

**SUNSET EVALUATION REPORT**  
**MEDICINE AND SURGERY**  
**Chapter 453, Hawaii Revised Statutes**

**A Report to the Governor and the Legislature of the State of Hawaii**

**Submitted by the**  
**Legislative Auditor of the State of Hawaii**

**Report No. 84-5**  
**January 1984**

## FOREWORD

Under the "Sunset Law," licensing boards and commissions and regulated programs are terminated at specified times unless they are reestablished by the Legislature. Hawaii's Sunset Law, or the Hawaii Regulatory Licensing Reform Act of 1977, scheduled for termination 38 occupational licensing programs over a six-year period. These programs are repealed unless they are specifically reestablished by the Legislature. In 1979, the Legislature assigned the Office of the Legislative Auditor responsibility for evaluating each program prior to its repeal.

This report evaluates the regulation of medicine and surgery under Chapter 453, Hawaii Revised Statutes. It presents our findings as to whether the program complies with the Sunset Law and whether there is a reasonable need to regulate medicine and surgery to protect public health, safety, or welfare. It includes our recommendation on whether the program should be continued, modified, or repealed.

We acknowledge the cooperation and assistance extended to our staff by the Board of Medical Examiners, the Department of Commerce and Consumer Affairs, and other officials contacted during the course of our examination.

Clinton T. Tanimura  
Legislative Auditor  
State of Hawaii

January 1984

## TABLE OF CONTENTS

<i>Chapter</i>		<i>Page</i>
1	INTRODUCTION .....	1
	Objective of the Evaluation .....	1
	Scope of the Evaluation .....	1
	Organization of the Report .....	1
	Framework for Evaluation .....	2
2	MEDICINE AND SURGERY .....	7
	Occupational Characteristics of Physicians .....	7
	Occupational Characteristics of Physician's Assistants .....	13
	Occupational Characteristics of Emergency Ambulance Personnel .....	15
	Nature of Regulation in Hawaii .....	19
3	EVALUATION OF THE REGULATION OF MEDICINE AND SURGERY .....	25
	Summary of Findings .....	25
	Need for Regulation .....	26
	Regulation of Physician-Support Personnel and Physician's Assistants .....	27
	Licensing Standards for Foreign Medical Graduates .....	30
	Applications Administration .....	33
	Enforcement Program .....	35
	Board Organization and Operations .....	46
	Recommendations .....	50

<i>Chapter</i>		<i>Page</i>
4	EVALUATION OF THE REGULATION OF EMERGENCY AMBULANCE PERSONNEL .....	53
	Summary of Findings .....	53
	Need for Regulation .....	53
	Regulatory Standards .....	54
	Regulatory Operations .....	60
	Recommendations .....	63
	Appendix: Responses of Affected Agencies .....	65

#### LIST OF TABLES

<i>Table</i>		<i>Page</i>
3.1	Number and Type of Medical Complaint Cases Filed Between January 1, 1979 and June 30, 1983 .....	27
3.2	Information Reporting Requirements .....	37

## Chapter 1

### INTRODUCTION

The Hawaii Regulatory Licensing Reform Act of 1977, or Sunset Law, repeals statutes concerning 38 state licensing boards and commissions over a six-year period. Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.

In 1979, the Legislature amended the law to make the Legislative Auditor responsible for evaluating each licensing program prior to its repeal and to recommend to the Legislature whether the statute should be reenacted, modified, or permitted to expire as scheduled. In 1980, the Legislature further amended the law to require the Legislative Auditor to evaluate the effectiveness and efficiency of the licensing program, even if he determines that the program should not be reenacted.

#### Objective of the Evaluation

The objective of the evaluation is: To determine whether, in light of the policies set forth in the Sunset Law, the public interest is best served by reenactment, modification, or repeal of Chapter 453, Hawaii Revised Statutes.

#### Scope of the Evaluation

This report examines the history of the statute on the regulation of medicine and surgery and the public health, safety, or welfare that the statute was designed to protect. It then assesses the effectiveness of the statute in preventing public injury and the continuing need for the statute.

#### Organization of the Report

This report consists of four chapters: Chapter 1, this introduction and the framework developed for evaluating the licensing program; Chapter 2, background information on the regulated industry and the enabling legislation; Chapter 3, our evaluation and recommendations on the operations of the Board of Medical Examiners with respect to the practice of medicine by physicians and

physician-support personnel; and Chapter 4, our evaluation and recommendations on the board's regulation of emergency ambulance service personnel.

### **Framework for Evaluation**

Hawaii's Regulatory Licensing Reform Act of 1977, or Sunset Law, reflects rising public antipathy toward what is seen as unwarranted government interference in citizens' lives. The Sunset Law sets up a timetable terminating various occupational licensing boards. Unless reestablished, the boards disappear or "sunset" at a prescribed moment in time.

In the Sunset Law, the Legislature established policies on the regulation of professions and vocations. The law requires that each occupational licensing program be assessed against these policies in determining whether the program should be reestablished or permitted to expire as scheduled. These policies, as amended in 1980, are:

1. The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

2. Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form of full licensure or other restrictions on the professions or vocations should be retained or adopted.

3. Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

4. Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

5. Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

6. Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

7. Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

We translated these policy statements into the following framework for evaluating the continuing need for the various occupational licensing statutes.

Licensing of an occupation or profession is warranted if:

1. There exists an identifiable potential danger to public health, safety, or welfare arising from the operation or conduct of the occupation or profession.
2. The public that is likely to be harmed is the consuming public.
3. The potential harm is not one against which the public can reasonably be expected to protect itself.
4. There is a reasonable relationship between licensing and protection of the public from potential harm.
5. Licensing is superior to other optional ways of restricting the profession or vocation to protect the public from the potential harm.
6. The benefits of licensing outweigh its costs.

**The potential harm.** For each regulatory program under review, the initial task is to identify the purpose of regulation and the dangers from which the public is intended to be protected.

Not all potential dangers warrant the exercise of the State's licensing powers. The exercise of such powers is justified only when the potential harm is to public health, safety, or welfare. "Health" and "safety" are fairly well understood. "Welfare" means well-being in any respect and includes physical, social, and economic well-being.

This policy that the potential danger be to the public health, safety, or welfare is a restatement of general case law. As a general rule, a state may exercise its police power and impose occupational licensing requirements only if such requirements tend to promote the public health, safety, or welfare. Under particular fact situations and statutory enactments, courts have held that licensing requirements for paperhangers, housepainters, operators of public dancing schools, florists, and

private land surveyors could not be justified.<sup>1</sup> In Hawaii, the State Supreme Court in 1935 ruled that legislation requiring photographers to be licensed bore no reasonable relationship to public health, safety, or welfare and constituted an unconstitutional encroachment on the right of individuals to pursue an innocent profession.<sup>2</sup> The court held that mere interest in the practice of photography or in ensuring quality in professional photography did not justify the use of the State's licensing powers.

**The public.** The Sunset Law states that for the exercise of the State's licensing powers to be justified, not only must there be some potential harm to public health, safety, or welfare, but also the potential harm must be to the health, safety, or welfare of that segment of the public consisting mainly of consumers of the services rendered by the regulated occupation or profession. The law makes it clear that the focus of protection should be the consuming public and not the regulated occupation or profession itself.

