government needs to continue serving as the consumer's representative in the evaluation and monitoring of health care providers and their services.

Each state and territory in the United States regulates physicians. A review of Colorado's regulatory system reveals that the quality of the BME's regulation is consistently good, particularly given the limited budget and staffing resources with which the Board has to work. In fact, The Public Citizens Health Research Group, a non-profit consumer protection organization, recently recognized the performance of our medical board as ranking 8th in the nation.

In summary, the state's decision to regulate physicians to promote and safeguard the interests of Colorado consumers is necessary and reasonable.

2. Ability of Statutes and Regulations to Enhance and Protect the Public Interest

In general, the Medical Practice Act and its companion rules constitute an adequate framework by which the public secures a minimum level of protection from deficient practitioners. The act has been amended through the years, either to correct gaps or deficiencies in the law or to address new issues of concern to the public and the profession. When the act is compared to its counterparts in other states, it stands up reasonably well to those criticisms that are commonly targeted at medical practice acts.

For example, some medical practice acts do not contain sufficient means to identify licensees who may warrant disciplinary action. State boards rely heavily on referrals or complaints to identify cases for investigation. Thus, if those in a position to identify possible violations of the MPA fail to do so, the capacity of the Board to provide adequate protection to the public is severely compromised.

In 1974, the BME received 19 consumer complaints regarding physicians, and in 1975 this figure dropped to 15. However, in 1976 the General Assembly amended the MPA to require all hospitals to report to the Board all disciplinary actions taken against physicians and all medical malpractice settlements or judgment by insurance companies doing business in Colorado. During the following year, the number of complaints received by the Board skyrocketed to 251. In addition to these revisions, the General Assembly also granted good faith immunity from suit to Board members while pursuing their official duties, and it adopted a "tattletale" law that imposes upon physicians a duty to report to the Board unprofessional conduct by fellow practitioners. Finally, the BME now views the licensure application and renewal process as a means of obtaining "markers" to identify problem physicians. Specifically, it requires that all physicians seeking to apply for a new or renew their licenses provide information on various actions or conditions that are of concern, including disciplinary actions imposed by other entities and relevant physical or mental impairments.

By virtue of these mandatory reporting laws, immunity protections, and self-reporting laws, the Colorado MPA has facilitated the identification of physicians who may pose a risk to the public. The Board hopes to strengthen its means of identifying cases by proposing supplemental provisions that will strengthen the current laws.

Another criticism that is typically leveled at state medical boards and their practice acts is that they fail to provide the public with access to the disciplinary process, that they are secretive beyond legitimate confidentiality protections, and that they are insufficiently accountable.

The Colorado MPA is susceptible to this criticism inasmuch as it exempts the Board from Sunshine, or open meetings law. This exemption provides authority to the Board to conduct its meetings and proceedings in closed session and it prohibits the public from inspecting minutes or records of the Board with respect to its action. The Board does make available to the public information regarding the current disciplinary status and history of a licensee and, as of July 1, 1993, it implemented the policy of making letters of admonition to licensees (formerly confidential) matters of public record. Furthermore, once the Board is finished with the investigative process and has decided to initiate formal action against a physician, the proceedings become public and open. It is true, however, that the public, including a complainant, is not privy to the Board's deliberations or investigation prior to the filing of formal charges.

When this confidentiality provision is compared with the medical practice acts of other states, it is clear that Colorado falls into the majority of jurisdictions by restricting public access to information before a formal board action or agreement.

Nevertheless, the issue of accounting to the public by way of access to the complaint process in disciplinary actions is one that has already merited attention in Colorado. As recently as 1993, proposed legislation was introduced in the General Assembly that sought to give every complainant the right to review the physician's written answer and to notify the Board of any perceived inaccuracies therein. The bill would have required the Board to transcribe its initial discussions about the complaint and answer and to provide all such information to the complainant. Additional provisions expanded the scope of disciplinary information that should be made available to the public. This bill was ultimately killed in Appropriations, but the issue of access to the complaint process that it attempted to resolve is one that will continue to arise in the future.

When the MPA is viewed comprehensively, it does contain provisions that enhance the function of public protection while providing due process safeguards to licensees. The definition of unprofessional conduct has been augmented to include behavior such as financial responsibility and sexual misconduct with patients. The Board is outfitted with a full complement of disciplinary sanctions that it may impose upon errant licensees, and the act is not encumbered with the onerous burden of proving unprofessional conduct by clear and convincing evidence. Additionally, the General Assembly has underscored the importance of diagnosing, evaluating and rehabilitating practitioners who suffer from physical or mental health impairments through its creation of a peer assistance program. Although this program benefits physicians most immediately, it also operates in the public interest by providing society with rehabilitated, healthy physicians who can return to medical practice without posing a risk to Colorado consumers.

3. Efficiency and Effectiveness of the BME

The BME regulates a base of over 13,000 licensed physicians, out of which 844 were new licensees to Colorado in FY 1992-1993. This large licensee population results in a demanding workload for the BME, particularly in the disciplinary arena.

The American Association of Retired Persons (AARP) has suggested that the simplest way to determine how well a state medical board is performing is to identify how many disciplinary actions it is taking. In Colorado, during FY 1992-1993, the Board reviewed 694 new complaints and reports regarding alleged unprofessional conduct by physicians, an increase of 16% over the previous year. Of those complaints, the Board took 95 disciplinary and enforcement actions against licensees. The number of disciplinary actions taken increased substantially over the last five years even while the amount of spending authority for the Board and legal services decreased, as the following chart illustrates.

Fiscal Year	Total Complaints Received	Total Disciplinary Actions	Total Board Expenditures	Legal Services Expenditure
1981	240	22	296,000	104,000
1982	341	38	361,000	131,000
1983	299	32	504,000	258,000
1984	385	23	476,000	163,000
1985	455	26	468,000	149,000
1986	564	47	635,000	274,000
1987	497	61	697,000	266,000
1988	479	69	874,000	273,000
1989	537	72	1,513,000	523,000
1990	592	67	1,492,000	387,000
1991	703	68	1,379,000	441,000
1992	599	66	1,363,000	445,000
1993	694	95	1,333,000	373,000

Moreover, during the last 9 fiscal years, Board disciplinary activity has resulted in an increase in the severity of sanctions imposed. The number of license revocations and suspensions and probation has increased steadily during this time.

	84-85	85-86	86-87	87-88	88-89	89-90	90-91	91-92	92-93
Revocation	2	0	4	2	4	6	6	4	8
Surrender of License/retirement	2	4	5	7	15	7	9	11	14
Suspension with/without probation	4	9	6	4	6	10	12	7	12
Probation (no suspension)/;practice limitation	6	19	22	35	33	26	19	23	31
Letter of Admonition	9	13	16	16	3	10	19	17	23
License granted with probation	3	0	6	3	4	3	1	3	3
License denied after hearing	0	2	2	0	2	0	0	0	1
Injunction/stipulated agreement	0	0	0	2	5	5	2	1	3
TOTAL	26	47	61	69	72	67	68	66	95
*NOTE: The above figures do not include cases in which formal charges were not filed or were dismissed due to lack of evidence.									

Another indicator of the Board's performance is the timeliness with which investigations and disciplinary actions are resolved. While some licensees express concern over the length of time it takes the Board to resolve matters that come before it, an analysis of Board statistics establishes that in FY 1992-1993, 45% of all active cases were resolved (investigated and disposed of) in less than three months. Twenty-one percent were closed within 6 months and 14% took 6 to 12 months to reach disposition. Finally, 20% of the caseload took more than 12 months to resolve, although these cases primarily consist of the complex formal disciplinary proceedings that include the full panoply of due process procedures (i.e. representation by counsel, discovery, expert testimony and hearing).

Those cases that go to hearing ordinarily experience the delays inherent in a disciplinary proceeding, but another contributing factor to the problem of untimely decisions is the Board's diminishing legal services moneys. The Board has increased legal services money in 1989, 1991 and 1992. Since those years the Division has had to reallocate money to other areas with even greater case growth (like Nursing). As the charts indicate, the growth in complaints has been consistent for the Medical Board. Increased legal services moneys would increase the Board's ability to prosecute disciplinary cases more efficiently and in greater numbers. (to it's previous $400,000 to $500,000 level)

Even given these impediments, the BME's track record of resolving over two-thirds of its caseload in less than 6 months is impressive when compared with other jurisdictions. For instance, the Texas Board of Medical Examiners takes 315 days on average to take disciplinary action and 267 days to resolve complaints.

Another critical factor that must be taken into account when examining board efficiency and effectiveness is the increased workload shouldered by the board and staff in the face of budget cutbacks.

The Board accomplishes the majority of its public protection duties through the review of applications for licensure and the review of complaints and other reports regarding alleged unprofessional conduct. As the statistics indicate, the disciplinary workload has increased without concurrent increase in staff, and the number of applications processed by the Board staff has also increased from approximately 700 applications to more than 900 annually. The workload associated with licensing functions may be alleviated by the 1994 statutory revision to the BME that allows the Board to delegate its licensing function to a subcommittee of the full Board so that hands-on review of individual applications will function more quickly.

The Board's workload and resources have been stretched by the incremental addition of subprograms and other responsibilities. Now, besides focusing on public protection through physician quality assurance, the Board is responsible in some measure for athletic trainers, unlicensed x-ray technicians, ensuring that licensees comply with insurance requirement, and mediating advertising disputes among different physician specialties. While valid arguments can be made to justify all of these functions, the bottom line is that they signify additional responsibilities that the Board has had to absorb into its existing staff and budget.

Another critical impediment to Board efficiency and effectiveness is the absence of automated data analysis capability. The Board runs and monitors its program manually, which hinders the Board's efficient operation in virtually every respect, particularly given the volume of information that the Board handles annually. The Board was reminded of this deficiency earlier this year when it was the only state medical board in the entire country that could not participate fully in the Federation of State Medical Board's comprehensive survey owing to its lack of computerization. A new system is currently being installed.

Of course, almost every state agency and board operates under burdensome workload requirements coupled with diminishing resources. However, when the Board's increasing caseload is viewed in context with elevated expectations regarding physician discipline and shrinking resources, the important mission of protecting the public from risk is bound to suffer at some point.

In spite of these problems, the disciplinary performance markers by which to judge the Board's efficiency and effectiveness demonstrate that it is performing its function efficiently and effectively under the circumstances.

4. Public Board Membership

There are two public members that are appointed by the Governor to serve on the 11-member Board. The percentage of public-to-professional members does not meet the 25% level endorsed by the Federation of State Medical Boards or similarly high levels endorsed by consumer groups.

However, the public members on the Board report that their views and opinions are given appropriate weight and consideration by the physician members, and they noted an interesting tendency of the physician members to support the imposition of harsher sanctions in disciplinary cases than the public members.

While the addition of two more public Board members (one for each panel) may benefit the Board and heighten public interest, the available evidence does not compel the conclusion that public participation is lacking. Moreover, the 20% public Board member level (1 of 5 on each panel) approximates and in some cases exceeds the participation level on other state medical boards. (Federation Table 2, below)

TABLE 2
BOARD STRUCTURE AND OPERATION - MEMBERSHIP - COMPOSITION AND TERMS

	Total Membership	MD	DO	Public	Other Health Professionals	Length of Terms	Consecutive Terms	Officers Selected
AL	15	15	-	-	-	5 yrs.	2	annually, elected
AK	7	5	-	2	-	4 yrs.	2	every 1-2 yrs., elected
AZ-M	12	9	-	2	1	5 yrs.	2	annually, elected
AZ-O	5	-	4	1	-	5 yrs.	2	annually, elected
AR	13	10	1	2	-	8 yrs.	no limit	annually, elected
CA-M	19	12	-	7	-	4 yrs.	2	annually, elected
CA-O	7	-	5	2	-	3 yrs.	3	annually, elected
CO	11	7	2	2	-	4 yrs.	no limit	biennially, elected
CT-M	9	6	-	3	-	4 yrs.	2	unspecified, Governor appointsr
DE	16	10	1	5	-	3 yrs.	2	annually, elected
DC	11	8	-	3	-	3 yrs.	1	as needed, elected
FL-M	15	12	-	3	-	4 yrs.	2	annually, elected
FL-O	7	-	5	2	-	4 yrs.	2	annually, elected
GA	13	10	2	1	-	4 yrs.	no limit	annually, elected
GM	5	5	-	-	-	unspecified	no limit	as needed, elected
HI-M	9	7	-	2	-	4 yrs.	2	annually, elected
ID	8	6	1	1	-	6 yrs.	unspecified	biennially, elected
IL	16	10	2	2	2	unspecified	no limit	unspecified
IN	7	5	1	1	-	4 yrs.	no limit	annually, elected
LA	9	5	2	2	-	3 yrs.	3	annually, elected
KS	15	5	3	3	4	4 yrs.	3	annually, elected
KY	11	8	1	2	-	4 yrs.	no limit	annually, elected
LA	7	7	-	-	-	6 yrs.	no limit	every 2 yrs., elected

	Total Membership	MD	DO	Public	Other Health Professionals	Length of Terms	Consecutive Terms	Officers Selected
ME-M	10	7	-	3	-	6 yrs.	no limit	biennially, elected
ME-O	No Information Provided							
MD	15	11	-	4	-	4 yrs.	no limit	annually, elected
MA	7	5	-	2	-	3 yrs.	2	annually, elected
MI-M	14	10	-	3	1	4 yrs.	2	annually, elected
MI-O	8	-	5	2	1	4 yrs.	2	annually, elected
MN	16	10	1	5	-	4 yrs.	2	annually, elected
MS	9	9	-	-	-	6 yrs.	no limit	annually, elected
MO	9	6	2	1	-	4 yrs.	no limit	annually, elected
MT	10	5	1	2	2	4 yrs.	no limit	annually, elected
NE	7	5	1	1	-	5 yrs.	2	annually, elected
NV-M	9	6	-	3	-	4 yrs.	2	biennially, elected
NV-O	4	-	3	1	-	4 yrs.	no limit	as needed, elected
NH	7	5	-	1	1	5 yrs.	2	every three years
NJ	16	8	2	4	2	3 yrs.	no limit	annually, elected
NM-M	6	5	-	1	-	4 yrs.	no limit	annually, elected
NM-O	5	-	3	2	-	5 yrs.	no limit	annually
NY	22	18	2	2	-	5 yrs.	2	annually, elected
NC	8	7	-	1	-	3 yrs.	2	annually, elected
ND	10	9	1	-	-	3 yrs.	2	annually, elected
OH	12	7	1	3	1	5 yrs.	no limit	annually, elected
OK-M	8	7	-	1	-	7 yrs.	no limit	annually, elected
OK-O	7	-	6	2	-	7 yrs.	no limit	annually, elected
OR	11	7	2	2	-	4 yrs.	2	annually, elected
PA-M	11(total includes Comm. of Prof. & Occ. Affairs + Secy. of Health)	6	-	2	1	4 yrs.	2	annually, elected
PA-O	9	-	5	2	1	4 yrs.	2	annually, elected
PR	9	9	-	-	-	5 mbrs, serve 5 yr. terms, 4 mbrs., serve 4 yr. terms	unspecified	unspecified
RI	13	5	2	6	-	3 yrs.	2	annually, elected
SC	10	8	1	1	-	4 yrs.	2	annually, elected
SD	6	4	1	1	-	5 yrs.	no limit	annually, elected
TN-M	5	5	-	-	-	5 yrs.	no limit	unspecified, elected
TN-O	5	-	5	-	-	5 yrs.	no limit	unspecified, elected
TX	15	9	3	3	-	6 yrs.	no limit	biennially, elected
UT-M	7	6	-	1	-	5 yrs.	2	annually, elected
UT-O	5	-	4	1	-	5 yrs.	2	annually, elected
VT-M	14	9	-	3	2	3 yrs.	2	annually, elected
VA	16	10	1	2	3	4 yrs.	2	annually, elected
VI	5	5	-	-	-	3 mbrs., serve 2 yr. terms, 2 mbrs., serve 4 yr. terms	unspecified	unspecified
WA-M	20	13	-	6	1	5 yrs.	no limit	Governor appointsr
WA-O	7	-	6	1	-	5 yrs.	no limit	annually, elected
WV-M	15	9	-	3	3	5 yrs.	2	biennially, elected
WV-O	5	-	3	2	-	3 yrs.	no limit	as needed, Governor appoints
WI	11	7	1	2	1 non-voting member	4 yrs.	2	annually, elected
WY	7	4	1	2	-	4 yrs.	3	annually, elected
TOTALS	**672**	**418**	**93**	**132**	**27**			

5. Conclusion

The need for continued medical regulation is based on the belief that the public interest is served by restricting the practice of the healing arts to qualified practitioners. All fifty states and the District of Columbia regulate medical practice, illustrating unanimous agreement that health care regulation is a public health and safety issue that warrants governmental participation.

RECOMMENDATION 1: THE COLORADO STATE BOARD OF MEDICAL EXAMINERS SHOULD BE CONTINUED.

RECOMMENDATIONS

The balance of this review contains recommended changes to the Medical Practice Act. Because the recommended changes are substantial, the proposed language is included in Appendix C.

I. LICENSURE ISSUES

RECOMMENDATION 2: REVISE LICENSURE REQUIREMENTS BY ESTABLISHING THE UNIFORM REQUIREMENT THAT ALL APPLICANTS MUST COMPLETE TWO YEARS OF POSTGRADUATE TRAINING.

Currently the MPA bifurcates postgraduate training requirements between graduates of medical schools in the U.S./Canada and other foreign medical schools. U.S. and Canadian graduates must complete a one year internship or approved postgraduate training program before they are eligible to apply for a medical license, while graduates from other medical schools (international medical graduates, or "IMGs") are required to complete three years of postgraduate training.

The differential has traditionally been supported by the notion that graduates of U.S./Canadian medical schools receive a consistently high standard of education that does not warrant a longer period of postgraduate training. On the other hand, because medical boards and academicians have determined that the level of education received by IMGs is not as predictable, a higher threshold of postgraduate training has been typically required of IMGs as a safeguard to prevent substandard practice.

The public protection policy consideration that drives a more intensive period of post-graduate training for IMGs continues to be valid. However, medical boards in other jurisdictions have confronted equal protection challenges by IMGs to similar statutory licensing schemes in which domestic and IMG applicants adhere to disparate postgraduate training requirements. In such cases, IMGs assert that the additional training requirements imposed upon them are discriminatory and deny them equal protection of the law.

A survey of the postgraduate training requirements of all 50 states establishes that 27 states require IMGs to receive 1 or 2 years of progressive postgraduate training. (AMA Table 16). Colorado's three year requirement for IMG's, therefore, is more strenuous than its counterparts in the majority of states.

On the other hand, only 12 states require their U.S./Canadian medical school graduates to complete 2 or more years of postgraduate medical training for licensure. (AMA Table 14). Despite the minimal postgraduate training requirements for U.S./Canadian graduates, though, the vast majority of these applicants do spend at least three years in postgraduate training by way of internships, residencies, and fellowships. For instance, a primary care residency program is typically undertaken for a period of three years.

In Colorado, the policy of safeguarding the public from licensed, yet substandard, medical practitioners can be upheld while avoiding a challenge from IMGs by making the pertinent licensing statutory provisions uniform. The statute should provide that all medical school graduates must complete two years of progressive medical training to meet licensing eligibility requirements.

From a public protection standpoint, this remedy accomplishes the goal of protecting the public from substandard practice by requiring all medical school graduates to complete two years of progressive postgraduate training. This standardization will bring Colorado into line with the medical training requirements imposed upon IMGs in the majority of other states. Moreover, it will not result in hardship to the U.S./Canadian applicants given their practice of undertaking additional postgraduate training beyond the present one-year requirement.

On the other hand, the goal of a medical training program is to make interns and residents increasingly independent. Consequently, some graduates of domestic medical schools who enter residency programs choose to become licensed before completing their residency but after the requisite one year training period has elapsed. Therefore, the ability of a licensed physician to write prescriptions after one year but before the completion of residency may benefit those rural areas where other licensed physicians are not available as resources.

RECOMMENDATION 3: ELIMINATE THE FIFTH PATHWAY LICENSING OPTION.

As already mentioned, IMGs are ordinarily required to undergo a more stringent course of postgraduate training than their counterparts who graduate from U.S. or Canadian medical schools. Section 12-36-107(2) lays out the exception to that rule.

Foreign medical schools typically require their graduates to complete a one year internship or social service rotation after completion of their academic curriculum. However, those students who complete the academic curriculum but neglect to serve their one-year rotation to earn their degree may nevertheless earn their doctorate in the United States if they complete a one-year clinical course through a U.S. medical school that has a "fifth pathway" program. Consequently, a foreign medical student who failed to earn his medical degree in a foreign country by completing a one-year clinical program may do so here by completing only one year of clinical training in the United States.

The significance of this program lies not in the one-year clinical component, however, but in the postgraduate training exemption it creates. Pursuant to 12-36-107.6(2), a student who completes his clinical medical training in a U.S. fifth pathway program is *not* considered to be an IMG. As a result, after completing the one-year fifth pathway clinical program, this category of student who was educated in a foreign medical institution must only complete one year of postgraduate training instead of the three years currently required of all IMGs.

Since 1991 when the fifth pathway program was reinstituted in Colorado, the Board has licensed 14 fifth pathway graduate students. This accommodation to a few medical students who, in reality, are IMGs but for the statutory exemption, does not promote any overriding public policy. The public interest is not served by permitting some foreign medical school graduates to complete only two years of clinical experience before licensure (one year clinical plus one year postgraduate) rather than the four years of clinical experience that all other IMGs are required to complete before licensure (one year clinical in the foreign country plus three years postgraduate in the U.S.). Accordingly, the statutory fifth pathway exemption should be repealed to restore an equal footing for all IMGs and consistent level of protection to the public whom these graduate students serve in Colorado.

RECOMMENDATION 4: THE 30-DAY TIME LIMIT BY WHICH APPLICATIONS FOR EXAMINATION MUST BE FILED WITH THE BME SHOULD BE EXTENDED TO 90 DAYS.

Currently, Section 12-36-111(2) requires applicants for licensure by examination to file their application for a Colorado license only 30 days before the examination. However, this time frame is antiquated since it was instituted several years ago when Colorado administered its own state Board examination.

By the late 1970's, all medical licensing jurisdictions in the United States, including Colorado, had adopted FLEX (the Federation Licensing Examination) or other, high-quality, nationally standardized examinations to replace individual state examinations for licensure. Although these examinations are scheduled to occur at established, consistent times (i.e., quarterly), the lead time required by the independent non-board entities that administer these national examinations extends beyond 30 days.