Consumers are all those who may be affected by the services rendered by the regulated occupation or profession. Consumers are not restricted to those who purchase the services directly. The provider of services may have a direct contractual relationship with a third party and not with the consumer, but the criterion set forth here may be met if the provider's services ultimately flow to and adversely affect the consumer. For example, the services of an automobile mechanic working for a garage or for a U-drive establishment flow directly to the employer, but the mechanic's workmanship ultimately affects the consumer who brings a car in for repairs or who rents a car from the employer. If all other criteria set forth in the framework are met, the potential danger of poor workmanship to the consuming public *may* qualify an auto mechanic licensing statute for reenactment or continuance.

**Consumer disadvantage.** The consuming public does not require the protection afforded by the exercise of the State's licensing powers if the potential harm is one from which the consumers can reasonably be expected to adequately protect themselves. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the provider of services.

1. See discussion in 51 *American Jurisprudence*, 2d., "Licenses and Permits," Sec. 14.

2. *Terr. v. Fritz Kraft*, 33 Haw. 397.

Consumer disadvantage can arise from a variety of circumstances. It may result from a characteristic of the consumer or from the nature of the occupation or profession being regulated. Age is an example of a consumer characteristic which may cause the consumer to be at a disadvantage. The highly technical and complex nature of the occupation is an illustration of occupational character that may result in the consumer being at a disadvantage. Medicine and law fit into the latter illustration. Medicine and law were the first occupations to be licensed on the theory that the general public lacked sufficient knowledge about medicine and law to enable them to make judgments about the relative competencies of doctors and lawyers and about the quality of services provided them by the doctors and lawyers of their choice.

However, unless otherwise indicated, consumers are generally assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them.

**Relationship between licensing and protection.** Occupational licensing cannot be justified unless it reasonably protects the consumers from the identified potential harm. If the potential harm to the consumer is physical injury arising from possible lack of competence on the part of the provider of service, the licensing requirement must ensure the competence of the provider. If, on the other hand, the potential harm is the likelihood of fraud, the licensing requirements must be such as to minimize the opportunities for fraud.

**Alternatives.** Depending on the harm to be protected against, licensing may not be the most suitable form of protection for the consumers. Rather than licensing, the prohibition of certain business practices, governmental inspection, or the inclusion of the occupation within some other existing business regulatory statute may be preferable, appropriate, or more effective in providing protection to the consumers. Increasing the powers, duties, or role of the consumer protector is another possibility. For some programs, a nonregulatory approach may be appropriate, such as consumer education.

**Benefit-costs.** Even when all other criteria set forth in this framework are met, the exercise of the State's licensing powers may not be justified if the costs of doing so outweigh the benefits to be gained from such exercise of power. The term, "costs," in this regard means more than direct money outlays or expenditure for a

licensing program. "Costs" includes opportunity costs or all real resources used up by the licensing program; it includes indirect, spillover, and secondary costs. Thus, the Sunset Law asserts that regulation which artificially increases the costs of goods and services to the consumer should be avoided; and regulation should not unreasonably restrict entry into professions and vocations by all qualified persons.

## Chapter 2

### MEDICINE AND SURGERY

Chapter 453, Hawaii Revised Statutes, establishes the Board of Medical Examiners to regulate the practice of medicine and surgery in Hawaii. It is authorized to license physicians, set standards for the education and training of physician-support personnel and physician's assistants, and certify emergency ambulance personnel.

This chapter reviews the occupational characteristics of the medical profession, the physician's assistant occupation, and the emergency ambulance service occupation. It also summarizes the State's medical practice act and describes the current roles and responsibilities of the Board of Medical Examiners.

#### Occupational Characteristics of Physicians

Medicine is defined as the art and science of the diagnosis and treatment of disease and the maintenance of health.<sup>1</sup> Physicians diagnose illnesses and injuries, treat patients, and advise patients on how to stay healthy. Physicians also engage in medical research, teaching, and administration.

In 1980, there were more than 460,000 physicians in the United States, including approximately 410,000 who were known to be professionally active. Two-thirds of the active physicians were engaged in office-based practice, a fourth worked in hospitals, and the remainder worked in medical research, teaching, and administration.<sup>2</sup>

**Development of the medical profession in the United States.** During colonial times, most physicians entered medical practice after serving an apprenticeship with established physicians. Few restraints were placed on the

1. *Dorland's Illustrated Medical Dictionary*, 26th Edition, Philadelphia, W.B. Saunders Company, 1981, p. 785.

2. U.S. Public Health Service, National Center for Health Statistics, *Health United States 1982*, Hyattsville, Md., United States Government Printing Office, December 1982, p. 114.

practice of medicine until 1760 when New York City passed a law requiring physicians to be licensed by examination in order to practice medicine or surgery. Twelve years later, New Jersey passed a similar law and by 1830, nearly all states had adopted some sort of medical practice regulations.<sup>3</sup> The rationale for these regulations was to protect the public against quacks and charlatans.

The early licensing laws were not very effective for several reasons. They did not exclude unlicensed persons from practicing medicine, did not enjoy widespread public support, and were not based on uniform standards of medical education.

Folk medicine and medical sects, such as practitioners of botanic medicine and homeopathy, competed with regular medicine. The various sects established their own medical schools and enjoyed great public popularity. Sectarian practitioners campaigned for a repeal of medical licensing laws claiming that the right to practice medicine was a basic freedom similar to the freedom of religion. Public skepticism about the effectiveness of regular medicine in treating illnesses and injuries, and a general opposition to the regulation of professions, lent support to the campaign against regulation. By 1850, most states had repealed their licensing laws.<sup>4</sup>

In 1847, a group of physicians established the American Medical Association (AMA) to develop a code of ethics for the medical profession and raise standards of medical education in the United States.<sup>5</sup> The association began to campaign for the reenactment of medical licensing laws and the establishment of state boards of medical examiners. Its campaign eventually drew support from sectarian practitioners who began to collaborate with physicians to obtain protection against untrained practitioners. The general public also began to support licensing because of advances in scientific medicine. In 1873, Texas established the first modern state board of medical examiners and by 1898, medical practice regulations had been enacted in all states.<sup>6</sup>

3. Richard Shryock, *Medical Licensing in America 1650-1965*, Baltimore, The Johns Hopkins Press, 1967, p. 23.

4. *Ibid.*, p. 30.

5. Morris Fishbein, *A History of the American Medical Association 1847-1947*, Philadelphia, W.B. Saunders Company, 1947, p. 25.

6. Shryock, *Medical Licensing in America 1650-1965*, pp. 54-55.

Despite licensing, entry into the medical profession remained relatively easy. The new licensing boards accepted graduates from any medical school as qualifying for licensure even though there were no uniform standards for medical schools. There were many profit-making medical schools with inadequate training programs which graduated physicians who were unqualified to practice medicine.

In the early 1900s, several movements to upgrade medical education converged, and as a result, state medical boards raised their licensure standards. The AMA made the reform of medical education its top priority. The association established a Council on Medical Education to raise and standardize medical education. It began to inspect and grade medical schools according to preset criteria. The Carnegie Foundation published a report in 1910 documenting widespread deficiencies in medical school curricula, faculties, facilities, and equipment. The foundation urged the abandonment of some schools, the merger of other schools with stronger institutions, and the production of fewer and better trained physicians.<sup>7</sup> At about the same time, the Association of American Medical Colleges began to require its members to maintain higher standards of medical education. Due to the various reform movements and the higher requirements established by state medical boards, 76 medical schools went out of business between 1906 and 1920.<sup>8</sup> The schools which remained tightened up their admission criteria and began to incorporate scientific training into their programs.