Applicants will not experience any hardship by having to submit their examination applications early given the predictability of the examination schedule. Therefore, the statutory 30 day deadline should be extended to 90 days.

RECOMMENDATION 5: OBSOLETE STATUTORY LANGUAGE REGARDING THE FREQUENCY WITH WHICH APPLICANTS MAY TAKE NATIONAL LICENSING EXAMINATIONS SHOULD BE DELETED.

Section 12-36-113 of the MPA sets forth requirements relating to examinations for a license to practice medicine. Subsection (2) of this provision states under what conditions an examinee may take subsequent examinations if two examinations have been attempted without success.

However, because the medical examinations have been nationalized and standardized, these requirements relating to the old, state board administered examinations are obsolete. The FLEX and other examinations for which applicants currently sit to meet Colorado licensure requirements possess their own sets of criteria regarding how often and when examinations may be taken. Accordingly, the statutory language in subsection (2) that commences with the phrase "If he fails in a current examination, . . ." is antiquated and should be deleted.

RECOMMENDATION 6: AMEND SECTION 12-36-122 TO DELETE POST-GRADUATE REGISTRATION REQUIREMENT.

The statutory provision that currently governs interns and residents requires these individuals to register with the Board. Additionally, it requires licensed physicians supervising residents and interns to report any acts or omissions that would constitute a violation of the act, along with the name of any person who hasn't progressed satisfactorily or has been dismissed from a program.

However, the Board has no regulatory authority over residents and interns, except to note reportable violations for use at such time as application for licensure is made, given their exempt status conferred upon them by Section 12-36-106(3)(k). Hence, the Board does not possess the jurisdiction necessary to discipline interns or residents while they are in post-graduate settings, even if they do commit violations of the act.

Under the present statutory language, licensed physicians who supervise residents and interns but fail to adhere to their mandatory reporting requirement engage in unprofessional conduct for which they can be disciplined, pursuant to Section 12-36-117(1)(n). Since the Board already has in place this mechanism to track reportable violations of interns and residents, the registration requirement regarding persons over whom the Board has no jurisdiction is moot. It likewise places an unnecessary strain upon limited Board resources. Therefore, the language requiring interns and residents to register with the Board should be eliminated.

RECOMMENDATION 7: SECTION 12-36-116 SHOULD BE AMENDED TO INCLUDE A COMPREHENSIVE LIST OF CIRCUMSTANCES IN WHICH THE BOARD MAY REFUSE TO GRANT AN APPLICANT A LICENSE.

I. The effective provisions of the MPA currently cite the instances in which the BME may refuse to grant a medical license in two places. First, it provides in Section 12-36-107(2), Qualifications for Licensure, that the Board may grant a license subject to probation or deny one based on the reasonable belief that unprofessional conduct has been committed. Then, in Section 12-36-116, Refusal of License, it again states the conditions under which a license may be refused. The redundant language in Section 12-36-107(2) should be deleted, particularly since that provision is designed to deal with qualifications for a license and not with circumstances warranting denial.

II. Moreover, language should be added to 12-36-116 so that all of the Board's possible actions regarding the refusal or restriction of a license are listed comprehensively. In particular, the following items should be included in section 116:

(a) The Board should be given the authority to refuse a license based upon an applicant's health impairment. This language conforms with a recommended change that is discussed later in this report.

(b) The Board should possess the authority to refuse a license or to grant one subject to terms of probation if an applicant's medical license in another state or foreign jurisdiction has been disciplined. Discipline should be defined to include any matter which is to be reported to the National Practitioner Data Bank pursuant to 45 CFR 60.8 *and* which is substantially defined as unprofessional conduct in the MPA. This language is necessary to vest the Board with authority to deny those applications for licensure of physicians whose licenses to practice in other states have been revoked or limited owing to unprofessional conduct. In the past, state boards have encountered the cases of certain physicians who have attempted to gain licensure in other states after they've been disciplined, suspended, or revoked elsewhere. Although the AMA's general counsel posited a guess that "at most 1% of the nation's 615,000 doctors have moved to a new state after receiving or being threatened with disciplinary actions," there exists, nevertheless, the problem of those physicians who are encouraged by state medical boards to move to other states to practice in exchange for reduced or dismissed discipline. Wall Street Journal, Vol. No. 95, *Gypsy Medicine: State Medical Boards Let Doctors Who Move Escape Any Discipline,* November 11, 1992.

While the proposed language will not prevent some physicians from successfully roaming to new states and from lying on their applications, it will give the BME the authority to limit or deny an application. The Board is currently entitled to information regarding an applicant's previous disciplinary history. This proposal merely takes the next logical step by permitting the Board to deny or limit a license based on that conduct before a license to practice medicine is issued in Colorado and before possible, further unlawful conduct or deficient care is encountered.

(c) The language in 12-36-116 that sets forth the applicant's right of review following the Board's refusal or limitation of a Colorado license should be augmented to provide:

> ***Any applicant whose application is denied or whose license is granted subject to terms of probation may proceed as provided in section 24-4-104(9), C.R.S. The acceptance by an applicant of a license subject to terms of probation shall be in lieu of and not in addition to the remedies set forth in section 24-4-104(9).***

This proposed language clarifies the scope of review available to an applicant whose license to practice medicine in Colorado has been granted subject to probation.

Section 24-4-104(9) permits an applicant whose request for a license has been denied the right to a hearing and judicial review so long as certain procedural requirements are satisfied. However, it does not confer the same right upon an applicant whose license is granted subject to terms of probation. Nevertheless, some physicians-applicants on probation have challenged whether their right of review is limited. Therefore, the recommended language sets forth those limitations with specificity and saves the Board having to spend resources defending its licensing decision involving probation.

II. UNPROFESSIONAL CONDUCT

Section 12-36-117 in the MPA currently identifies a laundry list of conduct, either by commission or omission, that is actionable under the act as unprofessional and warrants discipline by the Board. Some acts involve clinical competence and quality of care issues, while others involve ethical considerations.

In any event, the recommendations incorporated in this Sunset review propose primarily to do three things. First, they attempt to augment the conduct that is actionable based on behavior that the Board has confronted but over which it has no present jurisdiction; second, to streamline the standard and method by which acts of substandard care are reviewed and determined to be actionable; and third, to delineate health impairment issues as diseases, rather than unprofessional conduct, and to outline the scope of scrutiny, tracking, and disciplinary duties of the Board and the scope of reporting requirements expected of licensees.

A. <u>Recommendations Concerning the Scope of Unprofessional Conduct</u>

RECOMMENDATION 8: AMEND SECTION 12-36-117(1)(a) TO SPECIFY DECEITFUL CONDUCT VIS-A-VIS HOSPITAL PRIVILEGES AS ACTIONABLE.

The present provision designates as actionable any fraud, misrepresentation, or deception of a licensee while applying for, securing, renewing, or seeking reinstatement of a license or in taking an examination. This provision should be amended to include any such deceitful conduct that occurs when applying for, securing, renewing, or seeking (1) reinstatement of hospital privileges or (2) a medical license in this or in any other state. This revision aims to give the Board jurisdiction to discipline those physicians who lie to hospitals to obtain privileges so that patients can be treated in an acute care setting.

RECOMMENDATION 9: AMEND SECTION 12-36-117(1)(f) TO INCLUDE A DEFERRED SENTENCE AS GROUNDS FOR DISCIPLINE.

This section addresses the Board's authority to discipline a licensee when he has committed a felony. The section does not speak to deferred sentence situations. Such a situation would involve a defendant that pleads guilty to a felony offense in return for which he successfully completes time in public service ordered by the court. Upon successful completion of the term, the defendant is released from the jurisdiction of the court and the entire criminal offense is dismissed with prejudice.

The Board should have the authority to discipline physicians who are accepting deferred sentences for felonies. The Board could use the plea in the deferred sentence during the period of public service as proof of a criminal act which merits consideration of discipline. This would end the incentive for any physician to accept a deferred sentence in order to avoid action on their license, as well as hold the physician accountable for his behavior.

OPR recommends that the following language be amended to read:

> ***"Conviction of a felony or conviction of any crime that would constitute a violation of the Medical Practice Act. For purposes of this subsection, a conviction shall include a plea of guilty, a plea of nolo contendere or a deferred sentence prior to final sentencing or dismissal with prejudice:"***

RECOMMENDATION 10: AMEND SECTION 12-36-117(r) TO REQUIRE A PHYSICIAN TO REFRAIN FROM SEXUAL RELATIONS WITH A PATIENT FOR A PERIOD OF SIX-MONTHS FOLLOWING THE TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP.

In 1985, the BME was one of the first state licensing boards nationally to recognize that some physicians were taking improper advantage of the patient-client relationship b engaging in sexual relations with patients. That recognition resulted in the addition of subsection (r) of the unprofessional conduct provision, which prohibits a physician from engaging in a sexual act with a patient during the course of patient care. The rationale underlying this prohibition is that a physician may take undue advantage of a patient, upset the autonomy of patient-directed decisions in the physician-patient relationship, and use influence as an authority figure (who may know personal and sometimes intimate information about the patient), when the patient is most vulnerable and dependent.

A recent survey conducted anonymously among doctors establishes that, while formal legal charges of physician sexual misconduct are relatively rare, sexual involvements between physicians and their patients are "fairly common." These incidents average 10%, out of which 42% have been involved with more than two patients. The sexual liaisons do not usually last more than 12 months. Gartrell, N.K. et al., *Physician-Patient Sexual Contact: Prevalence and Problems*, West J Med. 1992; 157:139-43.

Another survey establishes that 37% of the polled physicians believe that sexual relationships with former patients are unethical if the physician uses or exploits the trust, knowledge, emotions, or influence derived from the professional relationship. Council on Ethical and Judicial Affairs, American Medical Association, *Sexual Misconduct in the Practice of Medicine*, JAMA 1991; 266:2741-45. Still other reports suggest that sexual involvement between patients and health care providers has long-term adverse psychosocial impact on patients similar to rape or incest. See Searight, H.R., Campbell, D.C., *Physician-Patient Sexual Contact: Ethical and Legal Issues and Clinical Guidelines*, Journal of Family Practice 1993, 36:6:247-256.

The Board has and continues to encounter several complaints detailing instances in which physicians have engaged in sexual acts with patients immediately or shortly after the termination of the formal relationship. These cases typically involve situations in which sexual involvements are terminated after the end of a physician-patient relationship. The Board must then determine whether the conduct is unprofessional conduct -- specifically, an act or omission failing to meet generally accepted standards of medical practice. These cases are difficult for the Board to resolve because the ethical questions concerning whether and at what point sexual contact with a former patient is appropriate are still hotly contested. The acceptable interval between ending the professional relationship and initiating the involvement has not been specified in the physician-patient setting.

However, Colorado and a handful of states have carved out a post-therapy cooling-off period in which psychotherapists are prohibited from engaging in sexual acts with former patients. Colorado forbids such relations for a 6-month period, while California prohibits them for 2 years. Florida deems the formal relationship "to continue in perpetuity," excluding any sanctioned sexual involvement ever.

It is the Department's position that public policy justifies the de facto prohibition of sexual relationships between physicians and their former patients for a determinate length of time. Although the formal relationship may have terminated, the physician is still in an authoritative position, and the relationship may result in the abuse of the former patient, particularly by the use of personal information gained almost exclusively through the physician-patient relationship. Moreover, given the consistent volume of complaints with which the Board wrestles regarding sexual involvement between physicians and their former patients, the Department believes that the Board and licensees will benefit by the imposition of a bright-line six-month period in which sexual relationships are prohibited. Of particular significance is the fact that the Colorado Medical Society, the professional association for physicians, endorses this cooling off period as prudent and reasonable.

RECOMMENDATION 11: THE PRESCRIPTIVE POWERS OF PHYSICIANS IN SECTION 12-36-117(1)(u) SHOULD BE AMENDED TO PROHIBIT THEIR ABILITY TO SELF-PRESCRIBE SCHEDULE III, IV AND V DRUGS, EXCEPT ON AN EMERGENCY BASIS.

The effective statutory language currently prohibits physicians from prescribing, distributing, or giving to oneself or to a family member certain defined controlled substances and schedule II drugs, except in emergency circumstances. This provision should be augmented to preclude a physician from self-prescribing schedule III, IV, and V drugs, except in emergency circumstances.

Drugs and drug products that are considered to be controlled substances fall within the jurisdiction of the federal and state Controlled Substances Acts, which divide drugs into five categories. Schedule I drugs, such as LSD, have no accepted medical use in treatment and their abuse potential is high, so they cannot be prescribed. Schedule II drugs such as Demerol, Percodan, and cocaine constitute the next highest abuse potential, but they do have accepted medical use and can be prescribed by physicians. The balance of controlled substances are categorized in declining order of abuse potential in Schedules III, IV, and V, with Schedule V drugs constituting the lowest abuse potential.

The Colorado Prescription Drug Abuse Task Force (a consortium of over 30 private and public agencies) has developed guidelines for the responsible prescriptions and administration of controlled substances handled by physicians. These guidelines set out recommended practices for the appropriate prescribing of controlled substances that have a demonstrated potential for inappropriate use and dependence formation. The guidelines are designed to protect physicians and their practices from becoming sources of drug diversion and prescription drug abuse. As the guidelines recognize, inappropriate controlled substance drug diversion and/or prescription practices frequently occur when dishonest or substance abuse-impaired physicians knowingly prescribe controlled drugs for purposes of abuse or profit.

The guideline sets forth unacceptable prescribing practices, specifically, the Schedule II self-prescription prohibition set forth in the Medical Practice Act. However, the guidelines expand upon the current proscription in section 117 by stating that :

> ***Prudent practice also would discourage the following:***
>
> ***Prescribing any controlled substance for yourself or a family member.***

These guidelines were reviewed by the BME, but they do not carry the weight of subsection 117(1)(u) inasmuch as they are not binding upon physicians. However, both the BME and the licensee-sponsored physician impairment program, CPHP, agree that section 12-36-117(1)(u) should be revised to make the self-prescription of Schedule III, IV, and V drugs a violation of the medical practice act, except under emergency circumstances.

This revision will permit the Board to protect the public from practitioners who abuse their powerful authority to prescribe controlled substances and who may be practicing while impaired. If implemented, this revision will give the Board jurisdiction to monitor, discipline and, if necessary, to divert any licensee who profits or becomes impaired as a result of self-prescribing. At the same time, however, the ability of physicians to self-prescribe under legitimate emergency circumstances will not be thwarted. This exception will protect rural physicians from operating under a disadvantage when situations warrant emergency self-prescription of controlled substances.

RECOMMENDATION 12: REVISE THE MPA TO INCLUDE THE FAILURE TO COMPLY WITH REQUIRED INSURANCE, FINANCIAL RESPONSIBILITY, AND REPORTING REQUIREMENTS AS UNPROFESSIONAL CONDUCT.

Currently Section 13-64-301 requires physicians to adhere to financial responsibility standards as a condition of licensure by maintaining minimum insurance coverage, a surety bond, or by depositing security otherwise approved by the Commissioner of Insurance. Although the language is mandatory, there is no prescribed penalty for failure to comply.

Its counterpart, section 13-64-303, requires physicians under certain circumstances to report medical malpractice final judgments, settlements, or arbitration awards to the BME. The penalty for failure to do so is a civil penalty of not more than $2,500.

The important public policy underlying the financial responsibility and reporting requirements ensures that patients who suffer harm as a result of the negligence of physicians shall be able to recover satisfactory compensation owing to sufficient financial resources. While the existing statute establishes this important requirement and prevents practitioners from receiving a reissued license for failure to comply, the MPA should be revised to give the Board the jurisdiction to discipline licensees for the same omission. Medical licenses are issued every two years, and arguably there are situations in which a non-complying licensee would be able to continue practicing without recourse for a lengthy period of time.

Likewise, one's failure to carry out the corresponding duty to report a medical malpractice judgment or settlement should be inscribed in the MPA in addition to carrying a civil money penalty. One of the only ways by which the Board is informed of possible substandard practice violations is through mandatory reporting requirements. The public interest obviously is placed at risk when the licensing board is not made aware of medical malpractice judgments or settlements and, hence, possible substandard practice. The General Assembly should underscore the importance of this duty by establishing that violations of section 13-64-303 is an unprofessional act warranting discipline.

RECOMMENDATION 13: THE MPA SHOULD BE REVISED TO IMPOSE A MANDATORY OBLIGATION UPON LICENSEES TO RESPOND IN WRITING TO A COMPLAINT ISSUED BY AN INDIVIDUAL OR BY THE BOARD.

The MPA currently requires the Board to notify a physician when a complaint has been received or initiated against the licensee by the Board. However, section 12-36-118(4)(a) permits, but does not require, the licensee to respond to the complaint in writing (the 20 day letter). Section 12-36-118(4)(a) goes on to provide that the Board shall refer the case to an inquiry panel for investigation, whether or not the licensee has responded. Therefore, the failure of a licensee to respond to a complaint at its outset appears superficially to harm the licensee.

However, the Board is charged with the mandatory duty to determine whether the complaint warrants discipline or a hearing, and the licensee's response is obviously germane to the full and fair hearing of the case. Consequently, in cases in which the physician fails to provide a response, the Board must devote resources that it cannot spare to investigation that otherwise could have been accomplished by way of a response. Not only does this hamper the Board's investigation, but it also impedes the Board's efficient and timely review and disposition of the case.

Other states have addressed this problem in their medical practice acts by changing the option of responding to a complaint into a duty, the violation of which is an act of unprofessional conduct. Colorado should follow suit.

It is important to note that the primary goal of this recommendation is not punitive but, rather, is aimed toward eliminating wasted time and resources when determining the merit of complaints. Therefore, because there are circumstances in which the licensee's ability to respond to a complaint within 20 days is impossible or unreasonable, the statutory provision should also contain language recognizing that a licensee does not violate the act if one's failure to respond to a complaint in timely fashion is due to conditions beyond the licensee's control.

RECOMMENDATION 14: SUBSECTION (2) OF SECTION 12-36-117 SHOULD BE REVISED TO DEFINE THE DISCIPLINE OF A PHYSICIAN'S LICENSE IN ANOTHER JURISDICTION AS UNPROFESSIONAL CONDUCT.

Section 12-36-117(2) currently empowers the Board to discipline those licensees who have been subject to disciplinary action in another state on grounds that are substantially similar to those that would constitute a violation of section 117 of the MPA. It provides that evidence of such disciplinary action is prima facie evidence of unprofessional conduct in Colorado.

However, given the manner in which licensees are often disciplined in other states, this language often impedes the Board's ability to sanction licensees for out-of-state conduct. For instance, other jurisdictions will frequently issue consent decrees or stipulations which impose discipline without making sufficient findings for the BME to determine whether the acts or omissions are "substantially" the same as conduct defined in the Colorado statute. In these cases, the Board has the burden of proving that the conduct was substantially the same as unprofessional conduct defined in subsection 117(1). To meet this burden, the Board is required to expend resources to investigate conduct that occurred outside Colorado. Moreover, many out-of-state decrees are crafted so that the licensee has not admitted guilt, another impediment to proving up the prima facie case.

Subsection (2) of the unprofessional conduct statute should be amended to protect the public safety, welfare, and interest from further possible harm flowing from a practitioner who has been disciplined in another state for conduct that is unprofessional in Colorado. The new language should provide that a Colorado licensee commits unprofessional conduct when the practitioner's license to practice medicine in another jurisdiction has been disciplined for conduct that is substantially similar to unprofessional conduct defined in section 12-36-117(1). By shifting the burden of proving the previous substantially similar violation, this amendment will permit the Board to discipline physicians for unprofessional conduct without having to expend resources to relitigate the case.

Of course, a shift in the burden of proof means that the respondent will be laboring under the burden of proving that the conduct was not substantially similar to subsection 117(1) conduct. However, such an individual will be in the position of presenting evidence of rehabilitation of mitigation during the disciplinary process.

Significantly, the proposed amendment comports with similar provisions in the medical practice acts of other states, such as Arizona and Oregon.

RECOMMENDATION 15: THE GENERAL ASSEMBLY SHOULD AMEND THE STATUTORY LANGUAGE THAT DEFINES ACCEPTABLE PUBLIC COMMUNICATIONS AND ADVERTISEMENTS.

Physicians in the past were prohibited from engaging in "advertising which is misleading, deceptive, or false." In 1991 this language was repealed and replaced with Section 12-36-128.5, a lengthy section that details advertising and public communication guidelines for physicians. The most contentious portion of this language charges the Board with the authority to determine whether physicians may hold themselves out to be "Board certified" in advertisements. To do that, the BME must determine which board specialty certifications are "substantially equivalent" to the generally recognized, standard board certification extended by the American Board of Medical Specialties (ABMS). That provision is supplemented by a rule that establishes criteria providing a basis for making such a determination.

The value of advertising oneself as "board certified" is that a physician who holds himself out to be such is traditionally understood to have achieved a prestigious level of expertise in a particular specialization. The problem is that several alternative "boards" (other than the ABMS) now offer "certification", and some of these boards apparently do not require its applicants to adhere to the same rigorous standards for accreditation as the ABMS.

According to the BME, the statutory revision that allows the Board to "OK" alternative board certifications was advocated by certain physician subspecialty groups, without the Board's approval, purportedly in an effort to gain a toehold in economic turf wars ongoing between specialties. On the other hand, the physician-proponents of these alternative board certification programs believe that they are entitled to advertise themselves as board-certified so long as the BME finds the certification is "substantially equivalent" to the ABMS standard.

One solution to this issue that is supported by some members of the Board and by the Colorado Medical Society is reversion to the old standard that prohibits "advertising that is deceptive, misleading, or false." The proponents of this solution agree that the Board, under this standard, will possess the latitude to address advertising issues on a case-by-case basis without being burdened by the oppressive requirements now in place in the statute.

An objective analysis of this issue establishes that much of what is included in the current statute and rule outlines acceptable and unacceptable advertising practices with a clarity of definition that benefits and protects the public. However, the Board's overriding experience with the new advertising provisions to date has been the forced mediation of contentious "doctor wars" over board certification and economic issues. This has arguably drained the Board's ability to deal with more pressing and deserving issues. Accordingly, the General Assembly should reinstitute the former advertising standard.

B. Recommendations Concerning the Standard of Review for Negligent Conduct

RECOMMENDATION 16: SECTION 12-36-117(p) SHOULD BE REVISED TO DEFINE UNPROFESSIONAL CONDUCT AS "ANY ACT OR OMISSION WHICH FAILS TO MEET GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE."