One of the side-effects of the reform movement was the development of a shortage of physicians in the United States. This shortage was aggravated as a result of World War II. Subsequently, immigration policies were adopted to encourage foreign medical graduates to emigrate to the United States. These policies remained in effect until the mid-1970s when new and expanded United States medical schools began to graduate larger numbers of physicians. Today, approximately 20 percent of all physicians in the United States are immigrants.<sup>9</sup>

**Education of physicians in the United States.** Physicians must have an enormous amount of scientific and technological knowledge in order to carry out

7. Paul Starr, *The Social Transformation of American Medicine*, New York, Basic Books, Inc., 1982, pp. 117-120.

8. James Bordley III, M.D. and A. McGehee Harvey, M.D., *Two Centuries of American Medicine: 1776-1976*, Philadelphia, W.B. Saunders Company, 1976, p. 165.

9. Starr, *The Social Transformation of American Medicine*, p. 427.

their role to prevent, control, and cure illnesses and injuries. They must be committed to an extended period of formal education and a lifetime of continuing education.

Medical education in the United States is strictly controlled by private national organizations sponsored by the medical profession. The Liaison Committee on Medical Education accredits medical schools; the Accreditation Council for Graduate Medical Education accredits graduate training programs together with review committees from various medical specialty organizations; and the Accreditation Council on Continuing Medical Education accredits continuing education courses for the AMA and various other organizations.<sup>10</sup>

Most medical schools in the United States require applicants to complete four years of undergraduate education to qualify for admission. Medical schools consist of another four years in which students learn basic medical sciences, clinical sciences and the art of taking patient histories and performing physical examinations. Students learn to use scientific and clinical data to arrive at clinical hypotheses and therapeutic decisions.

Students are awarded an M.D. degree when they graduate from medical school. Because the M.D. degree is no longer considered to be sufficient qualification for the independent practice of medicine, most new physicians enter a three to five year program of graduate medical education where they are known as "residents" or "resident physicians." Graduate programs are organized around medical specialty fields such as internal medicine or family practice. They are designed to allow physicians to assume progressively greater personal responsibility for patient care in a supervised, clinical setting. Completion of a graduate program qualifies physicians to apply for certification in their chosen specialty fields. Certification is awarded by private professional organizations and is unrelated to state licensing requirements.

Upon completing their formal education, most physicians in independent practice continue a program of study in order to keep up with changes in medical

10. Hedvah Shuchman et al, *Self-Regulation in the Professions: Medicine*, Glastonbury, Conn., The Futures Group, July 1981, pp. 7-8.

science and technology. Some physicians take formal courses of study in their specialty field; other physicians arrange their own course of study.

**Foreign medical graduates.** The medical profession has developed a national program for evaluating the qualifications of foreign medical graduates who wish to practice in this country. The Educational Commission for Foreign Medical Graduates (ECFMG) will certify physicians who meet the following requirements: (1) graduate from a recognized four year foreign medical school, (2) complete all educational requirements to practice medicine in the school's country, (3) obtain an unrestricted license to practice medicine in that country if a national of the country, and (4) pass a written examination.<sup>11</sup>

The AMA has also developed the "Fifth Pathway Program" to assist U.S. citizens who studied medicine in a foreign country to enter practice in this country. It will certify physicians who: (1) complete their undergraduate education in an accredited United States college or university, (2) graduate from a recognized foreign medical school, (3) complete all educational requirements of the medical school except for internship and/or social service, and (4) successfully complete one year of supervised clinical training in an approved U.S. program.<sup>12</sup> Physicians with ECFMG or Fifth Pathway Program certificates are eligible for appointment to graduate residency programs in the United States.

**Licensing.** All states require physicians to graduate from medical schools accredited by the Liaison Committee on Medical Education, or to be certified by the ECFMG in order to qualify for licensure. All but four states permit physicians who hold Fifth Pathway Program certificates to qualify for licensure on the same basis as ECFMG certified physicians. In addition, nearly all states require physicians to complete one or more years of an approved graduate residency program.

All states also require physicians to pass a written national examination. The Federation Licensing Examination, developed by the Federation of State Medical Boards, is used as the state board examination in all states. Most states will also accept certification by the National Board of Medical Examiners (NBME) in lieu of

11. Educational Commission for Foreign Medical Graduates, *1983 ECFMG Information Booklet*, Philadelphia, 1983, p. 7.

12. American Medical Association, *U.S. Medical Licensure Statistics 1980-1981 and Licensure Requirements 1982*, Chicago, 1982, pp. 7-11.

their state board examination requirement.<sup>13</sup> One of the requirements for NBME certification is successful completion of the NBME examination.

**Development of the medical profession in Hawaii.** Physicians first came to the Hawaiian Islands in 1778 on sailing ships commanded by Captain James Cook. The first foreign trained physician to reside in the islands arrived from Brazil in 1811 to serve as physician and secretary to King Kamehameha I. Nine years later, the first of several medical missionaries arrived from Boston to practice medicine in the islands. Shortly thereafter, other physicians began to settle in the islands.

In 1856, a group of physicians received a Royal Charter from King Kamehameha IV to establish the Hawaii Medical Association.<sup>14</sup> The purposes of this organization were to collect and diffuse medical knowledge in the islands, advance the interests of the medical profession, and cultivate harmony and good feeling among its members.

At about the same time, the first law regulating the practice of medicine in Hawaii was passed. It was unlawful for foreign-born physicians to practice unless they had presented evidence of their professional qualifications and good moral character to the Kingdom's Board of Health and obtained a certificate of approval from the Board of Health and a license from the Minister of the Interior.<sup>15</sup> In 1865, these regulations were extended to include physicians born in the islands by making it unlawful for any unlicensed person to practice medicine for compensation.<sup>16</sup>

In 1880, an act was passed specifically to regulate Chinese physicians. The Minister of the Interior was authorized to issue medical licenses to Chinese physicians who presented a diploma or authority to practice medicine in China, demonstrated good moral character, and presented evidence of identity. All documents had to be certified by the Chinese consulate. Once licensed, Chinese physicians were subject to the same laws as other physicians. In 1896, a Board of Medical Examiners was established to regulate all physicians and surgeons in

13. *Ibid.*, p. 12.

14. Editorial, "The Hawaii Medical Association Through the Years," *Hawaii Medical Journal*, 40:10, September 1981, p. 270.

15. Section 279, *The Civil Code of the Hawaiian Islands, Passed in the Year of Our Lord 1859*, Honolulu, 1859, p. 63.

16. *Laws of His Majesty Kamehameha V, King of the Hawaiian Islands, Passed by the Legislative Assembly at its Session, 1864-1865*, Honolulu, 1865, p. 7.

the islands, including Chinese practitioners. Since then, the medical practice act has been amended more than 60 times.

Today, there are 3,438 licensed physicians in Hawaii. Fifty-two percent of the physicians live on the island of Oahu, 11 percent live on the neighbor islands, and 37 percent live on the mainland or abroad.<sup>17</sup>

The major professional organization is the Hawaii Medical Association which has approximately 1,200 members, including currently licensed physicians, retired physicians, and medical students.<sup>18</sup> The association's purposes are to maintain the quality of medical care in the community, to strengthen and promote the interests of organized medicine, and to promote communication between the profession and the general public.

### **Occupational Characteristics of Physician's Assistants**

Physician's assistants diagnose and treat routine illnesses and injuries under the supervision of physicians. They take patient histories, perform physical examinations, perform diagnostic and therapeutic procedures, and provide follow-up care and patient education. Some physician's assistants are trained to work in medical specialty fields such as surgery or urology.

The concept of using physician's assistants to extend the delivery of medical care arose during the 1960s as a means of coping with the shortage of primary care physicians in the United States. Duke University offered the first physician's assistant training program in 1965. Its objectives were to utilize the skills and knowledge of ex-military medical corpsmen in order to upgrade the quality and reduce the cost of medical care for residents of rural and inner-city communities.<sup>19</sup> Physician's assistant training programs now admit students from a variety of health care backgrounds.

Research on the physician's assistant occupation has found that qualified physician's assistants are able to care for more than 60 percent of the

17. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*, October 1983.

18. Interview with Jennie Asato, Director of Communications, Hawaii Medical Association, April 22, 1983.

19. "Physician Assistants, Controversy Swirls Around New Profession," *Washington Post*, September 7, 1981.

patients who visit a family practitioner's office on any given day. It has also found that these new health professionals provide high quality medical care. A 1979 study concluded that physician extenders, which include physician's assistants and nurse practitioners:

"... have performed as well as physicians with respect to patient outcomes, proper diagnoses, management of 'indicator' medical conditions, frequency of patient hospitalization, manner of drug prescription, documentation of medical findings, and patient satisfaction."<sup>20</sup>

In 1980, there were approximately 9,500 employed physician's assistants in the United States. Most worked for physicians in private practice. About 25 percent were employed in hospitals, including Veterans Administration and Public Health Service hospitals, and a small number worked for prepaid health clinics.<sup>21</sup>

The number of physician's assistants working in Hawaii is unknown because the State does not have a mandatory certification program for this occupation, and it keeps no records on these practitioners. However, as of October 1983, ten physician's assistants had been certified by the board under a voluntary program.<sup>22</sup>

**Education and certification of physician's assistants.** In 1971, AMA recognized the new occupation and developed standards for the accreditation of physician's assistant training programs. Today, there are 55 accredited training programs for assistants to the primary care physician and three accredited training programs for surgeon's assistants.<sup>23</sup>

Prerequisites for admission into physician's assistant training programs usually include two years of undergraduate education with coursework in the basic sciences and some work experience in the health care field.

Accredited training programs are generally between 18 and 24 months long. The curriculum, which is based on the medical school model, is divided into two

20. U.S. Congressional Budget Office, *Physician Extenders: Their Current and Future Role in Medical Care Delivery, Background Paper*, Washington, D.C., U.S. Government Printing Office, April 1979, p. 11.

21. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, 1982-83 Edition, Washington, D.C., April 1982, p. 168.

22. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*.

23. Association of Physician Assistant Programs, *National Health Practitioner Program Profile 1983-1984*, Sixth Edition, Arlington, Va., 1982, p. 14.

parts. The first part includes classroom instruction in the basic medical sciences of anatomy, microbiology, pathology, pharmacology, physiology, and behavioral sciences. It also includes instruction in clinical diagnosis and preventive medicine. The second part includes clinical training in medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery. Upon graduation, physician's assistants are awarded a certificate or undergraduate degree. They are then eligible to take advanced training in ten medical specialty fields.

In 1972, the AMA collaborated with the National Board of Medical Examiners to develop a national board examination for physician's assistants. The first national board examination was offered in 1973. In 1975, the National Commission on Certification of Physician's Assistants (NCCPA) assumed the responsibility for administering the examination and certifying successful candidates. There were more than 9,000 nationally certified physician's assistants in the United States in 1981.<sup>24</sup>

Almost all states permit physician's assistants to practice medicine under the supervision of physicians, but states vary in their qualifying standards for physician's assistants, in the permitted scope of practice, and in the level of supervision required. Some states require approval over each supervisory relationship, and some states limit the number of physician's assistants that any one physician can employ.

States also vary in their standards for the education and certification of physician's assistants. Most states require physician's assistants to pass the NCCPA examination in order to qualify for state certification, and 17 states require them to graduate from AMA approved training programs.<sup>25</sup>

### **Occupational Characteristics of Emergency Ambulance Personnel**

Emergency ambulance personnel deliver pre-hospital emergency medical care to patients at the scene of an accident or sudden illness. They diagnose and treat a

24. Association of Physician Assistant Programs, *National Health Practitioner Program Profile 1983-1984*, p. 10.

25. The American Academy of Physician Assistants, *Summary of State Laws and Regulations for Physician Assistants*, Arlington, Va., November 1982.

variety of routine and serious medical emergencies under the direct or indirect supervision of physicians. They engage in rescue work and the transportation of invalid patients. They must also use and maintain medical and communications equipment and be able to work effectively under stressful conditions.

Until recently, ambulance services in the United States were provided by ambulance attendants with little or no medical training. The concept of using medically trained technicians to deliver medical services at the scene of an emergency was developed by the military during World War II and the Korean War. The more effective delivery of emergency medical services in the field reduced the death rate of battle casualties from 8 percent in World War I to less than 2 percent in Vietnam.<sup>26</sup>

In the 1960s, the concept of using medically trained technicians to deliver medical services at the scene of an emergency was incorporated into a nationwide drive to upgrade emergency ambulance services. This campaign received its impetus from the National Highway Safety Act that called for the development of standards for emergency medical services, including standards for the certification of emergency ambulance personnel.

The campaign was fueled by a report issued by the National Academy of Sciences that found that accidents were the leading cause of death among persons between the ages of one and 37, the fourth leading cause of death at all ages, and the primary cause of disability in this country. The academy called for a concerted effort to develop and mobilize emergency medical services to tackle what was termed a national "epidemic" of accidental death and disability. The academy also called for the development of standards for qualifying emergency ambulance personnel and for their supervision.<sup>27</sup>

Today, there are three nationally recognized types of emergency ambulance personnel: (1) the emergency medical technician (EMT) who is qualified to provide basic life support services, including such medical procedures as wound care and

26. Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, *Accidental Death and Disability: The Neglected Disease of Modern Society*, Rockville, Maryland, U.S. Government Printing Office, September 1966, p. 12.

27. *Ibid.*, pp. 8-15.

bandaging and cardiopulmonary resuscitation;<sup>28</sup> (2) the emergency medical technician-paramedic (EMT-P) who is qualified to provide a wide variety of advanced life support services, including more sophisticated medical procedures such as cardiac monitoring and starting intravenous therapy;<sup>29</sup> and (3) the emergency medical technician-intermediate (EMT-I) who is qualified to provide a limited number of advanced life support services.<sup>30</sup>

In 1982, there were slightly more than 440,000 emergency ambulance personnel in the United States, including 28,000 paramedics who are trained to provide advanced life support services.<sup>31</sup> In Hawaii, there were 382 board certified emergency ambulance personnel (including 165 paramedics, or mobile intensive care technicians as they are known here), as of October 1983.<sup>32</sup>

**National trends in education and certification of emergency ambulance personnel.** There are thousands of EMT training programs in the United States. Some of these programs are accredited by national organizations such as the National Association of Trade and Technical Schools, and some are approved by state emergency medical services programs. While admission requirements vary, most programs require applicants to be 18 years old, have a high school diploma, and have a valid driver's license. Some programs also require applicants to pass tests of reading comprehension and mathematical ability prior to admission.