Section 12-36-117(p) is the basic unprofessional conduct provision under which the Board asserts jurisdiction over most questions of clinical competence and quality of care issues. It currently bifurcates substandard care into two categories, grossly negligent medical practice and negligent medical practice. Unprofessional conduct in this context is specifically defined as:

> ***An act or omission constituting grossly negligent medical practice or two or more acts or omissions which fail to meet generally accepted standards of medical practice, whether the two or more acts or omissions occur during a single treatment of one patient, during the course of treatment of one patient, or during the treatment of more than one patient.***

This problematic language has required construction by state appellate courts. See *People v. Pfeiffer,* 725 P.2d 19 (Colo. App. 1986). As a practical matter, the Board must contend with two-or-more-act threshold language that permits physicians who have committed one negligent act to avoid any kind of discipline, no matter what the circumstances may be.

The standard is also equitably inconsistent. Complainants who have suffered as victims of the negligent act do not receive any satisfaction from the regulatory process unless the physician commits another negligent act, spurring the commencement of a disciplinary action. Moreover, physicians against whom complaints regarding one act of simple negligence have been pressed are left in limbo. In these circumstances, the Board operates under the questionable "one act and hold" policy whereby a case involving one act of simple negligence is held open and pending by the Board indefinitely. Consequently, a licensee does not possess any remedy or means to contest the complaint since it is neither prosecuted nor dismissed.

Perhaps the most compelling argument in favor of amending the provision is that, in its present form, it ill-serves the public policies of disciplining licensees who perform substandard care and protecting the public from substandard care and the risk of future negligent practice. Under the current standard, the Board is placed in the frustrating position of having to wait until the practitioner commits another blunder until it can take any action against the licensee. This impotent posture is statutorily-imposed, but the result is astonishing. By requiring the Board to sit on its thumbs until a second act occurs, its ability to protect the public from substandard care is effectively squelched.

The recommended language gives the Board the jurisdiction to review any conduct by a physician that is questionable from a patient care standpoint, regardless of whether it constitutes one or multiple negligent acts or omissions. The Department and the Board concur that this revision is vitally linked to its ability to carry out its regulatory functions.

However, it is anticipated that the regulated profession will object strenuously to an amendment that some believe vests a regulatory body with the discretion to discipline a physician who makes any mistake, no matter how minor. While broader language does theoretically involve a higher risk of regulatory abuse, two primary points mitigate this risk.

First, while this amendment does seek the authority to review acts of purported negligence for purposes of protecting the public, it does not seek to punish licensees for mistakes that do not merit discipline. The volume of complaints that the Board deals with prohibits it from expanding its disciplinary function and stretched resources to petty matters. Second, other states have incorporated similar one-act language into their medical practice acts without occurrence of overreaching or arbitrary disciplinary actions. (See statutory provisions of Florida, attached as Appendix B).

In addition, the other medical related boards at the department do not enjoy the latitude of two negligent acts. Their acts require the boards to consider a single occurrence of negligence as sufficient grounds for discipline. Why should a doctor be entitled to two negligent acts before discipline attaches when a nurse, dentist, chiropractor, etc. would not? Certainly each type of practitioner can do substantial damage to a patient through negligence. This type of distinction is unfair, unsupported by rational argument and should be remedied.

C. Recommendations Concerning Impaired Physician Discipline v. Diversion

RECOMMENDATION 17: THE MPA PROVISIONS DEFINING SUBSTANCE ABUSE AND OTHER HEALTH IMPAIRMENT PROBLEMS AS UNPROFESSIONAL CONDUCT SHOULD BE RECLASSIFIED AND REVISED TO ENCOURAGE DIVERSION AND REHABILITATION.

At this time, the MPA is drafted to provide that a physician who has a substance abuse problem or some other physical or mental condition which adversely affects his or her ability to practice is guilty of unprofessional conduct. The two provisions that specifically define these problems as unprofessional conduct are:

> ***12-36-117(1)(i): Habitual intemperance or excessive use of any habit forming drug as defined in section 12-22-102(13), or any controlled substance, as defined in section 12-22-303(7);***
>
> ***12-36-117(1)(o): Such physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient.***

Given that an impaired physician is currently committing unprofessional conduct by definition, the Board's statutory duty is to reach that physician through disciplinary action. Consequently, one who is afflicted with a manic-depressive disorder, for example, will be dealt with by the BME vis-a-vis a probationary order that is predicated upon unprofessional conduct.

There is a considerable amount of discussion in health care regulatory circles about the pros and cons of diversion as opposed to discipline. The aim of diversion programs is to rehabilitate health care providers. Rather than lose the services of physicians, diversion seeks to reclaim their health and abilities so that their education and skills can be subsequently utilized for the benefit of the public. The contrary view expresses the legitimate point that, although the diversion of physicians is admirable, the primary role of licensing bodies is to protect the public from substandard care and other risks attendant to physicians who practice while impaired.

There is no question that the Board's responsibility to protect the public interest is paramount. However, there is no escaping the fact that physicians and other health care providers suffer from health impairment problems, in part because of the unique stresses of the job and in part owing to physicians' proximity to controlled substances. The General Assembly has previously recognized that this problem warrants attention by sanctioning a statutorily-mandated diversion program. The creation of this program can fairly be construed as recognition that protection of the public is a goal that is not mutually exclusive to physician rehabilitation.

Right now Colorado physicians who suffer some sort of health impairment have the benefit of receiving treatment that is overseen by the legislatively-mandated health impairment program. Physicians typically participate in this program in one of three ways. Those physicians who recognize they need treatment enroll themselves in the program voluntarily. Others are reported by identified or anonymous referrals and, after being reviewed by the program, participate voluntarily. Finally, others receive treatment in diversion as a condition of discipline imposed by the BME, usually by way of a stipulation and/or probation.

One indicator of the program's success is that, since its establishment in 198_, case load statistics show that voluntary participation has steadily increased. The motivation to receive assistance for an impairment problem in this program is owing in large part to the guarantee of confidentiality unless: (1) the impairment affects the physician's ability to practice; (2) it poses a risk to the physician or others; or (3) the physician fails to complete the treatment program satisfactorily.

Some criticize the scope of confidentiality for its appearance or purported effect of permitting physicians to hide behind diversion to escape discipline and, ultimately, public scrutiny. Nevertheless, the diversion program's conditions regarding confidentiality are shared by the vast majority of states that also have diversion programs.

	Require impaired physician programs to report to the Board names of program participants	***Required Impaired physician programs to report to the Board names of licensees failing to satisfactorily complete the program/ treatment***		***Require impaired physician programs to report to the Board names of program participants***	***Required Impaired physician programs to report to the Board names of licensees failing to satisfactorily complete the program/ treatment***
AL	Yes, upon program completion	Yes	NV-M	No	No information provided
AK	No, except for compliance failures	Yes	NV-O	Yes	No information provided
AZ-M	Yes	Yes	NH	No	No
AZ-O	Yes	No information provided	NJ	No	No
AR	No	No information provided	NM-M	No, except those board mandated	No information provided
CA-M	No	Yes	NM-O	No	Yes
CA-O	No	No information provided	NY	No	Yes
CO	No, unless impairment affects ability	Yes	NC	No, except those who fail to comply or who present danger to public	Yes
CT-M	No	No information provided	ND	No	No information provided
DE	No	Yes	OH	No	Yes
DC	No	Yes	OK-M	No	No information provided
FL-M	No	Yes	OK-O	No	Yes
FL-O	No	Yes	OR	No	Yes
GA	No, unless licensee is under Board order	No information provided	PA-M	No	No information provided
GM	No information provided		PA-O	No	No information provided
HI-M	No	No information provided	PR	No	No information provided
ID	Yes	Yes	RI	No, but Board may inquire	Yes
IL	No, except institutions required to report	No information provided	SC	No	Yes
IN	No	Yes	SD	No	Yes
IA	No, unless impairment affects ability	No information provided	TN-M	No	No information provided
KS	Yes	Yes	TN-O	No	No information provided
KY	No	Yes	TX	No, except those Board mandated	Yes
LA	No, unless impairment affects ability	Yes	UT-M	Yes	No information provided
ME-M	No	Yes	UT-O	Yes	No information provided
ME-O	No	Yes	VT-M	No	Yes

MD	No	Yes	VA	Yes, unless exempted by state law	Yes
MA	No	Yes	VI	No	No information provided
MI-M	No	No information provided	WA-M	No	Yes
MI-O	No	No information provided	WA-O	No, except those who fail to complete/comply with program	Yes
MN	No	Yes	WV-M	No	Yes
MS	No	Treatment center usually sends informal notice of report by telephone	WV-O	Yes	Yes
MO	No	No information provided	WI	No	No
MT	No, except those who fail to complete/comply with program	Yes	WY	No	Yes, with significant relapse
NE	No	Yes	**TOTALS**	**Yes=10/No=56**	**Yes=40/No=2**

Despite the inherent conflict between diversion and discipline, there is a middle ground that will promote diversion without sacrificing the goal of safeguarding the public interest. The diversion program already permits physicians with personal health issues to remain outside of the disciplinary pipeline so long as they receive treatment for their condition and are regularly evaluated to ensure they are competent to practice medicine safely. The unprofessional conduct section of the MPA should be revised to reflect symmetry with the diversion approach in practice. That is to say, the Board can defray discipline so long as the applicant to the program is not a risk to himself or others, is safe to practice and has been complying with the terms of his diversion program. The Board must have the authority, however, to deal with any of the above situations. This authority should be clearly stated, and must include some sort of evaluation of the program which ensures appropriate admission, evaluation on safety grounds, etc.

While the proposed statutory revisions do not impact the confidentiality provisions that currently allow certain physicians to be treated without being reported to the BME, the recommended revisions do provide the Board with continuing jurisdiction to review and discipline physicians for unprofessional conduct if they practice or attempt to practice under conditions that place the public at risk.

The recommendations also incorporate a definition of "health impairment" and a hearing and review mechanism by which the Board must determine whether a licensee is impaired. This mechanism mirrors the hearing process for unprofessional conduct. Consequently, a determination of health impairment must be reached according to prescribed procedures and standards that safeguard the respondent's due process and hearing rights. Should a finding of health impairment be reached, the recommendations urge that the Board retain jurisdiction to place the licensee on probation or to discipline him as otherwise appropriate. The proposed revision anticipates that the

Board shall have the authority to attach strict conditions upon probation, including successful diversion treatment, periodic evaluation, and monitoring.

Finally, the reporting requirements that oblige licensees and treatment centers to report unprofessional conduct are updated to take into account the circumstances in which one is obligated to report a physician's health impairment.

In short, the revised MPA should ensure that the Board has the necessary authority and tools to determine, evaluate, monitor and, where appropriate, to discipline charges of health impairment. However, a physician's health impairment should not, with one important exception, be classified as unprofessional conduct. The following recommendations address the proposed changes.

Recommendation 18(a): Repeal Sections 12-36-117(1)(i) and (o). Amend subsection (i) to provide that a licensee is guilty of unprofessional conduct when "Providing or attempting to provide medical care to a patient while intoxicated by alcohol or any habit-forming drug as defined in section 12-22-102(13), or any controlled substance, as defined in section 12-22-303(7)."

Subsection (i) and (o), as mentioned before, incorporate habitual intemperance and other medical defects in the laundry list of unprofessional conduct. According to this language, one who does not manifest a health impairment during the course of practice and who does not cause harm to any patient or member of the public is nevertheless subject to discipline for unprofessional conduct. In other words, the conduct is not outcome based. This language should be deleted to further the policy of recognizing that such conduct, providing it has not caused another harm, is typically disease-related, is treatable through diversion, and should not be categorized as unprofessional conduct.

However, the rationale that drives the policy of diversion to treat impairments that are not manifested during medical practice should not apply to circumstances in which the licensee is actually practicing or attempting to practice while impaired. In such a situation, the risk of harm to the patient is enormous. The Board should have jurisdiction to discipline the licensee for committing unprofessional conduct, and subsection (i) should be revised to give the Board the authority to discipline a physician who practices or attempts to practice medicine while impaired.

<u>Recommendation 18(b)</u>: A new provision, Section 12-36-117.5, should be incorporated into the MPA that defines "health impairment" and exemptions thereto.

The impairment conduct that is deleted from the definition of "unprofessional conduct" must necessarily be defined in the MPA as the condition of "health impairment." This accomplishes the policy of treating and rehabilitating impaired physicians rather than disciplining them for unprofessional conduct. At the same time, the proposed language vests the Board with the jurisdiction to address and punish such conduct, if necessary. The definition and all of its trappings achieves the important goal of protecting the public while the physician is attempting rehabilitation.

The proposed definition of "health impairment" is framed to include the language of section 12-36-117(o), which currently describes as actionable conduct disabilities that render the physician unable to perform medical services with reasonable skill and safety to the patient.

Subsection (2) of the proposed statutory provision also provides that licensees who have received successful treatment for a health impairment for a period of five or more years are not subject to a determination by the Board that they suffer from a health impairment. This proposed language essentially provides a statute of limitations for actionable impairment. For example, a physician who has undergone treatment for substance abuse and who has remained sober for over five years would not be subject to the health impairment process. This exemption balances the goal of protecting the public from impaired physicians during rehabilitation against the due consideration that is arguably owed a licensee who, over time, has proved his or her successful rehabilitation.

<u>Recommendation 18(c)</u>: Section 12-36-118 should be amended to include the hearing procedures for the determination of a health impairment. This section should likewise define the acceptable actions that the Board may take upon reaching a determination of "health impairment."

The important procedural adjunct to the definition of "health impairment" is the proposed addition to subsection 118. This section outlines how the Board may reach a determination of health impairment and, if it does, what conditions it may impose upon the licensee.

Section 12-36-118 is a detailed provision that outlines the disciplinary action that the Board may take against licensees and the procedures with which it must comply before imposing discipline. Even though this review proposes that health impairment should be recognized as a condition distinct from unprofessional conduct, the Board must still operate within a procedural structure when determining whether such a condition exists and when imposing probationary or disciplinary conditions upon the licensee. The recommended amendments and additions to subsection 118 are designed to do that.

First, section 12-36-118(c)(III) should be revised to give the Board the authority to send a letter of admonition to a licensee when investigation discloses an instance of health impairment that does not warrant further formal action or evaluation.

Second, section 12-36-118(g) should be revised to provide that, if a formal complaint charging health impairment is filed against a licensee, the charge must be established as specified in the Colorado Administrative Procedure Act. This amendment comports with the due process requirements that are warranted in findings of unprofessional conduct.

Third, section 12-36-118(g) should be modified to include a new subsection (III.5) that delineates the actions that may be taken by Board against the licensee upon a finding of health impairment. Specifically, the new provision should permit the Board to:

(a) Place the licensee on probation for a definite or indefinite period, at the Board's discretion;

(b) Include in an order of probation conditions that are appropriate to ensure safety to the public and proper treatment for the licensee. (Such conditions should include blood and/or urine testing, medical and/or psychological treatment, supervisory practice requirements, and restrictions upon the scope of the licensee's practice); and

(c) Impose discipline upon the licensee for unprofessional conduct, whether the conduct was or wasn't caused by the health impairment.

Fourth, subsections 12-26-118(g)(IV) and (V) should be revised to include conforming amendments. The first revision permits the Board to suspend the physician's license to practice if he fails to comply with the conditions imposed after a finding of health impairment. The second revision permits the Board to take the licensee's prior disciplinary record into account when making orders relative to health impairment.

<u>Recommendation 18(d)</u>: The statutory provisions regarding licensing requirements and relicensure should be amended to permit the Board to deny or otherwise to place restrictions upon licenses upon a finding or admission of health impairment.

Just as the Board is authorized to refuse an applicant a new license for having engaged in unprofessional conduct or for not possessing the necessary qualifications, it should likewise have the authority to refuse a license or to condition it upon terms of probation in the event of health impairment. Section 12-36-116 should be amended to reflect this.

Also, the Board's ability to grant a temporary licenses to foreign medical graduates and to visiting U.S. Olympic committee physicians should be premised on its authority to restrict or condition the license in the event of health impairment. Sections 12-36-107(3) and (4) should be revised accordingly.

Recommendation 18(e): Section 12-36-118(3) should be amended to outline the licensee's duty to report another physician's health impairment.

The existing language in 118(3) imposes an obligation upon licensed physicians to report to the Board instances of unprofessional conduct that violates subsection 117. The language explicitly recognizes the physician-patient privilege by exempting treating physicians from

having to report the habitual intemperance or mental disability of their patient-licensee to the Board.

This provision should be amended to take the health impairment revision into account. Specific reporting obligations of licensees generally and of licensees who are members of peer assistance programs should be outlined to comport with the health impairment recommendations. In particular, licensees should have the duty to report any known or believed violations of the health impairment provision to the Board or to the statutorily-approved peer assistance program as defined in section 12-36-123.5.

Granting licensees the option to report to the Board or to the peer assistance program is designed so that licensees will be encouraged to report actual or suspected health impairment violations with confidence that the impaired physician will receive treatment rather than the temporary or permanent loss of a license. However, the soundness of this policy is predicated upon the peer assistance program's compliance with its agreement to report any licensee to the Board who fails to undergo or complete treatment or who constitutes a risk to himself or to others.

The available evidence suggests that the peer assistance program has dutifully fulfilled its reporting duty, and the most recent evaluation of the program concludes that its performance is outstanding. Even so, the report notes that CPHP reported only 2% of its admissions to the Board pursuant to its contractual agreement to report appropriate cases to the Board for discipline.

The proposed reporting requirement option is feasible only if it can be gained by ensuring that public safety considerations will be protected at similar or enhanced levels. Therefore, to ensure that the peer assistance program reporting requirement does not act as a shield that protects physicians from disciplinary action, the statute should impose upon licensees who are members of peer assistance programs a separate reporting requirement. The following duty language is crafted to balance the public safety considerations against those involving physician-patient and confidentiality privileges:

> ***No physician who is a member of a peer assistance program need report a health impairment as defined in section 12-36-117.5 unless, in the determination of the peer assistance program, the physician presents a danger to himself or others, in which case, a report to the Board shall be made.***

Inasmuch as the Board has jurisdiction over licensees and not a program, it cannot impose a reporting requirement statutorily; that is accomplished contractually. However, CPHP's contractual reporting duty is accompanied by its agreement to undergo periodic review by a third party. DORA recommends that the scope of this review should also include a review of patient admission and medical records for determination whether the program is fulfilling its duty to report those licensees to the Board who fails to undergo or complete treatment or who poses a risk to himself or others.

Recommendation 18(f): Section 12-36-117 should be amended to include a provision that defines a licensee's failure to comply with the reporting duty as unprofessional conduct warranting discipline.

Colorado was one of the first states in the nation to impose the statutory "tattletale provision" upon a licensee, requiring him to report unprofessional conduct violations to the Board for its action. However, that duty, both as it currently exists in 12-36-118(3) and as proposed in the previous recommendation, does not carry with it any penalty for failure to comply.

In keeping with the notion that emphasis on diversion carries with it a concomitant obligation to guard the public interest, welfare, and safety, the Department recommends that a licensee should be subject to discipline for failure to comply with her critical reporting requirement to the Board or to the peer assistance program. This important addition to the unprofessional conduct section provides the Board with authority to discipline licensees who take their reporting duty casually at the expense of public protection considerations. The proposed language will ensure that serious disciplinary consequences will attach to a licensee's failure to carry out his duty, whether as a licensee-practitioner or as a licensee-peer assistance program member.

In addition, this provision should outline those circumstances in which licensees do not need to report unprofessional conduct or health impairment violations. Licensees should be exempt from these reporting requirement when a professional review committee as defined in section 12-36.5-102 finds: (a) that unprofessional conduct has not occurred or that a health impairment does not exist; and (b) that no action of a restrictive or disciplinary nature has been taken against the physician by the committee. The effect of this provision is to impose upon licensees who are members of such committees the personal obligation to report violations under all but the specifically exempted circumstances.

III. DISCIPLINARY HEARING PROCEDURES

RECOMMENDATION 19: REVISE SECTION 12-36-118(1) TO OMIT THE OPTION OF PERMITTING AN ADVISER FROM THE HEARINGS PANEL TO ASSIST THE ADMINISTRATIVE LAW JUDGE.

At the time of the 1984 sunset review, the Board had the option of hearing a disciplinary case itself by utilizing the inquiry and hearing panel model or assigning a hearing to a hearing officer or administrative law judge from the Department of Administration. The Board had not been satisfied with decisions reached by hearing officers, but its reluctance to assign disciplinary hearings to the Department of Administration was about to be challenged by the increased caseload necessitating more hearings and, hence, more Board time.

Therefore, the Board lobbied for an alternative regulatory structure that would give it the flexibility to assign a case to an ALJ with the assistance of a Board member. In 1985, section 12-36-118(1) was amended to incorporate such a structure. Since then, the Board has had the option of assigning a disciplinary case to an administrative law judge for hearing and appointing a member of the hearings panel as an adviser to the ALJ to assist in obtaining and interpreting pertinent medical data.

Although the Board's caseload has continued to increase since 1985, the administrator of the medical board regulatory program can recall only one case in which this alternative regulatory structure was invoked. The Board's reluctance to assign cases to an ALJ has vanished and its earlier criticisms relative to ALJ decisions have not been borne out through the intervening years. Therefore, the language in section 12-36-118(1) that confers the Board with a third regulatory option--the hybrid ALJ-hearing panel member regulatory structure--is unnecessary and should be deleted.

RECOMMENDATION 20: REVISE SECTION 12-36-118(4)(a) TO STREAMLINE THE COMPLAINT AND INVESTIGATION PROCEDURE.

This provision is the authority on which the Board relies to initiate and investigate complaints. However, it should be amended in three respects.

First, the present language requires the entire Board to initiate a complaint against a licensee. Under the split panel system, the inquiry panel is the appropriate body that investigates facts and allegations that would cause it to initiate the complaint. Subsection (4)(a) should be revised to reflect that.

Second, the statute now requires the Board to notify the respondent of "the nature of all matters complained of." This should be revised to require the acting panel to mail or serve the respondent with a copy of the complaint.

Third, the statute imposes a mandatory obligation upon the inquiry panel to investigate each complaint that it receives. This obligation is fundamental; however, in circumstances in which complaints are made when substantial investigation has already been conducted, i.e. by state regulatory agencies or courts, and the products of that investigation are made available to the Board. Under these circumstances, the requirement that the Board launch a full investigation may be redundant. Therefore, the statute should be revised to authorize the inquiry panel to undertake further investigation if necessary.

RECOMMENDATION 21: SECTIONS 12-36-118(4)(b)(II) and 12-36.5-104 SHOULD BE REVISED TO REQUIRE PEER REVIEW COMMITTEES TO REPORT ALL DISCIPLINARY ACTION FINDINGS, CONCLUSIONS, AND ACTIONS TO THE BOARD.