Virtually all states follow a national standard EMT curriculum developed by the U.S. Department of Transportation. This curriculum requires a minimum of 81 hours of training in a variety of basic life support skills such as the management of shock and the immobilization of fractures.<sup>33</sup>

28. The National Registry of Emergency Medical Technicians, *Board Certification: Registered EMT-Ambulance and Registered EMT-Non Ambulance*, Columbus, Ohio, March 11, 1981, p. 3.

29. EMT/EMT-P Education Committee, National Association of Emergency Medical Technicians, *Career Information: Emergency Medical Technician and EMT-Paramedic*, Newton Highlands, Mass., no date, p. 1.

30. The National Registry of Emergency Medical Technicians, *Board Certification: Registered EMT-Intermediate*, Columbus, Ohio, January 1983, Foreword.

31. "State Survey," *Emergency Medical Services*, 1:6, October 1982, pp. 90-122.

32. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*.

33. The National Registry of Emergency Medical Technicians, *Board Certification: Registered EMT-Ambulance and Registered EMT-Non Ambulance*, p. 3.

There are some 340 EMT-P training programs in the United States.<sup>34</sup> Some of these programs are accredited by the AMA and others are approved by state emergency medical services programs. Although admission requirements vary, most programs require applicants to complete EMT training programs prior to admission.

Almost all states also follow a national standard EMT-P curriculum developed by the U.S. Department of Transportation. This curriculum requires training in a wide variety of advanced life support skills such as cardiac monitoring and the administration of intravenous therapy.

EMT-I training programs are modified versions of EMT-P programs. EMT-Is receive less training in advanced life support skills than those in EMT-P programs.

The National Registry of Emergency Medical Technicians provides professional certification of emergency ambulance personnel. It certifies emergency ambulance personnel who complete a course of training based on the national standard curricula, pass a national qualifying examination, and complete six months of work experience. The National Registry began to certify EMTs in the early 1970s. In 1978, it began to certify EMT-Ps, and in 1980, it began to certify EMT-Is. The Registry also requires nationally certified emergency ambulance personnel to fulfill continuing education requirements in order to maintain their certification.

In 1971, California was the first state to require emergency ambulance personnel to be state certified. Today, all states require emergency ambulance personnel to be state certified.<sup>35</sup> While certification standards vary among the states, the trend is toward recognition of National Registry certification requirements as the basis for state certification.

**Development of the emergency ambulance service occupation in Hawaii.** In 1915, the Honolulu Board of Supervisors established an emergency station in the police department after an unfortunate death occurred there. In 1916, the first police ambulance was purchased, and the following year, two ambulance attendants were hired to staff the ambulance. The emergency station was eventually moved to the site of what is now Queen's Medical Center.

34. Interview with Al Weigle, The National Registry of Emergency Medical Technicians, June 8, 1983.

35. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 182.

Until about 1970, most ambulance attendants had only basic first aid training. In 1970, the City and County of Honolulu issued a plan to train ambulance attendants to treat patients on their way to the hospital.<sup>36</sup> With a federal grant from the National Highway Traffic Safety Administration, the City and County of Honolulu contracted with the Hawaii Medical Association's Emergency Medical Services Program to develop a training program based on a medical model.

The Hawaii Medical Association designed a two-stage training program. The first stage trained EMTs to deliver basic life support services to patients at the scene of a medical emergency. The second stage trained mobile intensive care technicians (MICTs) to deliver advanced life support services. MICT students were selected from the ranks of EMTs. MICTs are equivalent to the national EMT-P. Today, EMTs and MICTs continue to be trained along the lines designed by the Hawaii Medical Association in the early 1970s. Pursuant to Act 148, SLH 1978, the Board of Medical Examiners is responsible for certifying them. As of October 1983, there were 217 board certified EMTs and 165 board certified MICTs.<sup>37</sup>

#### Nature of Regulation In Hawaii

**Board of Medical Examiners.** The board is composed of nine members who are appointed by the Governor and confirmed by the Senate. Seven members must be licensed Hawaii physicians, including one physician from each neighbor island county. Two must be public members. The members serve without pay but they are reimbursed for their expenses. The director of the department is authorized to hire a civil service-exempt executive secretary to staff the board. The board is authorized to delegate any of its powers and duties to the executive secretary or other department staff except the authority to adopt, amend or repeal rules and regulations; take final disciplinary action against a licensee; or restore a license which was revoked.

The board's overall purview is the regulation of the practice of medicine and surgery in the State. Section 453-1, HRS, defines the practice of medicine as:

36. Dave Shapiro, "Ambulance Master Plan Provides for 'Second Aid,'" *Honolulu Star-Bulletin*, September 26, 1970.

37. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*.

"... the use of drugs and medicines, water, electricity, hypnotism, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject."

Sections 453-1 and 453-2, HRS, permit the following persons to practice medicine without a license:

1. Persons who help others afflicted by a disease which has been declared hopeless by a licensed physician,
2. Persons who act in an emergency, or who engage in the domestic administration of family remedies,
3. Christian Scientists who merely practice their religious beliefs without implying a knowledge of medicine,
4. Commissioned medical officers when they engage in the discharge of their official duties,
5. Licensed out-of-state physicians who consult with licensed Hawaii physicians, and
6. Physician-support personnel and physician's assistants who work under the direction and control of licensed Hawaii physicians.

In addition, health care practitioners regulated by other statutes may practice medicine within the scope of their respective licensing laws.

The board is empowered to issue medical licenses to physicians, set standards for the medical education and training of physician-support personnel and physician's assistants, and certify emergency ambulance personnel. It is also empowered to set standards for informed consent and to administer an information reporting system relating to physician practices and performance. The board may discipline physicians and emergency ambulance personnel for a wide variety of reasons.

**Physicians.** Applicants for licensure must meet the following requirements: (1) demonstrate competence and professional knowledge, (2) graduate from AMA approved medical schools, (3) complete one year of internship or graduate training in AMA approved hospitals or programs or their equivalent, and (4) pass the state board examination. Applicants who are foreign medical graduates must: (1)

demonstrate competence and professional knowledge, (2) pass the qualifying examination of the Educational Commission for Foreign Medical Graduates, (3) complete three years of work experience or training in AMA approved hospitals, and (4) pass the state board examination.

The board may license applicants who are certified by the National Board of Medical Examiners without requiring them to pass the state board examination. In making its licensing decision, the board may require letters of evaluation, professional evaluation forms, and interviews with chiefs of service and chief residents in order to assess applicants' qualifications. The board is also authorized to issue limited and temporary licenses for a variety of reasons to physicians who have not passed the state board examination.

In addition to fulfilling initial licensing requirements, all physicians are required to take 100 hours of continuing medical education every two years in order to renew their licenses.

**Disciplinary authority over licensees.** The original medical practice act authorized the board to revoke medical licenses for professional misconduct, gross carelessness, and manifest incapacity. Over the years, the grounds upon which sanctions may be applied against licensees have increased. Today, the acts or conditions which could cause a license to be revoked, limited or suspended include the following:

1. Procuring a criminal abortion;
2. Employing any person to solicit patients;
3. Engaging in false advertising;
4. Being habituated to excessive use of drugs or alcohol;
5. Practicing medicine while impaired by drugs, alcohol, physical disability, or mental instability;
6. Procuring a license through fraud or permitting an unlicensed person to practice;
7. Professional misconduct, gross carelessness, or manifest incapacity;
8. Negligence or incompetence;

9. Conduct or practice contrary to the recognized ethical standards of the AMA or Hawaii Medical Association;

10. Violation of the conditions of a limited and temporary license;

11. Disciplinary action taken in other states for the same reasons as those cited in Hawaii's statutes;

12. Conviction of an offense substantially related to the qualifications or work of a physician; and

13. Violation of the Uniform Controlled Substance Act.

In connection with its disciplinary responsibilities, the board is required to review all adverse decisions reported to it by the peer review committees of medical societies, hospitals, and other health care institutions. To assist the board in carrying out its function of reviewing cases for possible disciplinary action, the director of Commerce and Consumer Affairs is responsible for appointing a medical advisory committee to serve as consultants to the board.

**Informed consent.** The board is required to establish standards for informed consent to specific treatment and surgical procedures. These standards are to be used as the basis for discussions between physicians and patients about treatment alternatives, risks and benefits.<sup>38</sup> The board's standards of informed consent must include a discussion of the condition being treated, the nature and character of the recommended treatment, and the recognized benefits and risks in the various alternative treatment approaches. In addition, as a result of a law enacted in 1983, the board is specifically required to establish standards for informed consent for surgical treatment of breast cancer.

**Medical professional corporations.** The board has adopted rules and regulations that require medical professional corporations to be licensed. The name of a professional corporation may not include the name of an unlicensed physician and it must be approved by the board. Licensed professional corporations are required to file annual reports with the board and to report all changes in their organization to the board.

38. Conference Committee Report No. 30 on House Bill 2700, Regular Session of 1976.

**Physician-support personnel and physician's assistants.** The board is required to adopt rules setting standards governing the medical education and training of physician-support personnel and physician's assistants that are at least equivalent to national standards.

In 1981, the board adopted rules establishing a voluntary certification program for physician's assistants. These rules require physician's assistants to graduate from AMA approved training programs, pass the qualifying examination of the National Commission on Certification of Physician's Assistants, and demonstrate good character and reputation, in order to qualify for certification. They also require certified physician's assistants to fulfill continuing medical education requirements in order to renew their certification every two years.

**Emergency ambulance personnel.** The board is required to certify emergency ambulance personnel who work as full or part-time employees of ambulance services.

In 1982, the board adopted rules governing the certification of emergency ambulance personnel in the State. The rules recognize two types of emergency ambulance personnel: the EMT and the MICT. Applicants must comply with National Registry certification requirements *and* pass a state approved training course or its equivalent, in order to qualify for certification. They must also comply with National Registry continuing education requirements, or their equivalent, in order to renew their certification every two years.

The board is authorized to revoke, suspend, or limit the certification of emergency ambulance personnel for good cause. In 1982, the board adopted rules and regulations authorizing it to take disciplinary action against emergency ambulance personnel for the same reasons generally that it may take disciplinary action against physicians.

C

C

C

## Chapter 3

### EVALUATION OF THE REGULATION OF MEDICINE AND SURGERY

This chapter contains our evaluation of the regulation of medicine and surgery under Chapter 453, Hawaii Revised Statutes. It includes our assessment of the regulatory operations of the Board of Medical Examiners with respect to the practice of medicine and surgery by physicians, physician-support personnel, and physician's assistants, and our recommendations on continued regulation of physicians, physician-support personnel, and physician's assistants.

#### Summary of Findings

We find as follows:

1. There is a clear and present danger to the public's health, safety, and welfare in the practice of medicine, and therefore, physicians should be licensed.
2. The board has failed to adopt rules governing the medical education and training of physician-support personnel and physician's assistants. This permits the unregulated practice of medicine.
3. Some of the board's licensing standards for foreign medical graduates are unnecessarily restrictive.
4. Some of the procedures for the licensing of physicians are deficient. These include inadequate procedures to check on the disciplinary history of applicants, inadequate procedures to declare absence or shortage areas for the issuance of limited and temporary licenses, and inappropriate license application instructions.
5. Statutory provisions that require various agencies and individuals to report medical malpractice and unprofessional conduct by physicians are not being effectively implemented, and some are not being implemented at all. In addition, some of the reporting requirements and the information made available are inadequate.
6. The role of the medical advisory committee is confused, and it does not appear to be functioning as intended by statute.

7. The board does not have sufficient staffing and budget support to carry out effectively its many duties and responsibilities. This is due in part to the fact that the executive secretary to the board devotes most of his time to administering the medical claims conciliation panels.

8. Some of the board's policies and procedures discourage public involvement in its activities.

### **Need for Regulation**

The practice of medicine by physicians poses a considerable danger to the health, safety, and welfare of the public. Medicine is a highly complex and technical field of knowledge that deals with profound issues of life and death. Consumers are at a disadvantage in choosing and relying on physicians. They often lack sufficient knowledge to make judgments about the competence of physicians or to assess the quality of care provided by them. In medical emergencies, consumers rarely have the luxury of choosing who will attend to their immediate medical needs. For these reasons, the State must intervene to ensure that physicians are qualified to enter medical practice and that they are competent in the performance of their medical duties.

Physicians diagnose and treat a variety of routine and serious medical conditions. Incompetent diagnosis or treatment may result in loss of life, permanent disability, or temporary disability. It may also result in substantial emotional distress and financial loss to patients and their families.

Our examination of medical complaint cases further illustrates the need to protect the public from possible harm. Between January 1, 1979 and June 30, 1983, 157 consumer complaints were filed with the department's Regulated Industries Complaints Office (RICO). The number and type of consumer complaints filed is summarized in Table 3.1. More than half of the complaints were cases of medical malpractice or unprofessional conduct. In addition, 21 adverse peer review decisions and 435 medical malpractice claims were filed against physicians during this time period.<sup>1</sup>

1. Regulated Industries Complaints Office, "Adverse Peer Review Decisions," June 21, 1983; and Medical Claims Conciliation Panels, Statistical Summary of MCCP Cases, August 1, 1983.

Table 3.1  
 Number and Type of Medical Complaint Cases  
 Filed Between January 1, 1979 and June 30, 1983

<i>Year</i>	<i>Medical Malpractice</i>	<i>Unprofessional Conduct</i>	<i>Fee Dispute</i>	<i>No Jurisdiction</i>	<i>Unlicensed Activity</i>	<i>Medicaid Fraud and Narcotics Violations</i>	<i>Total</i>
1983	8	8	8	4	4	3	35
1982	8	8	3	1	4	1	25
1981	12	12	5	10	0	3	42
1980	14	6	9	8	1	1	39
1979	4	6	4	1	0	1	16
Total	46	40	29	24	9	9	157

Source: Consumer Complaint Files, Regulated Industries Complaints Office, Department of Commerce and Consumer Affairs.

Our evaluation indicates that even with regulation, a significant potential for harm exists in the practice of medicine by physicians. Because of the potential for harm, because consumers cannot adequately judge the professional competence of physicians, and because they are at a disadvantage in choosing who will treat them in medical emergencies, there is a need for the State to regulate the medical profession. Licensing is the most appropriate form of regulation because it permits the State to enforce minimum standards of competency for entry into medical practice, and it permits the State to oversee the ongoing quality of care provided by physicians. All states currently require physicians to be licensed in order to practice medicine.

### **Regulation of Physician-Support Personnel and Physician's Assistants**

Section 453-2(4), HRS, authorizes physician-support personnel and physician's assistants to practice medicine under the direction and control of licensed physicians who retain full professional and personal responsibility for their work. It also requires the board to adopt rules setting standards governing the medical education and training of physician-support personnel and physician's assistants that are at least equal to national standards.