Peer review committees and certain other organizations are conferred with the statutory authority to discipline licensees for their unprofessional conduct. These committees usually assume quality control and disciplinary oversight over licensees who are employed by health care facilities or who exercise hospital privileges.

However, when the former peer review statue was repealed and replaced by the current statute, Section 12-36.5-101, et seq., a critical reporting duty was inadvertently lost in the transition. Peer review committees were formerly required, as a condition of the statutory good faith immunity they enjoy while performing these delegated statutory functions, to report the results of their professional review proceedings to the BME. The current statute does not require them to do so as a matter of course, and this negatively impacts the Board's ability to investigate and discipline a licensee in the event the physician has committed unprofessional conduct.

The legislative declaration of the peer review statute evidences the intent that committees exercise delegated, not autonomous, power from the BME. It was anticipated that these committees account to the Board. Therefore, the provision should be reinserted by amending Section 12-36.5-104(11) to include the following language:

> ***All professional review entities shall forward to the Colorado State Board of Medical Examiners any recommendation for, or final action regarding the taking of, any adverse action against the privileges, credentials, or status of the physician.***

Further, the MPA should be amended to conform to this provision by adding language to Section 12-36-118(4)(b)(II):

> ***The Board shall cause an investigation to be made when the Board is informed of:***
>
> . . . .
>
> ***(II) Disciplinary actions taken as a result of a professional review proceeding pursuant to part 1 of article 36.5 of this title against a physician. Such disciplinary actions shall be reported to the Board.***

RECOMMENDATION 22: THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING THE BOARD'S AUTHORITY TO IMPOSE DISCIPLINARY SANCTIONS IN FOUR SEPARATE WAYS.

The Board is vested with authority to impose a number of different sanctions upon a determination of unprofessional conduct. The General Assembly should consider amending this authority in four ways.

First, Section 12-36-118(4)(c)(II.5) gives the Board the option to send a letter of concern to a licensee whose conduct is "possibly errant" but does not warrant disciplinary action. The letter is essentially a warning. It is not intended to be A disciplinary action, and the Court of Appeals has so construed it not to constitute discipline. Nevertheless, the provision goes on to provide that if the Board learns of subsequent similar conduct, it shall send a letter of admonition to the licensee. Thus, the statute imposes a disciplinary sanction upon conduct that it has already characterized as not warranting discipline. This deficiency should be corrected by deleting the second sentence of this provision mandating the LOA.

Second, the General Assembly should amend Section 12-36-118(g)(III) to reflect that the Board no longer issues private or public censures as disciplinary sanctions. As of July 1, 1993 the Board's policy regarding confidential letters of admonition was changed to make LOAs a matter of public record. Therefore, they are now equivalent to public censure. As for private censure, all formal disciplinary action is required to be reported to the National Practitioners Data Bank which means, as a practical consequence, that there is no longer any such beast as a private or confidential sanction. Therefore, this sanction is obsolete and should also be eliminated.

Third, the General Assembly should consider giving the Board the authority to impose monetary fines upon licensees as a disciplinary sanction. As of 1993, 38 states authorized their medical boards to impose fines for the violation of their medical practice acts. (1992-1993 Exchange, Table 11) This sanction is also proposed by the Federation of State Medical Boards of the U.S. as one of several disciplinary actions that should be made available to the Board. The State of Washington incorporates this sanction into its code by authorizing its Board to order, separately or together with other disciplinary actions, "payment of a fine for each violation of this chapter, not to exceed one thousand dollars per violation." The Washington code goes on to give the Board enforcement authority for the untimely payment of a fine. See Washington Title 18 RCW: 18.130.165.

Fourth, the General Assembly should consider implementing another innovation included in Washington's code. That statute is similar to Colorado's MPA in that both are clearly established as public protection entities. Nevertheless, some members of the profession take the view that the primary focus of the BME ought to be rehabilitation of licensees, not public protection. The General Assembly may wish to consider restating the paramount mission of the BME in its disciplinary section to deflect any misunderstanding regarding the Board's primary function. The Washington statute provides:

> ***'In determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder or applicant."***

RECOMMENDATION 23: THE PROCEDURAL SAFEGUARDS RELATIVE TO FORMAL COMPLAINTS IN SECTION 12-36-118 SHOULD BE AMENDED TO CONFORM TO THE REQUIREMENTS OF THE COLORADO ADMINISTRATIVE PROCEDURES ACT.

The statutory language that sets forth the procedures attendant to the filing of a formal complaint predates the Colorado APA. Consequently, certain requirements in this section are antiquated. For instance, the Board is now required to forward to the physician a copy of the complaint <u>and</u> a citation that lists the sections of the MPA that are alleged to have been violated. This procedure is redundant and fails to provide any procedural due process protection to the licensee that is not afforded by the APA's requirement that the respondent receive a complaint that cites the alleged violation(s).

The General Assembly should repeal section 12-136-118(5)(a) through (d) and reenact subsection (5)(a) to provide that all formal complaints seeking disciplinary action against a physician conform to the requirements of section 24-4-105(2).

RECOMMENDATION 24: AMEND SECTION 12-36-118(9)(a) TO INCLUDE THE LICENSEE'S CONSENT TO PRODUCE MEDICAL RECORDS FROM OTHER TREATERS FOR PURPOSES OF BOARD-ORDERED MENTAL OR PHYSICAL EXAMS.

The current statutory scheme authorizes the Board to order a licensee to undergo a physical or mental exam if it has reasonable cause to believe that the licensee is unable to practice medicine safely. It also conditions the license upon the licensees' implicit consent to submit to mental or physical examinations when so directed by the Board and, further, to have waived all objections to the admissibility of the examining physician's testimony or examination reports on the ground of privileged communication. Should the physician fail to submit to such an exam, the Board is authorized to suspend the license to practice medicine. Section 12-36-118(9)(a)-(b).

Despite this broad authority, the Board has reported experiencing a certain amount of difficulty in determining whether a licensee can safely practice medicine. This impediment occurs when the examiner is unable to secure copies of medical records from physicians who have previously treated the licensee for physical or mental conditions that are similar to the one at issue. The inability to secure and consider this information impairs the examining physician's and Board's ability to make necessary determinations regarding the licensee's ability to practice. This impediment may, in some circumstances, seriously endanger the Board's ability to protect the public from the substandard practice of an impaired physician.

On the other hand, the licensees' important privacy interests in medical records of previous treaters must be taken into account when creating a solution to this problem. A striking example of how such a statutory provision may adversely affect a licensee is presented in a case where a physician enrolls in a peer assistance program for treatment under the promise of confidentiality. Should the Board independently order an exam, the proposed implied consent provision will automatically require the program to disclose any medical records of previous treaters in its possession. (The program will object on federal law grounds, and physicians are against the process as well, as a violation of the doctor-patient privilege.) The individual, the person to whom the confidentiality ran, is now in the predicament of losing his confidential entry into the program, which may have been one incentive to go into it in the first place, to defend his ability to practice safely.

Some of these concerns in the substance abuse arena are ameliorated due to existing federal regulations that strictly prohibit the disclosure of medical records of drug and alcohol abuse patients that are maintained by previous treaters in connection with the performance of any federally assisted alcohol and drug abuse program. Court intervention in these cases would clearly require a balancing of the interests at stake before anything was released. For all matters, however, the General Assembly should adopt language that allows the Board authority to request and receive all medical records necessary to conduct its examination and reach its conclusion about the licensee's safety to practice medicine.

This is only fair since it would allow the Board to seek confidential information needed to assess safety to practice, and if the applicant objected to such disclosure, a court could decide which records were relevant to the safety to practice decision. OPR recommends addition of the language "**or to release all medical records necessary to determine the licensee's ability to practice safely**" after the words "physical examination" in the last sentence of that subsection.

RECOMMENDATION 25: REPEAL SECTION 12-36-119(b).

Section 12-36-119(a) provides the Board with the means to reconsider its previous denial of licensure or imposition of any discipline or probation and to modify or reverse its prior action. The statute plainly states that, although the respondent may seek such relief by petitioning the Board, all further action (if any is taken) lies strictly within the discretion of the Board.

Subsection (b) is also phrased in discretionary language but, according to the Board and counsel, it has been misinterpreted by respondents as creating a separate avenue of appeal. These respondents argue that this provision imposes upon the Board the mandatory obligation to process a request for reconsideration by opening further investigation and embarking upon another formal hearing process. This interpretation requires this stage of appeal to be fulfilled before the final decision of the Board may ultimately be reviewed by the Colorado Court of Appeals pursuant to Section 12-36-119(c).

What respondents hope to accomplish by challenging the discretion of the Board to reconsider its orders is the creation of an additional level of review. However, this interpretation is in opposite to the legislative intent, evidenced by the plain language of the statute, that reconsideration of prior decisions lies solely within the discretion of the Board. And, in circumstances in which the decision to reconsider is wholly discretionary, there is no compelling reason why the review should be reduced to a set formula, which is precisely what Section 12-36-119(b) accomplishes. Here, any prejudice accruing to a respondent as a result of the Board's reconsideration (or lack thereof) can be addressed in the respondent's appeal by right to the Court of Appeals.

The interests of all parties can be negotiated if subsection 119(b) is repealed. The amended statute will continue to confer the Board with the discretion to reconsider its prior decisions, and it will continue to protect the respondent's right of appeal to the Court of Appeals. The end result will reduce any confusion over the right of appeal without compromising Board discretion or the respondent's appellate right of review.

IV. <u>MISCELLANEOUS RECOMMENDATIONS</u>:

RECOMMENDATION 26: UPDATE THE PROCEDURES FOR THE MAINTENANCE OF LICENSEE LISTS AND THE ESTABLISHMENT OF RENEWAL FEES.

Section 12-36-123 outlines the ministerial procedures with which the Board must adhere when maintaining licensee lists and establishing renewal fees and schedules. However, some of these procedures are obsolete while others require updated language to reflect current practices. For instance, subsection (1)(a) requires all licensees to pay fees and obtain a registration certificate for the current calendar year. This language should be changed to reflect the Board's practice of collecting fees and issuing certificates every two years.

Also, subsection (b) is altogether obsolete since it requires the licensee to submit continuing education information. Continuing education is a requirement that was eliminated from the MPA several years ago.

Other minor ministerial changes to Section 12-36-123 that should be effected to comport with current practices are reflected on the draft of the proposed statute.

RECOMMENDATION 27: THE STATUTORY LANGUAGE THAT ADDRESSES THE PEER ASSISTANCE PROGRAM FINANCING MECHANISM SHOULD BE RELOCATED TO THE APPROPRIATE SECTION OF THE MPA.

At present, Section 12-36-102(2) of the legislative declaration contains a mandate calling for the restructuring of the peer assistance financing mechanism. This provision ought not to be included in the legislative declaration. Instead, it should be placed in Section 12-36-123.5, the provision that addresses the physician peer assistance fund.

RECOMMENDATION 28: THE GENERAL ASSEMBLY SHOULD REQUIRE THE BOARD TO PUBLISH LISTS OF DISCIPLINARY ACTIONS.

Most consumer activists agree that one of the most effective ways to warn the public about "bad" doctors is to publicize the bad conduct and the resulting discipline. In Colorado, the public may obtain information regarding disciplined doctors in two ways. Individuals may call the Board and request information whether a doctor has been disciplined, or they may receive notice of discipline through a newsletter that is published by the Board every 9 to 12 months.

Publication of the newsletter is in danger of stopping because of budget cutbacks. To keep the level of public awareness regarding physician discipline at least at its current level, the General Assembly should consider increasing the Board's spending authority so that publication can continue. In the alternative or in addition, it should amend the statute to require the posting or publication of disciplinary actions on a routine basis in newspapers or other periodicals affording them scope.

RECOMMENDATION 29: AMEND THE QUALIFIED ATHLETIC TRAINER PROVISION TO NARROW THE SCOPE OF PRACTICE THAT ADDRESSES THE DIAGNOSIS OF PREEXISTING CONDITIONS.

Although the BME does not "regulate" athletic trainers (ATs), it was recently given the responsibility to define the scope of practice for qualified athletic trainers. The rationale underlying this authority is to provide a means by which those ATs who conform to minimum competencies may be exempted from the medical licensing requirements of the MPA. The term "qualified athletic trainer" essentially denotes an individual who has attained certification on a national level by completing minimum education and experience requirements and successfully completing the examination administered by the national association.

The approximately 200 qualified athletic trainers in Colorado are of the opinion that their profession should be actively regulated, rather than merely exempted, from the MPA. However, the existing evidence does not appear to support such a position, particularly since (1) the profession concedes that the scope of practice as defined by the BME mirrors the requirements imposed by states that regulate athletic trainers, and (2) only one or two complaints regarding Colorado athletic trainers have been reported to the national organization for alleged violations during the last few years.

The issue that merits consideration at this time is whether the scope of practice criterion, as defined in Section 12-36-106(3.5)(d)(V), should be constricted. That provision permits athletic trainers to identify pre-existing physical conditions which may pose a risk of injury to an athlete during the physical exam and screening, and physicians express the concern that an athletic trainer may not be equipped by education or training to identify all pre-existing conditions present. The athletic trainers agree that compromise language can be reached without impairing their scope of practice. Therefore, this subsection should be amended to reflect a narrower scope of practice regarding the identification of pre-existing injuries consonant with the skills, education, and training of a qualified athletic trainer.

RECOMMENDATION 30: PHYSICIAN ASSISTANTS SHOULD BE SUBJECT TO HEALTH IMPAIRMENT REQUIREMENTS. LIKEWISE, THEY SHOULD BE PERMITTED TO PARTICIPATE IN THE PEER ASSISTANCE PROGRAM.

Physician assistants (PAs) in Colorado play a key role in providing access to health care by dispensing medical skills and expertise to the public in conjunction with a licensed physician. The MPA and corollary rule are set up to ensure that PAs possess minimum education and experience competencies, provide delegated medical care while under the routine on-site supervision of a physician, and prescribes only those drugs as authorized by the Board and approved by the supervisory physician. The supervising physician is legally accountable for the care given by the PA, and s/he is also limited to supervising 2 PAs or non-physician health care providers unless otherwise permitted by the Board.

The increasing focus upon the need for access to medical care is driving many research projects that recommend increasing access through mid level practitioners, like PA's. The formal position taken by a Colorado taskforce is that PA's, as a profession, currently seek to expand their scope of practice under the MPA. Their statement of goals includes: (1) to possess prescriptive authority for controlled substances; (2) to treat medical conditions that relate to self-limited and stable chronic conditions in a collaborative manner that does not require the degree of physician supervision currently mandated; (3) to increase the number of PAs that one physician may supervise; (4) to eliminate the specific protocols now required; and (5) to impact the regulatory body by forming an advisory committee to the BME.

PAs are a valuable component of the health care industry in Colorado, particularly in those areas where access is lacking. However, PAs have emphasized their comfortability with the current collaborative practice situation with physicians. Neither the profession nor the medical society has proffered any data that supports the presumption that PAs are adequately trained and educated to practice autonomously in specialized or family practice settings. And, the PAs acknowledge that the Board grants supervision and protocol waivers when appropriate, weakening the argument that underserved areas are not benefiting from PA practice. Therefore, DORA remains neutral on the proposal for expanded scope of practice and autonomy.

Notwithstanding DORA's position regarding the foregoing requests, it is undisputed that PAs practice delegated medicine, including performing diagnoses, prescribing certain drugs, and performing medical procedures upon the public. Therefore, their health impairments and possible resulting substandard practice poses the same unique risk to the public as is posed by physicians. Under the circumstances, the General Assembly should consider amending the MPA to reflect the following:

(1) PAs should be subject to all requirements imposed upon physicians regarding health impairments. In particular, they should be required to submit to Board-ordered mental or physical examinations if there is reasonable cause to believe that a PA suffers from a health impairment. They should also be required to consent to waive prior medical records necessary for such an exam.

(2) Precisely because PAs are equally as susceptible to practicing while impaired, they should be granted access to the physician peer assistance program for purposes of treatment and rehabilitation. PAs should be assessed an appropriate amount as part of their registration fee, just as licensed physicians are.

RECOMMENDATION 31: SECTION 12-36-125 SHOULD BE AUGMENTED TO REQUIRE PHYSICIANS TO DISCLOSE THEIR INTEREST IN CLINICS, LABORATORIES, OR OTHER HEALTH CARE FACILITIES TO WHICH THEY REFER THEIR PATIENTS.

Section 12-36-125 prohibits physicians from entering into fee-splitting arrangements with any individual or entity who recommends or refers patients to the physician. The Board reports that it has received only two complaints regarding the violation of this provision during the last ten years.

However, an issue that continues to cause controversy is self-referral, or whether physicians should be permitted to refer patients for testing or treatment to health care facilities in which the physician has a financial or ownership interest. This situation arises most frequently when the physician refers the patient to a laboratory for tests. The risk that merits prevention is the situation in which a patient is referred to such a clinic for testing that ultimately benefits the physician financially.

The competing interest is that rural physicians and patients may not have the luxury of picking one among several clinics or laboratories, and the physician may have some interest in the one or few testing facilities available. Consequently, the prohibition of self-referral in these circumstances would jeopardize a patient's access to convenient health care.

To ensure against the potential harm attendant to self-referral while protecting the rural patient's access to health care, the General Assembly should consider amending Section 12-36-125 to require physicians to disclose that they are referring their patients to a health care facility in which they hold an interest. This compromise approach does not prohibit self-referral, but it does give the consumer the option of deciding whether to patronize a referred facility that financially benefits the physician.

RECOMMENDATION 32: THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING THE STATUTORY LANGUAGE THAT DEFINES ACCEPTABLE PUBLIC COMMUNICATIONS AND ADVERTISEMENTS.

Physicians in the past were prohibited from engaging in "advertising which is misleading, deceptive, or false." In 1991 this language was repealed and replaced with Section 12-36-128.5, a lengthy section that details advertising and public communication guidelines for physicians. The most contentious portion of this language charges the Board with the authority to determine whether physicians may hold themselves out to be "Board certified" in advertisements. To do that, the BME must determine which board specialty certifications are "substantially equivalent" to the generally recognized, standard board certification extended by the American Board of Medical Specialties (ABMS). That provision is supplemented by a rule that establishes criteria providing a basis for making such a determination.

The value of advertising oneself as "Board certified" is that a physician who holds himself out to be such is traditionally understood to have achieved a prestigious level of expertise in a particular specialization. The problem is that several alternative "boards" (other than the ABMS) now offer "certification", and some of these boards apparently do not require its applicants to adhere to the same rigorous standards for accreditation as the ABMS.

According to the BME, the statutory revision that allows the Board to "OK" alternative board certifications was advocated by certain physician subspecialty groups, without the Board's approval, purportedly in an effort to gain a toehold in economic turf wars ongoing between specialties. On the other hand, the physician-proponents of these alternative board certification programs believe that they are entitled to advertise themselves as board-certified so long as the BME finds the certification is "substantially equivalent" to the ABMS standard.

One solution to this issue that is supported by some members of the Board and by the Colorado Medical Society is reversion to the old standard that prohibits "advertising that is deceptive, misleading, or false." The proponents of this solution agree that the Board, under this standard, will possess the latitude to address advertising issues on a case-by-case basis without being burdened by the oppressive requirements now in place in the statute.

An objective analysis of this issue establishes that much of what is included in the current statute and rule outlines acceptable and unacceptable advertising practices with a clarity of definition that benefits and protects the public. However, the Board's overriding experience with the new advertising provisions to date has been the forced mediation of contentious "doctor wars" over board certification and economic issues. This has arguably drained the Board's ability to deal with more pressing and deserving issues. Accordingly, the General Assembly should reinstitute the former advertising standard prohibiting engaging in advertising which is misleading, deceptive, or false.

APPENDIX A

SUNSET STATUTORY EVALUATION CRITERIA

I. Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

II. If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

III. Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices of the Department of Regulatory Agencies and any other circumstances, including budgetary, resource and personnel matters;

IV. Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

V. Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

VI. The economic impact of regulation and, if national economic information is available, whether the agency stimulates or restricts competition;

VII. Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

VIII. Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

IX. Whether administrative and statutory changes are necessary to improve agency operations to enhance public interest.

APPENDIX B

APPENDIX C

12-36-101. Short title. This article shall be known and may be cited as the "Colorado Medical Practice Act".

12-36-102. Legislative declaration. ~~(1)~~ The general assembly declares it to be in the interests of public health, safety, and welfare to enact laws regulating and controlling the practice of the healing arts to the end that the people shall be properly protected against unauthorized, unqualified, and improper practice of the healing arts in this state, and this article shall be construed in conformity with this declaration of purpose.

~~(2) The general assembly further finds, determines, and declares that effective July 1, 1994, the physicians' peer health assistance fund shall be terminated, the balance of moneys in the fund shall be transferred, prior to June 30, 1994, to an administering entity selected by the board, which entity shall administer the programs of board-selected designated providers, and that the fiscal year beginning July 1, 1993 shall be used by the department of regulatory agencies as a transition year to plan for the transfer of responsibilities for such program.~~

12-36-103. State board of medical examiners - immunity - subject to termination - repeal of article. (1) (a) There is hereby created the Colorado state board of medical examiners, referred to in this article as the "board", which shall consist of nine physician members and two members from the public at large to be appointed by the governor and to have the qualifications provided in this article. On or after July 1, 1951, the state board of medical examiners as constituted under the law of this state immediately prior thereto is hereby abolished, but the members thereof shall constitute the initial board under this article, and the respective terms of such members shall extend through and expire on May 3 of the year in which their respective terms, as determined by their appointments under such prior law, would have expired. In 1953 and in each second year thereafter and until June 15, 1987, the governor shall appoint three physician members for terms beginning May 4 of said year and expiring May 3 of the sixth year thereafter. Persons who are physician members and who are holding office on June 15, 1987, are subject to the provisions of section 24-1-137, C.R.S. Thereafter, the terms of the members of the board shall be four years. One member of the public at large shall be appointed for a term ending May 3, 1979, and the other for a term ending May 3, 1981; thereafter, public member appointments made prior to June 15, 1987, shall be for six-year terms. Persons who are public member appointees and who are holding public office on June 15, 1987, are subject to the provisions of section 24-1-137, C.R.S. Thereafter, the terms of the members of the board shall be four years.

(b) Notwithstanding paragraph (a) of this subsection (1), of the members of the board whose terms are to expire on May 3, 1991, the terms of three of the members shall expire on May 3, 1991, the terms of three of the members shall be extended until May 3, 1992, and the terms of two of the members shall be extended until May 3, 1994. Thereafter, the terms of the members of the board shall be four years.

(2) The board shall be comprised at all times of seven members having the degree of doctor of medicine, and two members having the degree of doctor of osteopathy, all of whom shall have been licensed and actively engaged in the practice of their professions in this state for at least three years next preceding their appointments and shall have been residents of this state for at least five years next preceding their appointments, and two members of the public at large. In making appointments to the board, the governor shall give due consideration to recommendations submitted by the Colorado state medical society with respect to appointments to each office, if any, to be filled by a physician holding the degree of doctor of medicine and to recommendations submitted by the Colorado osteopathic association with respect to appointments to each office, if any, to be filled by a physician holding the degree of doctor of osteopathy.

(3) In the event a vacancy in the membership of the board occurs for any cause other than expiration of a term, the governor shall appoint a successor to fill the unexpired portion of the term of such member whose office has been so vacated and shall appoint such new member in the same manner as members for a full term. Each member of the board, before he enters upon the duties of his office, shall take an oath or affirmation to support the constitution of the United States and of the state of Colorado and to faithfully perform the duties of the office upon which he is about to enter. Members of the board shall remain in office until their successors have been appointed. A member of the board, upon notice and hearing, may be removed by the governor for continued neglect of duty, incompetence, or unprofessional or dishonorable conduct.

(4) The board shall elect biennially from its members a president, a vice-president, and a secretary. Regular meetings of the board or either panel, established pursuant to section 12-36-118, shall be held as scheduled by the board in the state of Colorado. Special meetings of the board may be called by the president or by three members of the board at any time on three days' prior notice by mail or, in case of emergency, on twenty-four hours' notice by telephone or telegraph, any such meetings to be held at the place designated in the call therefor. Except as provided in section 12-36-118 (6), a majority of the board shall constitute a quorum for the transaction of all business. All meetings of the board shall be deemed to have been duly called and regularly held, and all decisions, resolutions, and proceedings of the board shall be deemed to have been duly authorized, unless the contrary be proved.

(5) Members of the board shall be immune from suit in any action, civil or criminal, based upon any disciplinary proceedings or other official acts performed in good faith as members of such board.

(6) (a) The provisions of section 24-34-104, C.R.S., concerning the termination schedule for regulatory bodies of the state unless extended as provided in that section, are applicable to the Colorado state board of medical examiners created by this section.

(b) This article is repealed, effective July 1, 1995.

(7) After consultation with the board, the director of the division of registrations shall appoint an executive administrator for the board and such other personnel as are deemed necessary, pursuant to section 13 of article XII of the state constitution. At least one member of the board shall serve on any panel convened by the department of personnel to interview candidates for the position of executive administrator.

12-36-104. Powers and duties of board. (1) In addition to all other powers and duties conferred and imposed upon the board by this article, the board has the following powers and duties to:

(a) Adopt and promulgate, under the provisions of section 24-4-103, C.R.S., such rules and regulations as the board may deem necessary or proper to carry out the provisions and purposes of this article which shall be fair, impartial, and nondiscriminatory.

(b) Make investigations, hold hearings, and take evidence in all matters relating to the exercise and performance of the powers and duties vested in the board and, in connection with any investigation (whether before or after a formal complaint is filed pursuant to section 12-36-118) or hearing and through any member, the secretary, or chief administrative officer thereof, subpoena witnesses, administer oaths, and compel the testimony of witnesses and the production of books, papers, and records relevant to any inquiry or hearing. Any subpoena issued pursuant to this article shall be enforceable by the district court.

(c) Adopt a seal which shall be affixed to all licenses issued by the board;

(d) Repealed, L. 76, p. 421, sec. 8, effective July 1, 1976.

(e) Aid the several district attorneys of this state in the enforcement of this article and in the prosecution of all persons, firms, associations, or corporations charged with the violation of any of its provisions.

(2) The president of the board shall prepare and transmit annually, in the form and manner prescribed by the heads of principal departments pursuant to the provisions of section 24-1-136, C.R.S., a report accounting to the governor and the general assembly for the efficient discharge of all responsibilities assigned by law or directive to the board. The list of licensees described in section 12-36-123 and any other material circulated in quantity outside the executive branch shall be issued in accordance with the provisions of section 24-1-136, C.R.S.

<u>12-36-104.5. Limitation on authority.</u> The authority granted the board under the provisions of this article shall not be construed to authorize the board to arbitrate or adjudicate fee disputes between licensees or between a licensee and any other party.

<u>12-36-105. Surety bond. (Repealed)</u>

Repealed, effective July 1, 1979.

<u>12-36-106. Practice of medicine defined - exemptions from licensing requirements.</u> (1) For the purpose of this article "practice of medicine" means:

(a) Holding out one's self to the public within this state as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, pain, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever;

(b) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever;

(c) The maintenance of an office or other place for the purpose of examining or treating persons afflicted with disease, injury, or defect of body or mind;

(d) Using the title M.D., D.O., physician, surgeon, or any word or abbreviation to indicate or induce others to believe that one is licensed to practice medicine in this state and engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind, except as otherwise expressly permitted by the laws of this state enacted relating to the practice of any limited field of the healing arts;

(e) Performing any kind of surgical operation upon a human being; or

(f) The practice of midwifery, except:

(I) Services rendered by nurse-midwives licensed pursuant to article 38 of this title and certified by the American college of nurse midwives; or

(II) (A) Services rendered by a person properly registered as a direct-entry midwife and practicing in accordance with the provisions of article 37 of this title.

(B) This subparagraph (II) is repealed, effective July 1, 1996.

(2) If any person who does not possess and has not filed a license to practice medicine within this state, as provided in this article, and who is not exempted from the licensing requirements under this section, shall do any of the acts mentioned in this section as constituting the practice of medicine, he shall be deemed to be practicing medicine without complying with the provisions of this article and in violation thereof.

(3) Nothing in this section shall be construed to prohibit, or to require a license under this article with respect to any of the following acts:

(a) The gratuitous rendering of services in cases of emergency;

(b) The rendering of services in this state by a physician lawfully practicing medicine in another state or territory, but if any such physician does not limit such services to an occasional case or if he has any established or regularly used hospital connections in this state or if he maintains or is provided with for his regular use any office or other place for the rendering of such services, he shall possess a license to practice medicine in this state;

(c) The practice of dentistry under the conditions and limitations defined by the laws of this state;

(d) The practice of podiatry under the conditions and limitations defined by the laws of this state;

(e) The practice of optometry under the conditions and limitations defined by the laws of this state;

(f) The practice of chiropractic under the conditions and limitations defined by the laws of this state;

(g) The practice of religious worship;

(h) The practice of Christian Science, with or without compensation;

(i) The performance by commissioned medical officers of the armed forces of the United States of America or of the United States public health service or of the United States veterans administration of their lawful duties in this state as such officers;

(j) The rendering of nursing services and delegated medical functions by registered or other nurses in the lawful discharge of their duties as such;

(k) The rendering of services by students currently enrolled in an approved medical college, interns, or residents in a hospital or other place as required by their approved educational program subject to the conditions and limitations provided by this article;

(l) The rendering of services, other than the prescribing of drugs, by persons qualified by experience, education, or training, under the personal and responsible direction and supervision of a person licensed under the laws of this state to practice medicine, but nothing in this exemption shall be deemed to extend or limit the scope of any license, and this exemption shall not apply to persons otherwise qualified to practice medicine but not licensed to so practice in this state;

(m) The practice by persons licensed or registered under any law of this state to practice a limited field of the healing arts not specifically designated in this section, under the conditions and limitations defined by such law;

(n) The rendering of services by a nurse-midwife certified by the American college of nurse-midwives, whose services are performed pursuant to the responsible direction, supervision, and protocol of an identified and personally responsible physician and who is licensed pursuant to article 38 of this title and in concurrence with the board. The medical services of certified nurse-midwives shall be limited to those normally and routinely delivered by the supervisory physician or physicians.

(o) (I) The administration and monitoring of medications in facilities as provided in section 25-1-107 (1) (ee), C.R.S.

(II) This paragraph (o) is repealed, effective July 1, 1998. Prior to such repeal, the exemption to licensure requirement set forth in this paragraph (o) shall be subject to review pursuant to the provisions of section 2-3-1201, C.R.S., by the sunrise and sunset review committee, as set forth in section 2-3-1201, C.R.S., and the provisions of section 24-34-104 (5) to (12), C.R.S., concerning a wind-up period, an analysis and evaluation, public hearings, and claims by or against an agency shall apply to the operation of the program specified in this paragraph (o).

(p) The rendering of acupuncture services subject to the conditions and limitations provided in article 29.5 of this title;

(q) (I) The administration of nutrition or fluids through gastrostomy tubes as provided in section 27-10.5-103 (2) (k), C.R.S., as a part of residential or day program services provided through service agencies approved by the department of institutions pursuant to section 27-10.5-104.5, C.R.S.

(II) Repealed, L. 92, p. 2010, sec. 3, effective June 2, 1992.

(r) The administration of topical and aerosol medications within the scope of physical therapy practice as provided in section 12-41-113 (2);

(s) The rendering of services by an athletic trainer subject to the conditions and limitations provided in subsection (3.5) of this section.

(3.5) (a) The state board of medical examiners shall promulgate rules and regulations specifying the types of services which a qualified athletic trainer may render pursuant to paragraph (s) of subsection (3) of this section. In order to qualify for the exception allowed pursuant to said paragraph (s), such services must be rendered only by qualified athletic trainers who render the services, within the athletic trainer scope of practice as defined pursuant to this subsection (3.5), in the course of participation in an educational institution's sports program, an organized amateur sports organization, a professional sports organization, a recreational program of a county, municipal, or special district government, or an organized community sports event.

(b) For purposes of this subsection (3.5), "qualified athletic trainer" means a person:

(I) Who has a baccalaureate degree granted by an accredited college or university or a college or university approved by the state educational board or department in another state, which degree is in a field related to athletic training as defined by the college or university which granted the degree, and who has completed a minimum of one thousand five hundred actual hours of supervised clinical experience or internship training in athletic training under the supervision of a person accredited by a national athletic training standards organization designated by the state board of medical examiners; or

(II) Who has a baccalaureate degree with a major in athletic training which was granted through a college or university program which is accredited by a national athletic training standards organization designated by the state board of medical examiners and who has completed a minimum of eight hundred actual hours of supervised clinical experience or internship in athletic training under the supervision of a person accredited by a national athletic training standards organization designated by the state board of medical examiners.

(c) For purposes of this subsection (3.5), "athlete" means an individual participating in an educational institution's sports program, an organized sports organization, a professional sports organization, a recreational program of a county, municipal, or special district government, or an organized community sports event.

(d) For purposes of this subsection (3.5), "athletic trainer scope of practice" means the performance of all or some of the following functions by a qualified athletic trainer:

(I) The development and implementation of conditioning programs for athletes as defined in paragraph (c) of this subsection (3.5);

(II) The performance of strength testing using mechanical devices or other standard techniques;

(III) The application of tape, braces, and protective device to prevent injury;

(IV) The supervision of maintenance of athletic equipment to assure safety;

(V) The identification of preexisting physical conditions which may pose a risk of injury to an athlete during the physical examination and screening;

(VI) The determination of the level of functional capacity, decreased range of motion or muscular weakness of an injured athlete in order to establish the extent of an injury;

(VII) The administration of standard techniques of first aid;

(VIII) The use of emergency care equipment to aid the injured athlete by facilitating safe transportation to an appropriate medical facility;

(IX) The referral of an athlete to appropriate medical personnel as needed;

(X) The use of exercise and other therapies for which the athletic trainer has received formal training, not including drugs, to restore an injured athlete to normal function;

(XI) The maintenance of athletic training records;

(XII) The organization of a medical care service delivery system for athletes when needed;

(XIII) The establishment of plans to manage an athlete's medical emergencies;

(XIV) The education and counseling of athletes on sports health related topics;

(XV) The instruction of student athletic trainers; and

(XVI) The education and counseling of the general public with respect to appropriate athletic training programs.

(e) Nothing in this subsection (3.5) shall be construed as conferring any authority to practice, or to hold oneself out through advertisement or billing as providing, physical therapy as defined in section 12-41-103.

(f) The state board of medical examiners shall seek the voluntary assistance of physicians and athletic trainers in developing and formulating the rules and regulations required to be promulgated pursuant to this subsection (3.5). If such rules and regulations have not been promulgated by June 1, 1992, the board shall report to the sunrise and sunset review committee created by joint rule of the senate and house of representatives during the interim after the 1992 regular session of the general assembly concerning the reasons that those rules and regulations have not been promulgated.

(4) All licensees designated or referred to in subsection (3) of this section, who are licensed to practice a limited field of the healing arts, shall confine themselves strictly to the field for which they are licensed and to the scope of their respective licenses, and shall not use any title, word, or abbreviation mentioned in paragraph (d) of subsection (1) of this section, except to the extent and under the conditions expressly permitted by the law under which they are licensed.

(5) (a) A person licensed under the laws of this state to practice medicine may delegate to a physician assistant certified by the board the authority to perform acts which constitute the practice of medicine to the extent and in the manner authorized by rules and regulations promulgated by the board, including the authority to prescribe, on a case-by-case and per-patient visit basis as approved by the supervising physician, and dispense only such drugs as designated by the board. Such acts shall be consistent with sound medical practice. Each prescription issued by a physician assistant certified by the board shall have imprinted thereon the name of his supervising physician. Nothing in this subsection (5) shall limit the ability of otherwise licensed health personnel to perform delegated acts. The dispensing of prescription medication by a physician assistant shall be subject to the provisions of section 12-22-121 (6).

(b) (I) If the authority to perform an act is delegated pursuant to paragraph (a) of this subsection (5), the act shall not be performed except under the personal and responsible direction and supervision of a person licensed under the laws of this state to practice medicine, and said person shall not be responsible for the direction and supervision of more than two physician assistants at any one time without specific approval of the board. The board may define appropriate direction and supervision pursuant to rules and regulations.

(II) For purposes of this subsection (5), "personal and responsible direction and supervision" means that the direction and supervision of a physician assistant must be personally rendered by a licensed physician practicing in the state of Colorado and not through intermediaries. The extent of direction and supervision shall be determined by rules and regulations promulgated by the board and as otherwise provided in this paragraph (b); except that, when a physician assistant is performing a delegated medical function in an acute care hospital, the board shall allow supervision and direction to be performed without the physical presence of the physician during the time the delegated medical functions are being implemented if:

(A) Such medical functions are performed where the supervising physician regularly practices or in a designated health manpower shortage area;

(B) The licensed supervising physician reviews the quality of medical services rendered by the physician assistant every two working days by reviewing the medical records to assure compliance with the physicians' directions; and

(C) The performance of the delegated medical function otherwise complies with the board's regulations and any restrictions and protocols of the licensed supervising physician and hospital.

(III) If the state board of medical examiners has a reasonable belief that additional supervision or direction may be necessary it may issue a cease and desist order to the supervising physician or physician assistant to require that a function be delegated only on a case-by-case basis, or to require that the supervising physician be present on the premises in specific types of cases that arise in an acute care hospital setting. Such a cease and desist order shall become effective upon delivery to the supervising physician or physician assistant to whom it is issued. Any supervising physician or physician assistant who receives such an order may request a hearing on the merits of the order, which request shall be promptly granted. Any restriction or requirement imposed by such an order shall not be deemed a disciplinary action, restriction, or other limitation on the physician's license or the physician assistant's certification.

(c) To become certified, a physician assistant shall have:

(I) Successfully completed an education program for physician assistants which conforms to standards approved by the board, which standards may be established by utilizing the assistance of any responsible accrediting organization; and

(II) Successfully completed the national certifying examination for assistants to the primary care physician which is administered by the national commission on certification of physician assistants or successfully completed any other examination approved by the board; and

(III) Applied to the board on the forms and in the manner designated by the board and paid the appropriate fee established by the board pursuant to section 24-34-105, C.R.S.; and

(IV) Attained the age of twenty-one years.

(d) The board may determine whether any applicant for certification as a physician assistant possesses sufficient education, experience, or training in health care which may be accepted in lieu of the qualifications required for certification under subparagraph (I) of paragraph (c) of this subsection (5). Every person who desires to qualify for practice as a physician assistant within this state shall file with the secretary of the board his written application for certification, on which application he shall list any act the commission of which would be grounds for disciplinary action against a certified physician assistant under section 12-36-117, along with an explanation of the circumstances of such act. Such person shall also list any health impairment as defined in section 12-36-117.5 The board may deny certification to any applicant who has performed any act which constitutes unprofessional conduct, as defined in section 12-36-117. The board may place on probation as set forth in section 12-36-118(5)(c)(III.5) any applicant who suffers from a health impairment.

(e) No person certified as a physician assistant may perform any act which constitutes the practice of medicine within a hospital or nursing care facility which is licensed pursuant to part 1 of article 3 of title 25, C.R.S., or which is required to obtain a certificate of compliance pursuant to section 25-1-107 (1) (l) (II), C.R.S., without authorization from the governing board of the hospital or nursing care facility. Such governing board shall have the authority to grant, deny, or limit such authority to its own established procedures, but under no circumstances shall a physician assistant write prescriptions unless countersigned by the supervising physician.

(f) The board may take any disciplinary action with respect to a physician assistant certificate as it may with respect to the license of a physician, in accordance with procedures established pursuant to this article.

(g) Pursuant to the provisions of section 12-36-132, the board may apply for an injunction to enjoin any person from performing delegated medical acts which are in violation of this section or of any rules and regulations promulgated by the board.

(h) This subsection (5) shall not apply to any person who performs delegated medical tasks within the scope of the exemption contained in paragraph (l) of subsection (3) of this section.

(i) The board shall certify and keep a record of physician assistants who have been certified pursuant to paragraph (c) of this subsection (5) and shall establish renewal fees and schedules subject to the provisions of section 24-34-102 (8), C.R.S. Every certified physician assistant shall pay to the secretary of the board a registration fee to be determined and collected pursuant to section 24-34-105, C.R.S., and shall obtain a registration certificate for the current calendar year.

(j) This subsection (5) is repealed, effective July 1, 1995.

12-36-106.5. Child health associates - scope of practice. On and after July 1, 1990, any person who, on June 30, 1990, was certified only as a child health associate under the laws of this state shall, upon application to the board, be granted certification as a physician assistant. The practice of any such person shall be subject to the provisions of section 12-36-106 (5); except that such practice shall be limited to patients under the age of twenty-one.

12-36-107. Qualifications for licensure. (1) Subject to the other conditions and provisions of this article, a license to practice medicine shall be granted by the board to an applicant therefor only upon the basis of:

(a) The passing by the applicant of an examination approved by the board;

(b) A certification of record or other certificate of examination issued to or for the applicant by the national board of medical examiners, the national board of examiners for osteopathic physicians and surgeons, or the federation of state medical boards certifying that the applicant has passed examinations, including but not limited to examinations in the basic sciences, given by the respective boards;

(c) Any combination of the examinations provided in paragraphs (a) and (b) of this subsection (1) approved by the board;

(d) A valid, unsuspended, and unrevoked license or certificate issued to the applicant on the basis of an examination, by a duly constituted examining board, under the laws of any other state or of any territory of the United States or of the District of Columbia whose licensing standards at the time such license or certificate was issued were not substantially lower than those of the state of Colorado at that time for the granting of a license to practice medicine if:

(I) Under the scope of such license or certificate the applicant was authorized to practice medicine in all its branches, as defined in this article;

(II) Such examining board grants licenses, without further examination and otherwise on a substantially equal reciprocal basis, to applicants who possess a license to practice medicine granted by the board or heretofore granted by the state board of medical examiners as constituted under any prior law of this state;

(III) The medical school from which the applicant graduated was approved by this or such prior board at the time of the issuance of such license or certificate.

(2) No person shall be granted a license to practice medicine as provided by subsection (1) of this section unless he is at least twenty-one years of age, is a graduate of an approved medical college, as defined in section 12-36-108, and has satisfactorily completed at least two years of postgraduate training as defined in sections 12-36-109 and 12-36-110. ~~an approved internship of at least one year, as defined in section 12-36-109, or has completed at least one year of postgraduate training approved by the board. The board may grant a license subject to terms of probation or may refuse to grant a license to any such person if it has reasonable grounds to believe he has committed any of the acts or offenses defined in this article as unprofessional conduct.~~

(3) (a) (I) Notwithstanding any other provision of this article, an applicant of noteworthy and recognized professional attainment who is a graduate of a foreign medical school and who is licensed in a foreign jurisdiction if that jurisdiction has a licensing procedure may be granted a temporary license to practice medicine in this state, upon application to the board in the manner determined by the board, if the following conditions are met:

(A) The applicant has been invited by a medical school in this state to serve as a full-time member of its academic faculty for the period of his appointment, at a rank equal to an associate professor or above.

(B) The applicant's medical practice is limited to that required by his academic position and the limitation is so designated on the license in accordance with board procedure and is also limited to the core teaching hospitals affiliated with the medical school, as identified by the board, on which he is serving as a faculty member.

(II) An applicant who meets the qualifications and conditions set forth in subparagraph (I) of this paragraph (a) but is not offered the rank of associate professor or above may be granted a temporary license, for one year only, to practice medicine in this state, as a member of the academic faculty, at the discretion of the board and in the manner determined by the board; but if such person is granted a temporary license, he shall practice only under the direct supervision of a person who has the rank of associate professor or above.

(b) Such temporary license shall remain in force only while the holder is serving on the academic staff of a medical school. Such license shall expire one year after its date of issuance and may be renewed for up to one more year by a two-thirds vote of the board only after it has specifically determined that the conditions specified in paragraph (a) of this subsection (3) will continue during the ensuing period of licensure. The board may require an applicant for licensure under this subsection (3) to present himself to the board for an interview. The board may withdraw licensure granted by these provisions prior to the expiration of such license for unprofessional conduct as defined in section 12-36-117. The board may establish and charge a fee for such temporary license pursuant to section 24-34-105, C.R.S., not to exceed the amount of the fee for a two-year renewal of a physician's license.

(4) (a) Notwithstanding any other provision of this article, an applicant lawfully practicing medicine in another state or territory may be granted a temporary license to practice medicine in this state, upon application to the board in the manner determined by the board, if:

(I) The applicant has been invited by the United States Olympic committee to provide medical services at the Olympic training center at Colorado Springs or to provide medical services at an event in this state sanctioned by such committee; and

(II) The United States Olympic committee certifies to the board the name of the applicant, the state or territory of the applicant's licensure, and the dates within which the applicant has been invited to provide medical services; and

(III) The applicant's practice is limited to that required by the United States Olympic committee. Such medical services shall only be provided to athletes or team personnel registered to train at the Olympic training center or registered to compete in an event conducted under the sanction of the United States Olympic committee.