These provisions were added to the medical practice act by Act 111, SLH 1973, in order to permit newly evolving health occupations to function in the health care delivery system of the State and to protect public safety by ensuring that only qualified non-physicians are permitted to practice medicine.

The immediate impetus for passage of Act 111 was to authorize emergency ambulance personnel to practice medicine in the new emergency medical services program of the State. The term physician-support personnel as used in Act 111 includes, but is not limited to, emergency ambulance personnel. The board has adopted rules setting standards for the medical education, training, and certification of emergency ambulance personnel. However, it has yet to adopt any rules regulating other physician-support personnel, resulting in the potential danger of the unrestrained practice of medicine.

The board has been unable to define physician-support personnel. In 1981, the board asked the attorney general's office for assistance in defining physician-support personnel. The attorney general's office replied that the Legislature had delegated to the board the responsibility for defining the term, provided that it refers only to those newly evolving health occupations that can enhance the capacity for delivering health care in the State.<sup>2</sup> However, the issue was not resolved.

The board did establish standards for the nationally recognized and specific category of physician's assistants. In June 1981, the board adopted rules establishing a voluntary certification program for physician's assistants. In order to qualify for board certification, applicants must possess good moral character, graduate from training programs approved by the American Medical Association (AMA), and pass a written examination administered by the National Commission on Certification of Physician's Assistants. However, by making it a voluntary certification program, the board failed to comply fully with Section 453-2(4), HRS, which requires the board to adopt standards *governing* the medical education and training of physician's assistants. Since physician's assistants do not have to meet the board's standards, the voluntary certification program has had very little

2. Letter to Dr. Mary Bitterman, Director of Regulatory Agencies, from Randall Iwase, Deputy Attorney General, April 30, 1981.

impact. By October 1, 1983, only ten physician's assistants had registered with the board.<sup>3</sup>

Under present law, any person can practice medicine at the discretion of individual physicians. There are no legal restrictions on their scope of practice except that they may not prescribe controlled substances. Neither are there any legal guidelines delineating the level and type of medical supervision needed over their practice of medicine. Moreover, there are no standards to ensure that they are minimally competent to practice medicine.

The unrestrained practice of medicine by physician-support personnel and physician's assistants poses a potential danger to the public's health, safety, and welfare. Non-physicians who diagnose and treat illnesses and injuries may misdiagnose conditions, prescribe inappropriate treatment, and render incompetent medical care. Although Section 453-2(4), HRS, requires physicians to retain full professional and personal responsibility for the work of physician-support personnel and physician's assistants, there is no assurance that this results in an adequate level of control over medical practice by non-physicians.

Currently, physicians could employ individuals who might not have adequate education and training to practice medicine. In addition, unlicensed physicians could practice medicine under the direction and control of licensed physicians, raising such undesirable possibilities as allowing a physician whose license has been revoked by the board to practice medicine in another physician's office or allowing physicians who have failed to meet the board's licensing requirements to practice medicine despite apparent shortcomings in their qualifications. The board has discussed a case in which an unlicensed physician who failed the state board examination went to work as a physician's assistant. However, the board permitted this practice as it had not adopted any rules on the matter.

The current statutory approach authorizing qualified non-physicians to extend medical care under the direction and control of physicians has the potential to enhance the delivery of health care in the State. However, in order for this approach to be safe and effective, certain amendments to the medical practice act are necessary.

3. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*.

*First*, the term "physician-support personnel" should be deleted from Section 453-2(4), HRS, since it is overly broad, and the board has been unable to define the term.

*Second*, the statutes should be amended to establish a mandatory licensing program for physician's assistants. Thirty-five other states already require the certification of physician's assistants.<sup>4</sup>

*Third*, the statutes should be amended to authorize only licensed and certified health care personnel to practice medicine within their scope of practice under the direction and control of physicians. This will enable emergency ambulance personnel and physician's assistants (once a licensing program has been established for them) to practice medicine but not others at the present time. Other new health professionals should be allowed to enter the practice of medicine only when their credentials are recognized and appropriate regulatory programs are established by legislation.

*Fourth*, the board should adopt rules establishing guidelines for a reasonable minimum level of supervision to ensure the safe and effective practice of medicine by these personnel.

### **Licensing Standards for Foreign Medical Graduates**

Some of the board's licensing standards for foreign medical graduates are outdated and overly restrictive. These include the special examination requirement, the three years' work experience requirement, and the board's policy with respect to foreign medical graduates who have completed the Fifth Pathway Program. In 1981, foreign medical graduates constituted 6 percent of all initial licenses issued in Hawaii whereas nationwide, they amounted to 16.6 percent of all initial licenses.<sup>5</sup>

**Special examination requirement.** Section 453-4(2)(B), HRS, requires foreign medical graduates to pass the national examination of the Educational Commission for Foreign Medical Graduates (ECFMG) to be eligible for the state

4. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 168.

5. American Medical Association, *U.S. Medical Licensure Statistics 1980-1981 and Licensure Requirements 1982*, p. 3.

board examination. This requirement is overly restrictive as it prevents the board from accepting instead the national certificate issued by ECFMG to foreign medical graduates who have fulfilled all of its requirements to enter medical practice in the United States.

In order to obtain an ECFMG certificate, foreign medical graduates are required to graduate from a recognized four-year medical school, complete all educational requirements to practice medicine in the school's country, obtain an unrestricted license to practice if a national of the school's country, and pass a recognized written examination.

The ECFMG recognizes any one of three national written medical examinations as qualifying foreign medical graduates for certification: (1) the ECFMG examination, (2) the Visa Qualifying Examination, administered by the National Board of Medical Examiners, or (3) the Federation Licensing Examination that is administered by the Federation of State Medical Boards. In addition to passing one of these national examinations, ECFMG requires alien graduates of foreign medical schools to pass one of two national written English language tests: the ECFMG examination or the Test of English as a Foreign Language, administered by the Educational Testing Service.

Hawaii's requirement that foreign medical graduates must pass the ECFMG examination means that those certified by either of the other two examinations cannot be licensed in Hawaii. This unnecessarily restricts or impedes entry into Hawaii by nationally qualified physicians. In order to conform with national standards, and to retain the flexibility of these standards, Section 453-4(2)(B), HRS, should be amended to permit ECFMG certified physicians to qualify for licensure. This approach is taken by 43 states and the District of Columbia.<sup>6</sup>

**Three years' work experience requirement.** Section 453-4(2)(B), HRS, requires foreign medical graduates to complete three years of internship or residency training in an AMA approved hospital to be eligible to take the state board examination. The three years' work experience requirement is outdated and overly restrictive.

6. *Ibid.*, p. 14.

After the three years' work experience requirement was added to the law in 1957, the ECFMG program was developed and gained widespread acceptance. Consequently, most states have amended their laws to adopt less restrictive work experience requirements. By 1982, 29 states and the District of Columbia allowed foreign medical graduates to complete only one year of graduate training and eight states required two years of graduate training. Only seven states, including Hawaii, required foreign medical graduates to complete three years' work experience. The remaining six states did not have a graduate training requirement.<sup>7</sup>

In order to establish more reasonable qualification standards for foreign medical graduates, Section 453-4(2)(B), HRS, should be amended to require foreign medical graduates to complete one year of graduate training in order to qualify for licensure. This requirement, used in conjunction with the ECFMG certification requirement and the requirement that foreign medical graduates pass the state board examination, should provide adequate protection to the public.