(b) Such temporary license shall remain in force while the holder is providing medical services at the invitation of the United States Olympic committee and only during the time certified to the board but not longer than ninety days without extension by the board. The board may establish and charge a fee for such temporary license pursuant to section 24-34-105, C.R.S., not to exceed one-half the amount of the fee for a two-year renewal of a physician's license. No physician shall be required to pay more than one temporary license fee in each calendar year. Physicians temporarily licensed under this subsection (4) are subject to discipline by the board for unprofessional conduct as defined in section 12-36-117 and are subject to probation and restriction for any health impairment as defined in section 12-36-117.5.

12-36-107.5. Colorado resident physicians trained at foreign medical schools. (Repealed)

Repealed, effective July 1, 1988.

12-36-107.6. Foreign medical school graduates - degree equivalence. (1) For graduates of schools other than those approved by the liaison committee for medical education or the American osteopathic association, the board may require three years of postgraduate clinical training approved by the board. An applicant whose foreign medical school is other than as defined in section 12-36-108 shall be eligible for licensure at the discretion of the board if the applicant meets all other requirements for licensure and holds specialty board certification, current at the time of application for licensure, conferred by a regular member board of the American board of medical specialties or the American osteopathic association. The factors to be considered by the board in the exercise of its discretion in determining the qualifications of such applicants shall include the following:

(a) The information available to the board relating to the medical school of the applicant; and

(b) The nature and length of the post-graduate training completed by the applicant.

~~(2) An applicant who has completed the academic curriculum in residence at a foreign medical school, but who did not complete an internship or social service, and who thereafter has completed a year of supervised clinical training at a hospital in the United States, which training was affiliated with a medical school offering a fifth pathway program, shall be deemed to have attained the equivalent of the degree of doctor of medicine at a United States medical school approved by the liaison committee for medical education and, for purposes of the application for licensure, such applicant shall not be considered a graduate of a foreign medical school. "Fifth pathway program" means the program which was in effect in Colorado pursuant to the provisions of section 12-36-107.5 (1), as such section existed prior to its repeal effective July 1, 1988, or a similar statutorily-based program of another state.~~

12-36-108. Approved medical college. An approved medical college is a college which conforms to the minimum educational standards for medical colleges or for osteopathic colleges as established respectively by the American medical association and by the American osteopathic association, or a college which is approved by either of said associations. The board shall have the authority, upon its own investigation of the educational standards and facilities thereof, to approve any other medical college.

12-36-109. Approved internship. An approved internship is an internship of at least one year in a hospital conforming to the minimum standards for intern training established by the American medical association or by the American osteopathic association, or an internship approved by either of said associations. The board has the authority, upon its own investigation, to approve any other internship.

12-36-110. Approved residency. An approved residency is a residency in a hospital conforming to the minimum standards for residency training established by the American medical association or by the American osteopathic association, or a residency approved by either of said associations. The board has the authority, upon its own investigation, to approve any other residency.

12-36-111. Applications for license. (1) Every person desiring a license to practice medicine shall make application to the board, such application to be verified by oath and to be in such form as shall be prescribed by the board. Such application shall be accompanied by the license fee and such documents, affidavits, and certificates as are necessary to establish that the applicant possesses the qualifications prescribed by this article, apart from any required examination by the board. The burden of proof shall be upon the applicant, but the board may make such independent investigation as it may deem advisable to determine whether the applicant possesses such qualifications and whether the applicant has at any time committed any of the acts or offenses defined in this article as unprofessional conduct.

(2) An applicant for a license on the basis of an examination by the board shall file his application at least ~~thirty~~ ninety days prior to the announced date of the examination. If such applicant is not, at the time of filing his application, a graduate of, but is then in attendance at, an approved medical college, he shall submit to the board, in lieu of a diploma or other required evidence of graduation, a written statement from the dean or other authorized representative of such approved medical college that the applicant will receive his diploma at the end of the then current school term; but in any such case the applicant shall not be permitted to take the examination until he has filed with the board his diploma or other acceptable evidence of graduation from such approved medical college and has complied with the requirements of subsection (1) of this section, and no license shall be issued to him until he has satisfied the board that he has completed at least one year of approved internship or approved postgraduate training and has otherwise met the requirements for the issuance of a license under this article.

12-36-112. License fee. An applicant for a license to practice medicine shall pay a fee to be determined and collected pursuant to section 12-36-123.5 (2) (b) or established pursuant to section 24-34-105, C.R.S.

12-36-113. Examinations. (1) Examinations for a license to practice medicine shall be held not less than twice in each year at such times and places as may be specified by the board, if there are applicants desiring to be examined. The examination shall be conducted in the English language and shall cover the basic and clinical sciences and such other subjects as the board may prescribe. The examinations shall be fair and impartial and practical in character. The examination papers shall not disclose the name of any applicant but shall be identified by a number to be assigned.

(2) The board shall be responsible for determining the passing score to reflect a standard of minimum competency for the practice of medicine. If an applicant fails to meet such minimum passing score, he may be reexamined at any subsequent scheduled examination upon paying a fee to be determined and collected pursuant to section 24-34-105, C.R.S.~~ If he fails in a second examination, a further examination may be taken, but not less than one year after the date of the preceding examination, and he shall be required to file a new application and pay a fee to be determined and collected pursuant to section 24-34-105, C.R.S. The board may determine by regulation whether any second or further examination shall be on all subjects included in the scheduled examination. No fees remitted with an application shall be refunded, but, in case an applicant is prevented through no fault of his own from taking the examination applied for, he may take a subsequently scheduled examination within one year without payment of another fee or submission of a new application.~~

(3) Repealed, L. 79, p. 525, sec. 31, effective July 1, 1979.

12-36-114. Issuance of licenses - prior practice prohibited. (1) If the board determines that an applicant possesses the qualifications required by this article and is entitled thereto, the board shall issue a license to practice medicine which shall be signed by the president or vice-president, attested by the secretary, and sealed with the seal of the board.

(2) Prior to the approval of such license, the applicant shall not engage in the practice of medicine in this state, and any person who practices medicine in this state without first obtaining approval of such license shall be deemed to have violated the provisions of this article.

(3) All holders of a license to practice medicine granted by the board, or by the state board of medical examiners as constituted under any prior law of this state, shall be accorded equal rights and privileges under all laws of the state of Colorado, shall be subject to the same duties and obligations, and shall be authorized to practice medicine, as defined by this article in all its branches.

12-36-115. License must be recorded. (Repealed)

Repealed, effective July 1, 1979.

12-36-116. Refusal of license. If the board determines that an applicant for a license to practice medicine does not possess the qualifications required by this article, that he has done any of the acts defined in section 12-36-117 as unprofessional conduct or that he suffers from a health impairment as defined in section 12-36-117.5, or that his license has been disciplined in another state or foreign jurisdiction, it may refrain from issuing a license or it may grant a license subject to terms of probation. For purposes of this section, discipline shall include any matter which is to be reported pursuant to the requirements of 45 CFR § 60.8 and is substantially similar to unprofessional conduct as defined in section 12-36-117. ~~and the applicant may proceed as provided in section 24-4-104(9), C.R.S.~~ Any applicant whose application is denied or whose license is granted subject to terms of probation may proceed as provided in section 24-4-104 (9), C.R.S. The acceptance by an applicant of a license subject to terms of probation shall be in lieu of and not in addition to the remedies set forth in section 24-4-104(9), C.R.S.

12-36-117. Unprofessional conduct. (1) "Unprofessional conduct" as used in this article means:

(a) Resorting to fraud, misrepresentation, or deception in applying for, securing, renewing, or seeking reinstatement of privileges at any hospital, a license to practice medicine in this state or any other state or in taking the examination provided for in this article;

(b) Procuring, or aiding or abetting in procuring, criminal abortion;

(c) to (e) Repealed, L. 79, p. 525, sec. 31, effective July 1, 1979.

~~(f) Conviction of a felony or pleading guilty or nolo contendere to a felony.~~

(f) Conviction of a felony or conviction of any crime that would constitute a violation of the Medical Practice Act. For purposes of this subsection, a conviction shall include a plea of guilty, a plea of nolo contendere or a deferred sentence prior to final sentencing or dismissal with prejudice;

(g) Administering, dispensing, or prescribing any habit-forming drug, as defined in section 12-22-102 (13), or any controlled substance, as defined in section 12-22-303 (7), other than in the course of legitimate professional practice;

(h) Conviction of violation of any federal or state law regulating the possession, distribution, or use of any controlled substance, as defined in section 12-22-303 (7), and, in determining if a license should be denied, revoked, or suspended, or if the licensee should be placed on probation, the board shall be governed by the provisions of section 24-5-101, C.R.S. For purposes of this subsection, a conviction shall include a plea of guilty, a plea of nolo contendere or a deferred sentence prior to final sentencing or dismissal with prejudice;

~~(i) Habitual intemperance or excessive use of any habit-forming drug as defined in section 12-22-102 (13), or any controlled substance, as defined in section 12-22-303(7);~~

(i) Providing or attempting to provide medical care to a patient while intoxicated by alcohol or any habit-forming drug as defined in section 12-22-102 (13), or any controlled substance, as defined in section 12-22-303(7);

(j) Repealed, L. 79, p. 525, § 31, effective July 1, 1979;

(k) The aiding or abetting, in the practice of medicine, of any person not licensed to practice medicine as defined under this article or of any person whose license to practice medicine is suspended;

(l) Repealed, L. 79, p. 525, sec. 31, effective July 1, 1979.

(m) Except as otherwise provided in section 25-3-103.7, C.R.S., practicing medicine as the partner, agent, or employee of, or in joint adventure with, any person who does not hold a license to practice medicine within this state, or practicing medicine as an employee of, or in joint adventure with, any partnership or association any of whose partners or associates do not hold a license to practice medicine within this state, or practicing medicine as an employee of or in joint adventure with any corporation other than a professional service corporation for the practice of medicine as defined in section 12-36-134. Any licensee holding a license to practice medicine in this state may accept employment from any person, partnership, association, or corporation to examine and treat the employees of such person, partnership, association, or corporation.

(n) Violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this article;

~~(o) Such physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient;~~

~~(p) An act or omission constituting grossly negligent medical practice or two or more acts or omissions which fail to meet generally accepted standards of medical practice, whether the two or more acts or omissions occur during a single treatment of one patient, during the course of treatment of one patient, or during the treatment of more than one patient;~~

(p) Any act or omission which fails to meet generally accepted standards of medical practice;

(q) ~~Repealed, L. 91, p. 884, sec. 3, effective July 1, 1991.~~ Advertising which is misleading, deceptive, or false.

(r) Engaging in a sexual act with a patient during the course of patient care or during the period of six months following the termination of the physician/patient relationship. "Sexual act", as used in this paragraph (r), means sexual contact, sexual intrusion, or sexual penetration as defined in section 18-3-401, C.R.S.;

(s) Refusal of an attending physician to comply with the terms of a declaration executed by a patient pursuant to the provisions of article 18 of title 15, C.R.S., and failure of the attending physician to transfer care of said patient to another physician;

(t) (I) Violation of abuse of health insurance pursuant to section 18-13-119, C.R.S.; or

(II) Advertising through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that the licensee will perform any act prohibited by section 18-13-119 (3), C.R.S.

(u) Violation of any valid board order including any order made pursuant to sections 12-36-118(5)(c)(III) or 12-36-118(5)(c)(III.5) or any rule or regulation promulgated by the board in conformance with law;

(v) Dispensing, injecting, or prescribing an anabolic steroid as defined in section 18-18-102 (3), C.R.S., for the purpose of the hormonal manipulation that is intended to increase muscle mass, strength, or weight without a medical necessity to do so or for the intended purpose of improving performance in any form of exercise, sport, or game;

(w) Dispensing or injecting an anabolic steroid as defined in section 18-18-102 (3), C.R.S., unless such anabolic steroid is dispensed from a pharmacy prescription drug outlet pursuant to a prescription order or is dispensed by any practitioner in the course of his professional practice;

~~(x) Prescribing, distributing, or giving to a family member or to oneself except on an emergency basis any controlled substance as defined in section 18-18-204, C.R.S., or as contained in schedule II of 21 U.S.C. sec. 812, as amended;~~

(x)(I) Prescribing, distributing, or giving to oneself except on an emergency basis any controlled substance as defined in section 18-18-204 to 207, C.R.S., or as contained in schedule II, III, IV and V of 21 U.S.C. sec. 812, as amended;

(II) Prescribing, distributing, or giving to a family member except on an emergency basis any controlled substance as defined in section 18-18-204, C.R.S., or as contained in schedule II of 21 U.S.C. sec. 812, as amended;

(y) Failing to report to the board any adverse action taken against the licensee by another licensing agency in another state or country, any peer review body, any health care institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court for acts or conduct that would constitute grounds for action as described in this article;

(z) Failing to report to the board the surrender of a license or other authorization to practice medicine in another state or jurisdiction or the surrender of membership on any medical staff or in any medical or professional association or society while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this article;

(aa) Failing to accurately answer the questionnaire accompanying the renewal form as required pursuant to section 12-36-123 (2) (b);

(bb) (I) Engaging in any of the following activities and practices: Willful and repeated ordering or performance, without clinical justification, of demonstrably unnecessary laboratory tests or studies; the administration, without clinical justification, of treatment which is demonstrably unnecessary; the failure to obtain consultations or perform referrals when failing to do so is not consistent with the standard of care for the profession; or ordering or performing, without clinical justification, any service, x-ray, or treatment which is contrary to recognized standards of the practice of medicine as interpreted by the board.

(II) In determining which activities and practices are not consistent with the standard of care or are contrary to recognized standards of the practice of medicine, the board of medical examiners shall utilize, in addition to its own expertise, the standards developed by recognized and established accreditation or review organizations which organizations meet requirements established by the board by rule and regulation. Such determinations shall include but not be limited to appropriate ordering of laboratory tests and studies, appropriate ordering of diagnostic tests and studies, appropriate treatment of the medical condition under review, appropriate use of consultations or referrals in patient care, and appropriate creation and maintenance of patient records.

(cc) Falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records.

(dd) Committing a fraudulent insurance act, as defined in section 10-1-127, C.R.S.;

(ee) Violating the provisions of section 8-42-101 (3.6), C.R.S.

(ff) Any violation of the provisions of section 12-36-202 or any rule or regulation of the board adopted pursuant to that section.

(gg) Failing to report to the board <u>or to the designated peer assistance program</u> pursuant to the duty set forth in section 12-36-118(3). A licensee need not report unprofessional conduct or a health impairment that has been reviewed by a professional review committee as defined in section 12-36.5-102(3) only if the professional review committee makes a finding that no unprofessional conduct has occurred or that no health impairment exists and no action of a restrictive or disciplinary nature, including resignation in lieu of the imposition of discipline or restrictions, is taken by the professional review committee.

(hh) Failure to establish and continually maintain financial responsibility as required by § 13-64-301;

(ii) Failure to respond to a complaint issued pursuant to section 12-36-118(4) unless due to conditions beyond the licensee's control.

~~(2) A revocation or suspension of a license to practice medicine in any other state, territory, or country for disciplinary reasons shall be deemed to be prima facie evidence of unprofessional conduct. This subsection (2) shall apply only to revocations or suspensions based upon acts or omissions in such other state, territory, or country substantially as defined as unprofessional conduct pursuant to subsection (1) of this section.~~

(2) Discipline of a license to practice medicine in any other state, territory, or country shall be deemed to be unprofessional conduct. For purposes of this subsection "discipline" shall include any sanction required to be reported pursuant to 45 CFR § 60.8. This subsection (2) shall apply only to discipline based upon acts or omissions in such other state, territory, or country substantially as defined as unprofessional conduct pursuant to subsection (1) of this section.

<u>12-36-117.5 Health Impairment</u> (1) A "health impairment" as used in this article means:

(a) Psychoactive substance abuse or psychoactive substance dependence as defined in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised or any other physical or mental disability, which has a reasonable potential to render the licensee unable to perform medical services with reasonable skill and with safety to the patient.

(2) Any condition set forth in subsection 12-36-117.5(1)(a) which has been successfully treated for a period of five years shall not constitute a health impairment. Any such condition which has been treated for less than five years shall be actionable by the board. Nothing in this subsection shall limit the period of probation or the terms of that probation which may be ordered by a hearings panel pursuant to subsection 12-36-118(5)(c)(III.5)

<u>12-36-118. Disciplinary action by board - immunity.</u> (1) The president of the board shall divide those members of the board other than himself into two panels of five members each, four of whom shall be physician members. Each panel shall act as both an inquiry and a hearings panel. Members of the board may be assigned from one panel to the other by the president. The president may be a member of both panels, but in no event shall the president or any other member who has considered a complaint as a member of one panel acting as an inquiry panel take any part whatever in the consideration of a formal complaint involving the same matter. ~~other than with regard to the appointment of an advisor to an administrative law judge.~~ All matters referred to one panel for investigation shall be heard, if referred for formal hearing, by the other panel or a committee thereof. However, in its discretion, either inquiry panel of the board may elect to refer a case for formal hearing to a qualified administrative law judge, ~~with or without an assigned advisor from the hearings panel~~, in lieu of a hearings panel of the board for his initial decision pursuant to the provisions of section 24-4-105, C.R.S. ~~Should the inquiry panel elect to have an advisor assist with the administrative law judge, the advisor would be assigned to the hearing by the president of the board. The advisor would assist the administrative law judge in obtaining and interpreting medical data pertinent to the hearing. The advisor would be excluded from the hearings panel review of the decision of the administrative law judge.~~ The initial decision of the administrative law judge may be reviewed pursuant to section 24-4-105 (14) and (15), C.R.S., by the filing of exceptions to the initial decision by the respondent or the board's counsel with the hearings panel which would have heard the case if it had not been referred to an administrative law judge or by review upon the motion of such hearings panel.

(2) Investigations shall be under the supervision of the panel to which they are assigned. The persons making such investigation shall report the results thereof to the assigning panel for appropriate action.

(3) In the discharge of its duties, the board may enlist the assistance of other physicians licensed to practice medicine in this state. Physicians have the duty to report to the board any physician known, or upon information and belief, to have violated any of the provisions of sections 12-36-117 ~~(1)~~ or 12-36-117.5; ~~except that no physician who is treating another physician for a mental disability or habitual intemperance or excessive use of any habit-forming drug shall have a duty to report his patient unless, in the opinion of the treating physician, the impaired physician presents a danger to himself or others.~~ except that a report to the board need not be made in the case of health impairment as defined in section § 12-36-117.5 if a report identifying the physician in question is made to a peer assistance program approved by the board as defined in section 12-36-123.5 No physician who is a member of a peer assistance program need report a health impairment as defined in section 12-36-117.5, unless, in the determination of the peer assistance program, the physician presents a danger to himself or others, in which case, a report to the board shall be made. Any person or entity participating in good faith in the making of a complaint or report or participating in any investigative or administrative proceeding pursuant to this section shall be immune from any liability, civil or criminal, that otherwise might result by reason of such action. When acting in their official capacity, members of the board shall be immune from any liability, civil or criminal, that otherwise might result by reason of participating in the investigation of or an administrative proceeding in connection with a complaint or report pursuant to this section or by reason of any disciplinary action taken by the board pursuant to this section as a result of such a complaint or report.

(4) (a) Complaints in writing relating to the conduct of any physician licensed or authorized to practice medicine in this state may be made by any person or may be initiated by an inquiry panel of the board on its own motion. The physician complained of shall be given notice by certified mail of the ~~nature of all matters complained of~~ complaint and shall be given twenty days to make explanation or answer thereto. Upon receipt of the physician's answer or at the conclusion of twenty days ~~if no answer has been received~~, ~~the matter shall be referred to one panel acting as an inquiry panel for that particular case, referred to in this subsection (4) as the "inquiry panel", for investigation.~~ the inquiry panel may conduct further investigation. The investigation may be made by one or more members of the inquiry panel, by one or more physicians who are not members of the board, by a member of the staff of the board, ~~or~~ by a professional investigator, or by any other person or organization as the inquiry panel directs, and it shall be entirely informal.

(b) The board shall cause an investigation to be made when the board is informed of:

(I) Disciplinary actions taken by hospitals to suspend or revoke the privileges of a physician and reported to the board pursuant to section 25-3-107, C.R.S.;

(II) Disciplinary actions taken as a result of a professional review proceeding pursuant to part 1 of article 36.5 of this title against a physician. Such disciplinary actions shall be reported to the board;

(III) An instance of a medical malpractice settlement or judgment against a physician reported to the board pursuant to section 10-1-124, C.R.S.; or

(IV) Physicians who have been allowed to resign from hospitals for medical misconduct. Such hospitals shall report the same.

(c) On completion of an investigation, the inquiry panel shall make a finding that:

(I) The complaint is without merit and no further action need be taken with reference thereto;

(II) There is no reasonable cause to warrant further action with reference thereto;

(II.5) The investigation discloses an instance of conduct which, in the opinion of the inquiry panel, does not warrant formal action by the board and should be dismissed but in which the inquiry panel has noticed indications of possible errant conduct by the licensee that could lead to serious consequences if not corrected, in which case, a confidential letter of concern shall be sent to the physician against whom a complaint was made. ~~If the board learns of second or subsequent actions of the same or similar nature by the licensee, the board shall send a letter of admonition to the physician, and such letter need not remain confidential.~~

(III) The investigation discloses an instance of unprofessional conduct or health impairment which, in the opinion of the inquiry panel, does not warrant formal action by the board but which should not be dismissed as being without merit; in such case, a certified letter, return receipt requested, of admonition shall be sent to the physician against whom a complaint was made and a copy thereof to the person making the complaint, but, when a letter of admonition is sent by the inquiry panel to a physician complained against, such physician shall be advised that he has the right to request in writing, within twenty days after receipt of the letter, that formal disciplinary proceedings be initiated against him to adjudicate the propriety of the conduct upon which the letter of admonition is based. If such request is timely made, the letter of admonition shall be deemed vacated, and the matter shall be processed by means of formal disciplinary proceedings; or

(IV) The investigation discloses facts which warrant further proceedings by formal complaint, as provided in subsection (5) of this section, in which event the complaint shall be referred to the attorney general for preparation and filing of a formal complaint.

(d) All proceedings pursuant to this subsection (4) shall be expeditiously and informally conducted so that no physician is subjected to unfair and unjust charges and that no complainant is deprived of his right to a timely, fair, and proper investigation of his complaint.

(e) On or before December 1, 1988, and on or before each December 1 thereafter, the board shall submit to the general assembly a report describing the activities of the board for the previous fiscal year. Such report shall include, but need not be limited to, the following:

(I) The number of active cases or unresolved complaints which the board had as of the beginning of the fiscal year;

(II) The number of complaints or reports received pursuant to paragraph (b) of this subsection (4);

(III) The status of and actions taken on those complaints or cases during the year;

(IV) An analysis of all cases which were active during the year and which were not resolved within ninety days, to include the nature of the complaint, the reason for the delay past ninety days, the period of time required for each case for initial inquiry, investigation, and decision for referral to the attorney general, and the period of time required for the hearing and decision regarding any disciplinary action;

(V) Any other comments by the board which it deems to be relevant to its functioning.

~~(5) (a) All formal complaints seeking disciplinary action against a physician shall be filed with the board. A formal complaint shall set forth the charges with sufficient particularity as to inform the physician clearly and specifically of the acts of unprofessional conduct or health impairment with which he is charged.~~

~~(b) Upon the filing of a formal complaint, the board shall issue a citation, together with a copy of the complaint attached thereto. The citation shall require said physician to file with the board, within twenty days after service thereof, a written answer to the complaint. Such citation and complaint may be served by certified mail, return receipt requested, addressed to the physician at his last registered or known post-office address. The return receipt signed by the physician complained of shall be proof of service thereof. In the event that the physician refuses to accept such certified mail and sign the receipt therefor, the citation and a copy of the complaint may be served upon him as other process and proof thereof are made, all as provided in rule 4 of the Colorado rules of civil procedure. The time to answer shall commence from the date of service.~~

~~(c) It is the duty of the physician so served with such citation to file with the board his answer to the complaint in which he shall admit or deny the material allegations thereof and shall set forth any affirmative defenses he may have. He may include in his answer any request for a more particular statement of the alleged acts of unprofessional conduct or health impairment or may raise any other objections, including a plea that the complaint does not charge unprofessional conduct or a health impairment warranting the imposition of discipline.~~

~~(d) If the physician so charged fails to answer the complaint as provided in paragraph (c) of this subsection (5) or fails to appear at the hearing after receiving due notice of the time and place thereof, the panel to which the hearings function has been assigned in that particular case, referred to in this subsection (5) as the "hearings panel", may proceed to hear the complaint and make its findings and recommendations as provided in this subsection (5).~~

~~(e)~~ (5)(a) All formal complaints shall conform to the requirements of section 24-4-105, C.R.S. Except as provided in subsection (1) of this section, all formal hearings shall be conducted by the hearings panel. The physician may be present in person, and by counsel if he so desires, to offer evidence and be heard in his defense. At formal hearings, the witnesses shall be sworn, and a complete record shall be made of all proceedings had and testimony taken. Hearings on formal complaints shall be conducted in accordance with paragraph ~~(f)~~ (b) of this subsection (5) and the applicable provisions of section 24-4-105, C.R.S.

~~(f)~~ (b) Except as provided in subsection (1) of this section, an administrative law judge shall preside at the hearing, and he shall advise the hearings panel on all such legal matters in connection with the hearing as the panel may request. He shall provide such advice or assistance as the hearings panel may request in connection with its preparations of its findings and recommendations or conclusions to be made. Such administrative law judge shall have the authority to administer oaths and affirmations, sign and issue subpoenas, and perform such other duties as the hearings panel may authorize him to perform. Such administrative law judge shall have the qualifications provided in section 24-30-1003 (2), C.R.S., with five years' experience as a licensed attorney.

~~(g)~~ (c),~~(g)~~ (I) To warrant a finding of unprofessional conduct or health impairment, the charges shall be established as specified in section 24-4-105 (7), C.R.S. Except as provided in subsection (1) of this section, the hearings panel shall make a report of its findings and conclusions which, when approved and signed by a majority of those members of the hearings panel who have conducted the hearing pursuant to paragraphs ~~(e)~~ a and ~~(f)~~ b of this subsection (5), shall be and become the action of the board.

(II) If it is found that the charges are unfounded and unproven, the hearings panel, or an administrative law judge sitting in lieu of the hearings panel pursuant to subsection (1) of this section, shall enter an order dismissing the complaint; whereupon, the matter shall be terminated, but any person who has filed a complaint in the proceedings who desires to have the matter of dismissal of the complaint reviewed may seek such review pursuant to the provisions of section 12-36-119.

(III) If the hearings panel finds the charges of unprofessional conduct proven and orders that discipline be imposed, it shall also determine the extent of such discipline in the form of a letter of admonition, ~~private censure, public censure~~, suspension for a definite or indefinite period, or revocation of license to practice. In determining what disciplinary action is appropriate, the hearings panel must first consider what sanctions are necessary to protect the public. Only after such provisions have been made may the hearings panel consider and order requirements designed to rehabilitate the licensee or applicant. In any discipline other than revocation of a license to practice, the hearings panel may also order that the physician be granted probation and allowed to continue to practice during the period of such probation. The hearings panel may also include in any disciplinary order which allows the physician to continue to practice such conditions as said panel may deem appropriate to assure that the physician is physically, mentally, morally, and otherwise qualified to practice medicine in accordance with generally accepted professional standards of practice, including any or all of the following:

(A) Submission by the respondent to such examinations as the hearings panel may order to determine his physical or mental condition or his professional qualifications;

(B) The taking by him of such therapy or courses of training or education as may be needed to correct deficiencies found either in the hearing or by such examinations;

(C) The review or supervision of his practice as may be necessary to determine the quality of his practice and to correct deficiencies therein; and

(D) The imposition of restrictions upon the nature of his practice to assure that he does not practice beyond the limits of his capabilities.

(III.5) If the hearings panel finds the charges of health impairment proven it may place the licensee on probation for a definite or indefinite period. In determining what probationary terms and conditions are appropriate, the hearings panel must first consider what provisions are necessary to protect the public. Only after such provisions have been made may the hearings panel consider and order requirements designed to rehabilitate the licensee or applicant. A finding that a physician suffers from a health impairment shall not limit the board's ability to discipline that physician for conduct defined as unprofessional conduct whether or not the unprofessional conduct was caused by the health impairment. The hearings panel may also include in any order of probation such conditions as it may deem appropriate to assure that the health impairment is properly treated and that the licensee is safe to practice in accordance with generally accepted professional standards, including any or all of the following:

(A) Testing of the respondent's blood or urine to determine whether the respondent has consumed alcohol or any other psychoactive substance. The frequency and other conditions of the testing shall be as the hearings panel deems fit;

(B) The taking by the respondent of such treatment as may be indicated by the nature of the health impairment;

(C) The review or supervision of the respondent's practice as may be necessary to determine the quality of that practice and to correct deficiencies therein; and

(D) The imposition of restrictions upon the nature of the respondent's practice to assure that the respondent does not practice beyond the limits of the respondent's capabilities.

(IV) Upon the failure of the physician to comply with any conditions imposed by the hearings panel pursuant to subparagraph (III) or (III.5) of this paragraph ~~(g)~~ (c),~~(g)~~, unless due to conditions beyond the physician's control, the hearings panel may order suspension of the physician's license to practice in this state until such time as the physician complies with such conditions.

(V) In making any of the orders provided in subparagraphs (III), (III.5) and (IV) of this paragraph ~~(g)~~, the hearings panel may take into consideration the physician's prior disciplinary record. If the hearings panel does take into consideration any prior discipline of the physician, its findings and recommendations shall so indicate.

(VI) In all cases of revocation, suspension, or probation, the board shall enter in its records the facts of such revocation, suspension, or probation and of any subsequent action of the board with respect thereto.

(VII) to (IX) (Deleted by amendment, L. 79, p. 516, sec. 14, effective July 1, 1979.)

(h) The attorney general shall prosecute those charges which have been referred to him by the inquiry panel pursuant to subparagraph (IV) of paragraph (c) of subsection (4) of this section. The board may direct the attorney general to perfect an appeal.

(6) A majority of the members of the board, three members of the inquiry panel, or three members of the hearings panel shall constitute a quorum. The action of a majority of those present comprising such quorum shall be the action of the board, the inquiry panel, or the hearings panel.

(7) Upon the expiration of the term of suspension, the license shall be reinstated by the board if the holder thereof furnishes the board with evidence that he has complied with all terms of the suspension. If such evidence shows he has not complied with all terms of the suspension, the board shall revoke the license at a hearing, notice of which and the procedure at which shall be as provided in this section.

(8) In case any person holding a license to practice medicine in this state is determined to be mentally incompetent or insane by a court of competent jurisdiction and a court enters, pursuant to part 3 or part 4 of article 14 of title 15 or section 27-10-109 (4) or 27-10-125, C.R.S., an order specifically finding that the mental incompetency or insanity is of such a degree that the person holding a license is incapable of continuing to practice medicine, his license shall automatically be suspended by the board, and, anything in this article to the contrary notwithstanding, such suspension shall continue until the licensee is found by such court to be competent to practice medicine.

(9) (a) If the board has reasonable cause to believe that a person licensed to practice medicine in this state or certified as a physician assistant in this state ~~is unable to practice medicine with reasonable skill and safety to patients because of a condition described in section 12-36-117 (1) (i) or (1) (o)~~, suffers from a health impairment it may require such licensee to submit to mental or physical examinations by physicians designated by the board. Upon the failure of such licensee to submit to such mental or physical examinations, unless due to circumstances beyond his control, the board may suspend such licensee's license to practice medicine in this state until such time as he submits to the required examinations.

(b) Every person licensed to practice medicine or certified to practice as a physician assistant in this state shall be deemed, by so practicing or by applying for annual registration of his license to practice medicine in this state, to have given his consent to submit to mental or physical examinations when directed in writing by the board and, further, to have waived all objections to the admissibility of the examining physician's testimony or examination reports on the ground of privileged communication. Subject to applicable federal law, such physician or physician assistant shall also be deemed to have waived all objections to the production of medical records from other treaters which may be necessary for the evaluation set out in section 12-36-118(9)(a) above.

(c) The results of any mental or physical examination ordered by the board shall not be used as evidence in any proceeding other than before the board.

(10) Investigations, examinations, hearings, meetings, or any other proceedings of the board conducted pursuant to the provisions of this section shall be exempt from the provisions of any law requiring that proceedings of the board be conducted publicly or that the minutes or records of the board with respect to action of the board taken pursuant to the provisions of this section be open to public inspection.

(11) A person licensed to practice medicine who, at the request of the board, examines another person licensed to practice medicine shall be immune from suit for damages by the person examined if the examining person conducted the examination and made his findings or diagnosis in good faith.

(12) (a) The executive director of the department of regulatory agencies may direct the board to conduct an investigation of a person licensed to practice medicine about whom the executive director has received complaints.

(b) The board, within sixty days, shall accept or reject the directive of the executive director under paragraph (a) of this subsection (12), and the board shall notify the executive director of its decision. If the board rejects the investigation or if, upon review, the executive director and the attorney general find that the board has not proceeded with a thorough investigation, the executive director may then cause an investigation to be made of the complaints presented to him; but no new investigation shall be made by the executive director for the sole reason of disagreement with the findings and conclusions of the board. In any investigation conducted by the executive director pursuant to this paragraph (b), the executive director may utilize the staff, records, and moneys of the board. After an investigation and, if necessary, a hearing, the executive director shall submit to the board the findings of fact and conclusions of law for further action.

(c) Except as specifically provided in this subsection (12), actions taken by the executive director are subject to the limitations imposed by section 24-1-105 (1), C.R.S., relating to the powers, duties, and functions of the board under a **type 1** transfer.

(13) Within thirty days after the board takes final action, which is of public record, to revoke or suspend a license of a physician or to place a licensee on probation based on competence or professional conduct, the board shall send notice thereof to any hospital in which the licensee has clinical privileges, as indicated by the licensee.

12-36-119. Reconsideration and Review of action of board. (1) (a) The board, on its own motion or upon application, at any time after the refusal to grant a license, the imposition of any discipline as provided in section 12-36-118, or the ordering of probation, as provided in section 12-36-118 (5) (g) (III), may reconsider its prior action and grant, reinstate, or restore such license or terminate probation, or reduce the severity of its prior disciplinary action. The taking of any such further action, or the holding of a hearing with respect thereto, shall rest in the sole discretion of the board.

~~(b) Upon the receipt of such application, it may be forwarded to the attorney general for such investigation as may be deemed necessary. A copy of the application and the report of investigation shall be forwarded to the hearings panel which shall consider the same and report its findings and conclusions. The proceedings shall be governed by the applicable provisions governing formal hearings in disciplinary proceedings. The attorney general may present evidence bearing upon the matters in issue, and the burden shall be upon the applicant seeking reinstatement to establish the averments of his application as specified in section 24-4-105 (7), C.R.S. No application for reinstatement or for modification of a prior order shall be accepted unless the applicant deposits with the board all amounts unpaid under any prior order of the board.~~

(2) The action of the board in refusing to grant a license, in taking any disciplinary action as provided in section 12-36-118, or in placing a physician on probation may be reviewed by the court of appeals by appropriate proceedings under section 24-4-106 (11), C.R.S.

12-36-120. Other licensees of board - disciplinary action. (Repealed)

Repealed, effective July 1, 1985.

12-36-121. Duplicates of license. The board is authorized to issue a duplicate license to any person to whom a license to practice medicine in this state has been issued, upon application, properly verified by oath, establishing to the satisfaction of the board that the original license has been lost or destroyed and upon payment to the board of a fee to be determined by regulation adopted by the board. No person shall be entitled to a duplicate license unless he is a licensee in good standing.

12-36-122. Internship - residency - registration. Any person serving an approved internship or an approved residency, as defined by this article, in a hospital in the state of Colorado may do so for an aggregate period of not to exceed six years without a license to practice medicine or the payment of any fee. ~~Such person must register with the board in such manner and form as the board shall prescribe.~~ Licensed physicians responsible for supervision of interns or residents in graduate training programs are required to report to the board anything concerning an individual in such graduate medical education programs which would constitute a violation of this article. Such physicians shall also report to the board any individual who has not progressed satisfactorily in the program or who has been dismissed from the program for inadequate performance or ethical reasons.

12-36-123. Procedure - registration - fees. (1) (a) The board shall establish procedures for the maintenance of licensee lists and the establishment of renewal fees and schedules, which fees and schedules shall be established subject to the provisions of section 24-34-102 (8), C.R.S. Every licensee shall pay the board ~~secretary~~ a registration fee to be determined and collected pursuant to section 24-34-105, C.R.S., and shall obtain a registration certificate for the current ~~calendar year~~ renewal period.

(b) ~~A licensee desiring to obtain an annual registration certificate shall submit the information necessary to show that he has fulfilled the board's continuing medical education requirements pursuant to paragraph (c) of this subsection (1). Any licensee aggrieved by a decision relating to such continuing education requirements may ask the executive director of the department of regulatory agencies to review such requirements in accordance with the procedures established by section 24-34-102 (11), C.R.S.~~

(b) The board shall establish a questionnaire to accompany the renewal form. Said questionnaire shall be designed to determine if the licensee has acted in violation of or has been disciplined for actions that might be construed as violations of this article or that might make the licensee unfit to practice medicine with reasonable care and safety. Failure of the applicant to answer the questionnaire accurately shall be considered unprofessional conduct as specified in section 12-36-117.

(c) Applicants for relicensure shall not be required to attend and complete continuing medical education programs, except as directed by the board to correct deficiencies of training or education as directed under section 12-36-118 (5) ~~(g)~~, (c) (III) (B).

(2) (a) The ~~secretary~~ board shall mail to each such licensee at his last address as shown by the records of the board, ~~during December of each year,~~ , in accordance with the renewal schedule established subject to the provisions of section 24-34-___, notice of the foregoing provisions together with such form of application for registration as may be prescribed by the board. Failure of any licensee to pay the registration fee prescribed by subsection (1) of this section means that the license has lapsed, and the name of any lapsed licensee shall be omitted from such list.

(b) Upon application made to the board by any ~~such~~ lapsed licensee on a form prescribed by the board, his license shall be reinstated, subject to the payment to the board of the current renewal fee and a reinstatement fee determined by the board pursuant to section 24-34-105, C.R.S. If, before or after such application for reinstatement has been made, charges are preferred against the licensee by the board or by any person, as provided by section 12-36-118, the board shall defer action on the pending application for reinstatement, if any, and proceed with a hearing on such charges in accordance with section 12-36-118 and thereupon shall reinstate, further suspend, or revoke such license. No license to practice medicine which has lapsed for more than two years shall be reinstated unless the applicant demonstrates to the board his continued professional competence in such manner as prescribed by the board.

12-36-123.5. Physicians' peer health assistance fund. (1) (a) There is hereby created in the state treasury the physicians' peer health assistance fund. The fund shall consist of moneys required to be credited to the fund pursuant to subsection (2) of this section and all interest earned on the investment of moneys in the fund. Any interest earned on investment of moneys in the physicians' peer health assistance fund shall be credited at least annually to said fund. No moneys shall be appropriated from the general fund for payment of any expenses incurred under this section, and no such expenses shall be charged against the state. Moneys in the fund shall be subject to annual appropriation by the general assembly to the board to be used for the purposes described in subsection (3) of this section.

(b) Effective July 1, 1994, the physicians' peer health assistance fund shall be terminated, the balance of moneys in the fund shall be transferred, prior to June 30, 1994, to an administering entity selected by the board, which entity shall administer the programs of board-selected designated providers, and that the fiscal year beginning July 1, 1993 shall be used by the department of regulatory agencies as a transition year for plan for the transfer of responsibilities for such program.

~~(b)~~(c) Prior to June 30, 1994, the board shall transfer the balance in the fund, if any, to the administering entity chosen by the board pursuant to subsection (3.5) of this section.

(2) When renewing a license pursuant to this article in the year 1987 or 1988, each physician licensee and certified physician assistant shall pay, in addition to the biennial license renewal fee, an additional fee of thirty dollars. For license renewals in the year 1989 and in each year thereafter, such additional fee shall be paid biennially and shall be in an amount determined by the board by rule but shall not exceed thirty dollars. The additional fees collected pursuant to this subsection (2) shall be transmitted to the state treasurer, who shall credit the same to the physicians' peer health assistance fund.

(3) (a) At least annually, the board shall make grants from the physicians' peer health assistance fund to one or more recognized peer assistance programs for physicians and physician assistants needing assistance in dealing with their physical, emotional, or psychological problems which could become detrimental to their ability to practice medicine.

(b) To be eligible to receive a grant, a peer assistance program shall:

(I) Provide for the education of physicians and physician assistants in the recognition and prevention of their physical, emotional, and psychological problems and provide for intervention when necessary or under circumstances which may be established by the board by rule;

(II) Offer assistance to a physician and physician assistants in identifying his physical, emotional, or psychological problems;

(III) Evaluate the extent of the physical, emotional, or psychological problems and refer the physician or physician assistant for appropriate treatment;

(IV) Monitor the status of a physician or physician assistant referred for treatment;

(V) Provide counseling and support for a physician referred for treatment and his family;

(VI) Agree to receive referrals from the board; and

(VII) Make its services available to all licensed Colorado physicians and certified physician assistants.

(c) Any grant made by the board pursuant to the provisions of this subsection (3) may be used only for educational and intervention services and services related to the identification of the physical, emotional, or psychological problems and the evaluation, diagnosis, referral for treatment, and monitoring and evaluation of the treatment of the physician participant. Costs of treatment shall be the responsibility of the physician participant himself.

(3.5) (a) No later than June 30, 1994, the board shall transfer the balance in the fund, if any, to the administering entity chosen by the board pursuant to paragraphs (d) and (e) of this subsection (3.5).

(b) Effective July 1, 1994, as a condition of licensure in this state, every applicant shall pay to the administering entity that has been selected by the board pursuant to the provisions of paragraphs (d) and (e) of this subsection (3.5) an amount set by the board not to exceed twenty-eight dollars per year, which amount shall be used to support designated providers that have been selected by the board to provide assistance to physicians and physician assistants needing help in dealing with physical, emotional, or psychological problems which may be detrimental to their ability to practice medicine.

(c) The board shall select one or more peer health assistance programs as designated providers. To be eligible for designation by the board a peer health assistance program shall:

(I) Provide for the education of physicians and physician assistants with respect to the recognition and prevention of physical, emotional, and psychological problems and provide for intervention when necessary or under circumstances which may be established by rules promulgated by the board;

(II) Offer assistance to a physician in identifying physical, emotional, or psychological problems;

(III) Evaluate the extent of physical, emotional, or psychological problems and refer the physician and physician assistants for appropriate treatment;

(IV) Monitor the status of a physician and physician assistants who has been referred for treatment;

(V) Provide counseling and support for the physician and physician assistants and for the family of any physician and physician assistants referred for treatment;

(VI) Agree to receive referrals from the board;

(VII) Agree to make their services available to all licensed Colorado physicians all to all certified Colorado physician assistants.

(d) The administering entity shall be a qualified, nonprofit private foundation that is qualified under section 501 (c) (3) of the federal "Internal Revenue Code of 1986", as amended, and shall be dedicated to providing support for charitable, benevolent, educational, and scientific purposes that are related to medicine, medical education, medical research and science, and other medical charitable purposes.

(e) The responsibilities of the administering entity shall be:

(I) To collect the required annual payments;

(II) To verify to the board, in a manner acceptable to the board, the names of all physician applicants and physician assistant applicants who have paid the fee set by the board;

(III) To distribute the moneys collected, less expenses, to the approved designated provider, as directed by the board;

(IV) To provide an annual accounting to the board of all amounts collected, expenses incurred, and amounts disbursed; and

(V) To post a surety performance bond in an amount specified by the board to secure performance under the requirements of this section. The administering entity may recover the actual administrative costs incurred in performing its duties under this section in an amount not to exceed ten percent of the total amount collected.

(4) No grant shall be made by the board pursuant to subsection (3) of this section until sufficient moneys have been credited to the physicians' peer health assistance fund in accordance with subsection (2) of this section.

(5) Nothing in this section shall be construed to create any liability on the board or the state of Colorado for the actions of the board in making grants to peer assistance programs, and no civil action may be brought or maintained against the board or the state for an injury alleged to have been the result of the activities of any state-funded peer assistance program or the result of an act or omission of a physician <u>or physician assistant</u> participating in or referred by a state-funded peer assistance program.

(6) Subsections (1), (2), and (3) of this section and this subsection (6) are repealed, effective June 30, 1994.

<u>12-36-124. Certification of licensing.</u> Upon request therefor and the payment of a fee determined pursuant to section 24-34-105, C.R.S., the secretary of the board shall issue its certificate or endorsement with respect to the licensing of, and the official record of the board relating to, any licensee to whom a license to practice medicine in this state has been issued by this or any prior board; and, upon request therefor and the payment of a fee determined pursuant to section 24-34-105, C.R.S., the secretary shall issue a certificate evidencing that any such licensee is duly licensed to practice medicine in this state.

<u>12-36-125. Division of fees - independent advertising or marketing agent.</u> (1) (a) If any person holding a license issued by the board or by the state board of medical examiners as constituted under any prior law of this state divides any fee or compensation received or charged for services rendered by him as such licensee or agrees to divide any such fee or compensation with any person, firm, association, or corporation as pay or compensation to such other person for sending or bringing any patient or other person to such licensee, or for recommending such licensee to any person, or for being instrumental in any manner in causing any person to engage such licensee in his professional capacity; or if any such licensee shall either directly or indirectly pay or compensate or agree to pay or compensate any person, firm, association, or corporation for sending or bringing any patient or other person to such licensee for examination or treatment, or for recommending such licensee to any person, or for being instrumental in causing any person to engage such licensee in his professional capacity; or if any such licensee, in his professional capacity and in his own name or behalf, shall make or present a bill or request a payment for services rendered by any person other than the licensee, such licensee commits a class 3 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

(b) Notwithstanding the provisions of paragraph (a) of subsection (1) of this section, a licensee may pay an independent advertising or marketing agent compensation for the advertising or marketing services rendered on the licensee's behalf by such agent, including compensation which is paid for the results or performance of such services on a per patient basis.

(c) As used in this subsection (1), "independent advertising or marketing agent" means a person, firm, association, or corporation which performs advertising or other marketing services on behalf of licensees, including referrals of patients to licensees resulting from patient-initiated responses to such advertising or marketing services.

(2) Violation of the provisions of this section shall constitute grounds for the suspension or revocation of a license to practice medicine or the placing of the holder thereof on probation.

(3) The board shall not have the authority to regulate, directly or indirectly, advertising or marketing activities of independent advertising or marketing agents except as provided in this section. The board may, in the name of the people of the state of Colorado, apply for an injunction in the district court to enjoin any independent advertising or marketing agent from the use of advertising or marketing which the court finds on the basis of the evidence presented by the board to be misleading, deceptive, or false or otherwise in violation of section 12-36-128.5; except that a licensee shall not be subject to discipline by the board, injunction, or prosecution in the court under this article or any other law for advertising or marketing by an independent advertising or marketing agent if the factual information which the licensee provides to the advertising or marketing agent is accurate and not misleading, deceptive, or false and the licensee has otherwise complied with the provisions of section 12-36-128.5.

12-36-126. Recovery of fees illegally paid. If any licensee, in violation of section 12-36-125, divides or agrees to divide any fee or compensation received by him for services rendered in his professional capacity with any person whomsoever, the person who has paid such fee or compensation to such licensee may recover the amount unlawfully paid or agreed to be paid from either the licensee or from the person to whom such fee or compensation has been paid, by an action to be instituted within two years from the date on which such fee or compensation was so divided or agreed to be divided.

12-36-127. Liability of persons other than licensee. If any person, firm, association, or corporation receives, either directly or indirectly, any pay or compensation given or paid in violation of section 12-36-125, such person, firm, association, or corporation, and the officers and directors thereof, commits a class 3 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

12-36-128. Advertising. (Repealed)

Repealed, effective May 3, 1985.

~~12-36-128.5. Public communications and advertisements. (1) For purposes of this section:~~

~~(a) "False, fraudulent, misleading, or deceptive statement or claim" includes, but is not limited to, a statement or claim which:~~

~~(I) Contains a misrepresentation of fact;~~

~~(II) Is likely to mislead or deceive because of a failure to disclose material facts;~~

~~(III) Is intended or is likely to create false or unjustified expectations of favorable results;~~

~~(IV) Relates to charges or fees, other than a standard consultation charge or fee or a range of charges or fees for specific types of services, without fully and specifically disclosing all variables and other material factors affecting such fees; or~~

~~(V) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to be misled or be deceived.~~

~~(b) "Physician" means a person licensed to practice medicine in this state.~~

~~(c) "Public communication" includes, but is not limited to, communication by means of television, radio, motion pictures, newspapers, books, or lists or directories of physicians.~~

~~(2) No physician shall disseminate or cause to be disseminated any public communication which contains a false, fraudulent, misleading, or deceptive statement or claim and which is intended to or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the physician's practice of medicine.~~

~~(3) No physician shall disseminate or cause to be disseminated any advertisement which includes the charge or fee for the rendering of professional services or the furnishing of products and which:~~

~~(a) Contains a false, fraudulent, misleading, or deceptive statement or claim;~~

~~(b) Does not clearly and exactly identify the charge or fee for each professional service or product, except as otherwise allowed in paragraph (c) of this subsection (3), without the use of the phrases "as low as", "and up", or "lowest prices" or words or phrases of similar import;~~

~~(c) Does not include in the charge for any product the charges or fees for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.~~

~~(4) No physician shall disseminate or cause to be disseminated any advertisement which refers to professional services, or the charge or fee for services, and which uses words of comparison unless such comparison is based on verifiable data substantiating the comparison. Any physician so advertising shall be prepared to provide data sufficient to establish the accuracy of that comparison.~~

~~(5) No physician shall compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.~~

~~(6) No physician shall use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a false, fraudulent, misleading, or deceptive statement or claim.~~

~~(7) A violation of any provision of this section by a physician shall constitute grounds for revocation or suspension of such physician's license or other disciplinary action.~~

~~(8) Any advertisement disseminated or caused to be disseminated by a physician may include the following:~~

~~(a) A statement of the name of the physician;~~

~~(b) A statement of addresses and telephone numbers of the offices maintained by the physician;~~

~~(c) A statement of office hours regularly maintained by the physician;~~

~~(d) A statement of languages, other than English, fluently spoken by the physician or a person in the physician's office;~~

~~(e) A statement that the physician limits his or her practice to specific fields;~~

~~(f) A statement that the physician is certified or is eligible for certification by a specifically identified private or public board or parent association if that board or association is an American board of medical specialties member board or a board or association with substantially equivalent requirements approved by the state board of medical examiners;~~

~~(g) A statement that the physician provides services under a specified private or public insurance plan or health care plan;~~

~~(h) A statement of names of schools and postgraduate clinical training programs from which the physician has graduated, together with the degrees received;~~

~~(i) A statement of publications authored by the physician;~~

~~(j) A statement of teaching positions currently or formerly held by the physician, together with pertinent dates;~~

~~(k) A statement of the physician's affiliations with hospitals or clinics;~~

~~(l) A statement of the charges or fees for professional services rendered by or products furnished by the physician;~~

~~(m) A statement that the physician regularly accepts installment payments for charges or fees;~~

~~(n) Otherwise lawful images of a physician, the physician's physical facilities, or a product to be advertised;~~

~~(o) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of product advertised;~~

~~(p) A statement providing public health information encouraging preventative or corrective care;~~

~~(q) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.~~

~~(9) Notwithstanding any other provision of law, the costs of the board in enforcing this section may be awarded against any physician found to be in violation of any provision of this section.~~

12-36-129. Violation - penalties. (1) Except as provided in subsections (2) and (2.5) of this section, if any person, association, or corporation practices medicine within this state without complying with the provisions of this article or if any person, association, or corporation otherwise violates any provision of this article, such person or any officer or director of any such association or corporation commits a class 2 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.; and any person committing a second or subsequent offense commits a class 6 felony and shall be punished as provided in section 18-1-105, C.R.S.

(2) Any person who presents as his own the diploma, license, certificate, or credentials of another, or who gives either false or forged evidence of any kind to the board, or any member thereof, in connection with an application for a license to practice medicine, or who practices medicine under a false or assumed name, or who falsely impersonates another licensee of a like or different name commits a class 6 felony and shall be punished as provided in section 18-1-105, C.R.S.

(2.5) Any person who violates section 12-36-117 (1) (w) commits a class 5 felony, and any person committing a second or subsequent violation commits a class 3 felony; and such persons shall be punished as provided in section 18-1-105, C.R.S.

(3) No action may be maintained against an individual who has been the recipient of services constituting the unlawful practice of medicine for the breach of a contract involving the unlawful practice of medicine or the recovery of compensation for services rendered under such a contract.

(4) When an individual has been the recipient of services constituting the unlawful practice of medicine, whether or not he knew that the rendition of the services was unlawful:

(a) He or his personal representative is entitled to recover the amount of any fee paid for the services; and

(b) He or his personal representative may also recover a reasonable attorney fee as fixed by the court, to be taxed as part of the costs of the action.

(5) (a) No specialty society or association of physicians, whether through by-laws, rules, regulations, or otherwise, and no licensed physician may discriminate against any other person licensed to practice medicine if such physician is otherwise qualified for membership and, if board certification or board eligibility is a membership requirement, such board certification or board eligibility in a specialty must be granted by either the American board of medical specialists or the American osteopathic association, based upon his training either as a doctor of medicine or as a doctor of osteopathy with respect to any aspect of membership in such specialty society or association of physicians. Notwithstanding any other remedies provided under this article, any licensed physician so discriminated against shall have a private right of action for damages against any such licensed physician and against the specialty society or association of physicians.

(b) Any licensed physician, specialty society, or association of physicians held liable for a violation of this subsection (5) shall pay the costs and reasonable attorney fees incurred by the aggrieved physician associated with his pursuit of any claim for relief authorized by this subsection (5).

12-36-130. Moneys collected. (Repealed)

Repealed, effective July 1, 1979.

12-36-131. Existing licenses. (1) Nothing in this article shall be construed to invalidate or affect the license of any person holding a valid, unrevoked, and unsuspended license to practice medicine in this state on July 1, 1951, except as otherwise provided by this article.

(2) Nothing in this article shall be construed to invalidate the license of any person holding a valid, unrevoked, and unsuspended license on June 30, 1979, to practice medicine in this state or to affect any disciplinary proceeding or appeal pending on June 30, 1979, or any appointment to the board, the inquiry panel, or the hearings panel made on or before June 30, 1979.

12-36-132. Injunctive proceedings. (1) The board may, in the name of the people of the state of Colorado, through the attorney general of the state of Colorado, apply for an injunction in any court of competent jurisdiction to enjoin any person from committing any act prohibited by the provisions of article 13, 30, 34, 36, 39, or 41 of this title.

(2) If it is established that the defendant has been or is committing an act prohibited by said articles, the court shall enter a decree perpetually enjoining said defendant from further committing said act.

(3) Such injunctive proceedings shall be in addition to and not in lieu of all penalties and other remedies provided in this article.

12-36-133. Postmortem examinations by licensed physician - definition - application of this section. (1) As used in this section, "person or persons" shall include any individual, partnership, corporation, body politic, or association.

(2) Consent for a licensed physician to conduct a post mortem examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: Father, mother, husband, wife, child, guardian, next of kin, or, in the absence of any of the foregoing, a friend or a person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of one of them shall be deemed sufficient.

(3) Nothing in this section shall be construed as a repeal of any provision of part 6 of article 10 of title 30, C.R.S.

12-36-134. Professional service corporations for the practice of medicine. (1) Persons licensed to practice medicine by the board may form professional service corporations for the practice of medicine under the Colorado corporation code, if such corporations are organized and operated in accordance with the provisions of this section. The articles of incorporation of such corporations shall contain provisions complying with the following requirements:

(a) The name of the corporation shall contain the words "professional company" or "professional corporation" or abbreviations thereof.

(b) The corporation shall be organized solely for the purposes of conducting the practice of medicine only through persons licensed by the board to practice medicine in the state of Colorado.

(c) The corporation may exercise the powers and privileges conferred upon corporations by the laws of Colorado only in furtherance of and subject to its corporate purpose.

(d) All shareholders of the corporation shall be persons licensed by the board to practice medicine in the state of Colorado, and who at all times own their shares in their own right. They shall be individuals who, except for illness, accident, time spent in the armed services, on vacations, and on leaves of absence not to exceed one year, are actively engaged in the practice of medicine in the offices of the corporation.

(e) Provisions shall be made requiring any shareholder who ceases to be or for any reason is ineligible to be a shareholder to dispose of all his shares forthwith, either to the corporation or to any person having the qualifications described in paragraph (d) of this subsection (1).

(f) The president shall be a shareholder and a director and, to the extent possible, all other directors and officers shall be persons having the qualifications described in paragraph (d) of this subsection (1). Lay directors and officers shall not exercise any authority whatsoever over professional matters. Notwithstanding section 7-5-102, C.R.S., relating to the terms of office of directors and section 7-5-103, C.R.S., relating to the classification of directors, a professional service corporation for the practice of medicine may provide in the articles of incorporation or the bylaws that the directors may have terms of office of up to six years and that the directors may be divided into either two or three classes, each class to be as nearly equal in number as possible, with the terms of each class staggered to provide for the periodic, but not annual, election of less than all the directors.

Editor's note: This version of paragraph (f) is effective until July 1, 1994.

(f) The president shall be a shareholder and a director and, to the extent possible, all other directors and officers shall be persons having the qualifications described in paragraph (d) of this subsection (1). Lay directors and officers shall not exercise any authority whatsoever over professional matters. Notwithstanding sections 7-108-103 to 7-108-106, C.R.S., relating to the terms of office and classification of directors, a professional service corporation for the practice of medicine may provide in the articles of incorporation or the bylaws that the directors may have terms of office of up to six years and that the directors may be divided into either two or three classes, each class to be as nearly equal in number as possible, with the terms of each class staggered to provide for the periodic, but not annual, election of less than all the directors.

Editor's note: This version of paragraph (f) is effective July 1, 1994.

(g) The articles of incorporation shall provide and all shareholders of the corporation shall agree that all shareholders of the corporation shall be jointly and severally liable for all acts, errors, and omissions of the employees of the corporation or that all shareholders of the corporation shall be jointly and severally liable for all acts, errors, and omissions of the employees of the corporation except during periods of time when each person licensed by the board to practice medicine in Colorado who is a shareholder or any employee of the corporation has a professional liability policy insuring himself and all employees who are not licensed to practice medicine who act at his direction in the amount of fifty thousand dollars for each claim and an aggregate top limit of liability per year for all claims of one hundred fifty thousand dollars or the corporation maintains in good standing professional liability insurance which shall meet the following minimum standards:

(I) The insurance shall insure the corporation against liability imposed upon the corporation by law for damages resulting from any claim made against the corporation arising out of the performance of professional services for others by those officers and employees of the corporation who are licensed by the board to practice medicine.

(II) Such policies shall insure the corporation against liability imposed upon it by law for damages arising out of the acts, errors, and omissions of all nonprofessional employees.

(III) The insurance shall be in an amount for each claim of at least fifty thousand dollars multiplied by the number of persons licensed to practice medicine employed by the corporation. The policy may provide for an aggregate top limit of liability per year for all claims of one hundred fifty thousand dollars also multiplied by the number of persons licensed to practice medicine employed by the corporation, but no firm shall be required to carry insurance in excess of three hundred thousand dollars for each claim with an aggregate top limit of liability for all claims during the year of nine hundred thousand dollars.

(IV) The policy may provide that it does not apply to: Any dishonest, fraudulent, criminal, or malicious act or omission of the insured corporation or any stockholder or employee thereof; the conduct of any business enterprise, as distinguished from the practice of medicine, in which the insured corporation under this section is not permitted to engage but which nevertheless may be owned by the insured corporation or in which the insured corporation may be a partner or which may be controlled, operated, or managed by the insured corporation in its own or in a fiduciary capacity, including the ownership, maintenance, or use of any property in connection therewith; when not resulting from breach of professional duty, bodily injury to, or sickness, disease, or death of any person, or to injury to or destruction of any tangible property, including the loss of use thereof; and such policy may contain reasonable provisions with respect to policy periods, territory, claims, conditions, and other usual matters.

(2) Repealed, L. 85, p. 524, sec. 17, effective July 1, 1985.

(3) The corporation shall do nothing which, if done by a person licensed to practice medicine in the state of Colorado employed by it, would violate the standards of professional conduct as provided for in section 12-36-117. Any violation by the corporation of this section shall be grounds for the board to terminate or suspend its right to practice medicine.

(4) Nothing in this section shall be deemed to diminish or change the obligation of each person licensed to practice medicine employed by the corporation to conduct his practice in accordance with the standards of professional conduct provided for in section 12-36-117. Any person licensed by the board to practice medicine who by act or omission causes the corporation to act or fail to act in a way which violates such standards of professional conduct, including any provision of this section, shall be deemed personally responsible for such act or omission and shall be subject to discipline therefor.

(5) Nothing in this section shall be deemed to modify the physician-patient privilege specified in section 13-90-107 (1) (d), C.R.S.

(6) A professional service corporation may adopt a pension, profit-sharing (whether cash or deferred), health and accident, insurance, or welfare plan for all or part of its employees including lay employees if such plan does not require or result in the sharing of specific or identifiable fees with lay employees, and if any payments made to lay employees, or into any such plan in behalf of lay employees, are based upon their compensation or length of service, or both, rather than the amount of fees or income received.

(7) Except as provided in this section, corporations shall not practice medicine. Employment of a physician in accordance with section 25-3-103.7, C.R.S., shall not be considered the corporate practice of medicine.

12-36-135. Injuries to be reported - penalty for failure to report - immunity from liability. (1) It shall be the duty of every physician who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument which he believes to have been intentionally inflicted upon a person, or any other injury which he has reason to believe involves a criminal act to report such injury at once to the police of the city, town, or city and county or the sheriff of the county in which the physician is located. Any physician who fails to make a report as required by this section commits a class 2 petty offense, as defined by section 18-1-107, C.R.S., and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars, or by imprisonment in the county jail for not more than ninety days, or by both such fine and imprisonment.

(2) Any physician who, in good faith, makes a report pursuant to subsection (1) of this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making of such report, and shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

12-36-136. Determination of death. (1) An individual is dead if:

(a) He has sustained irreversible cessation of circulatory and respiratory functions; or

(b) He has sustained irreversible cessation of all functions of the entire brain, including the brain stem.

(2) A determination of death under this section shall be in accordance with accepted medical standards.

12-36-137. Inactive license. (1) Any person licensed to practice medicine pursuant to section 12-36-114 may apply to the board to be transferred to an inactive status. Such application shall be in the form and manner designated by the board. The board may grant such status by issuing an inactive license or it may deny the application as set forth in section 12-36-116.

(2) Any person applying for a license under this section shall:

(a) Provide an affidavit to the board that the applicant, after a date certain, shall not practice medicine in this state unless the applicant is issued a license to practice medicine pursuant to subsection (5) of this section;

(b) Pay the license fee as authorized pursuant to section 12-36-112; and

(c) Comply with any financial responsibility standards promulgated by the board pursuant to section 13-64-301 (1), C.R.S.

(3) Such inactive status shall be plainly indicated on the face of any inactive license issued under this section.

(4) The board is authorized to undertake disciplinary proceedings as set forth in sections 12-36-117 and 12-36-118 against any person licensed under this section for any act committed while the person was licensed pursuant to this article.

(5) Any person licensed under this section who wishes to resume the practice of medicine shall file an application in the form and manner the board shall designate, pay the license fee promulgated by the board pursuant to section 12-36-112, and meet the financial responsibility requirements promulgated by the board pursuant to section 13-64-301 (1), C.R.S. The board may approve such application and issue a license to practice medicine or may deny the application as set forth in section 12-36-116.

12-36-138. Rules and regulations - compliance with reporting requirements of federal act. (Repealed)

Repealed, effective July 1, 1989.

12-36-139. Limitations on liability relating to professional review actions. (Repealed)

Repealed, effective July 1, 1989.

12-36-201. Legislative declaration. (1) The general assembly hereby finds, determines, and declares that public exposure to the hazards of ionizing radiation used for diagnostic purposes should be minimized wherever possible. Accordingly, the general assembly finds, determines, and declares that for any physician licensed to practice medicine to allow an untrained person to operate a machine source of ionizing radiation, including without limitation a device commonly known as an "x-ray machine", or to administer such radiation to a patient for diagnostic purposes is a threat to the public health and safety.

(2) It is the intent of the general assembly that physicians licensed to practice medicine utilizing unlicensed persons in their practices provide those persons with a minimum level of education and training before allowing them to operate machine sources of ionizing radiation; however, it is not the general assembly's intent to discourage education and training beyond this minimum. It is further the intent of the general assembly that established minimum training and education requirements correspond as closely as possible to the requirements of each particular work setting as determined by the Colorado state board of medical examiners pursuant to this part 2.

(3) The general assembly seeks to ensure, and accordingly declares its intent, that in promulgating the rules and regulations authorized by this part 2, the board will make every effort, consistent with its other statutory duties, to avoid creating a shortage of qualified individuals to operate machine sources of ionizing radiation for beneficial medical purposes in any area of the state.

12-36-202. Board authorized to issue regulations. (1) (a) The Colorado state board of medical examiners shall adopt rules and regulations prescribing minimum standards for the qualifications, education, and training of unlicensed persons operating machine sources of ionizing radiation and administering such radiation to patients for diagnostic medical use. No licensed physician shall allow any unlicensed person to operate any machine source of ionizing radiation or to administer any such radiation to any patient unless such person has met the standards then in effect under rules and regulations adopted pursuant to this section. The board may adopt rules and regulations allowing a grace period in which newly hired operators of machine sources of ionizing radiation shall receive the training required pursuant to this section.

(b) For purposes of this part 2, "unlicensed person" means any person who does not hold a current and active license entitling the person to practice medicine under the provisions of this article.

(2) The board shall seek the assistance of licensed physicians in developing and formulating the rules and regulations promulgated pursuant to this section.

(3) The required number of hours of training and education for all unlicensed persons operating machine sources of ionizing radiation and administering such radiation to patients shall be established by the board by rule on or before July 1, 1992. This standard shall apply to all persons in medical settings other than hospitals and similar facilities licensed by the department of health pursuant to section 25-1-107, C.R.S. Such training and education may be obtained through programs approved by the appropriate authority of any state or through equivalent programs and training experience including on-the-job training as determined by the board.

READER RESPONSE FORM

TO: Colorado Department of Regulatory Agencies
Office of Policy and Research
1560 Broadway, Suite 1550
Denver, CO 80202

RE: Sunrise/Sunset Report on
(Report Title and Date)

FROM:
(Your Name and Address)

DATE:

I have read your report and found it:

Excellent _____ Good _____ Fair _____ Poor _____

Here are my suggestions for improving the report:

The report was thorough in its coverage of the subject:

Yes _____ No _____

Comments:

The report was fair in its treatment of the issues:

Yes _____ No _____

Comments:

Thank you for your response. We hope you found our report useful.

Revised January, 1994.