**Fifth Pathway Program.** In 1971, AMA established a national certification program known as the Fifth Pathway Program to assist U.S. citizens graduating from foreign medical schools to enter medical practice in this country. In order to qualify for Fifth Pathway Program certification, U.S. foreign medical graduates are required to: (1) complete their premedical education in an accredited United States college or university, (2) study medicine in a recognized foreign medical school, (3) complete all educational requirements to practice medicine in the school's country *except* for internship and/or social service, and (4) complete a one year supervised clinical training program or clerkship in the United States. Upon completing their clinical clerkships, the U.S. foreign medical graduates receive their Fifth Pathway Program Certificate. They are then eligible to enter the first year of graduate training in an accredited United States residency training program. The AMA has recommended that state medical boards treat Fifth Pathway Program graduates in the same manner as foreign medical graduates certified by ECFMG.

The board does not recognize physicians with Fifth Pathway Program certificates. It requires them to also pass the ECFMG examination, complete three years of work experience, and pass the state board examination in order to

7. *Ibid.*

qualify for licensure. This again unnecessarily restricts entry into the profession in Hawaii. It would be more reasonable to permit Fifth Pathway Program graduates to qualify for licensure on the same basis as ECFMG certified foreign medical graduates. They would then be allowed to take the state board examination after completing their residency experience requirement. This would conform with the policies of 46 other states.<sup>8</sup>

### **Applications Administration**

There are three problem areas in the applications process. These include inadequate procedures to check on the disciplinary history of physician applicants, inadequate procedures to declare absence or shortage areas for the issuance of limited and temporary licenses, and inappropriate license application instructions.

**Procedures to check on the disciplinary history of physician applicants.** The board has implemented two procedures to check on the disciplinary history of applicants for a regular medical license. First, the board requires each applicant to order an "AMA Profile" which contains information on the physician's education, training, licensing history and disciplinary actions, if any. This document is mailed directly to the board. Second, the board requires applicants to send a "Verification of License-Physician" form to each state in which they have practiced during the last five years. This form requests information from state medical boards on whether the applicant's medical license has ever been revoked, suspended, surrendered, limited, or placed on probation and information on whether the applicant is currently under investigation and whether any disciplinary action is pending against the physician. This form is also returned directly to the board. The verification of license procedure was implemented in 1982 after the board learned that a physician was licensed to practice in Hawaii while a disciplinary action was pending against him in another state.

There is a third procedure that can be implemented to ensure that all available information on a physician's disciplinary history is reviewed prior to the issuance of a license. The Federation of State Medical Boards publishes a monthly list of physicians against whom disciplinary actions have been taken in any of the 50 states. According to the executive secretary, this list contains about 50 names each

8. *Ibid.*, p. 11.

month, but this information is not reviewed prior to the issuance of a medical license because it would be too cumbersome.

Although a review of the federation's lists is an additional workload for the licensing clerk, a check on the disciplinary history of applicants for a medical license is one of the most important steps that can be taken to protect the public's health, safety, and welfare. Therefore, the board should consider implementing a procedure to review the lists prior to the issuance of a license.

The board also issues limited and temporary licenses to physicians for a variety of reasons. Between January 1, 1979 and mid-1983, the board issued more than 50 limited and temporary licenses to physicians who agreed to practice medicine in areas where there was an absence or shortage of physicians, in government agencies, or under the sponsorship of licensed physicians pending successful completion of the state board examination. At the present time, no checks are made of the history of these applicants. Neither AMA Profiles nor Verification of License-Physician forms are required. In order to adequately protect the public, the board should implement the same verification procedures for applicants for a limited and temporary license as it requires for applicants for a regular medical license.

**Procedures to declare an absence or shortage area for the issuance of a limited and temporary license.** Section 453-3(1), HRS, authorizes the board to issue a limited and temporary license to physicians who agree to practice in an area where there is an absence or shortage of physicians. This provision was added to the medical practice act in 1965 in order to facilitate adequate medical coverage to all residents of the State.

The board has adopted rules to implement this licensing procedure. The rules authorize the board to declare an absence or shortage area upon certification by a county medical society that there is inadequate medical care in a certain area of the State, provided that the county medical society's findings are corroborated by a member of the board. Between January 1, 1979 and mid-1983, five absence or shortage area licenses were issued by the board.

The board's rules are vague because they do not contain any guidelines for the declaration of an absence or shortage area. They are also inappropriate because they involve private professional organizations in the decisionmaking process. This creates a potential for conflict of interest since it may be contrary to the interests of the established medical community to declare an absence or shortage area.

The board should set clear and specific guidelines for the declaration of absence or shortage areas and remove county medical societies from participation in the decisionmaking process. In setting its guidelines, the board should consider using federal criteria and recognizing areas already designated by the federal government as "medically-underserved areas" and "health manpower shortage areas." The board may also want to consider setting guidelines to take care of situations in which the temporary loss of a physician would create an absence of essential primary or specialty care in a community.

**Inappropriate license application instructions.** The physician license application contains some instructions that are out-of-date or misleading. It states that applicants are required to fill out and notarize good moral character forms, although this licensing requirement was repealed in 1983. It states that foreign medical graduates must complete their work experience in AMA approved institutions in the United States, although the board licenses physicians who have completed their work experience in AMA approved institutions in Canada as well. It also states that foreign medical graduates must attach a photocopy of a *full* ECFMG certificate to their applications, although the board requires that they pass the ECFMG examination and will accept ECFMG test result letters as evidence that this requirement has been met. This delays the application process as it takes several months for ECFMG certificates to be processed and mailed to eligible candidates whereas test results are available approximately eight weeks after the examination. The application instructions should be revised to conform with existing statutes and rules.

### **Enforcement Program**

The medical license is a very broad license that permits physicians to practice in any specialty field of medicine. It is also a lifetime grant of privilege that is subject only to the condition that physicians take 100 hours of continuing medical education every two years in order to renew their licenses. Because of the high degree of discretion allowed to individual physicians, and because of the many dangers inherent in the practice of medicine, the State needs to develop and maintain a strong enforcement program that identifies and disciplines physicians whose performance and conduct endanger the public's health, safety, and welfare.

In recent years, numerous improvements have been made in the statutes governing the State's medical practice enforcement program. Information reporting requirements have been established that enhance the State's ability to identify and discipline physicians whose performance and conduct could endanger the public.

The consumer complaints function has been transferred to the department's Regulated Industries Complaints Office to remove the potential for bias in contested case hearings and to increase the efficiency of the complaints process. A medical advisory committee composed of physicians has been established to assist in the review of physicians referred for possible disciplinary action. New grounds for disciplinary action against physicians have been added to the medical practice act, and new disciplinary sanctions have been enacted that enable the board to impose fair and appropriate sanctions on errant physicians.

Despite these changes, some improvements are still needed in the State's medical practice enforcement program in order to increase its effectiveness and efficiency. These include improving the information reporting system, clarifying the role and function of the medical advisory committee, and improving the processing of consumer complaints by RICO.

**Information reporting requirements.** Several laws have been passed that require various agencies and individuals to report cases involving possible medical malpractice and unprofessional conduct to the board. These reporting requirements, along with one requirement that was enacted in 1931, are summarized in Table 3.2 and described below.

**Peer review committees.** The medical profession is organized to oversee the performance of physicians through a network of peer review committees. These committees are composed entirely of physicians and they are run by hospitals, other health care institutions, and medical societies. When a peer review committee finds that a physician's performance is substandard, it may issue an adverse decision against the physician. The adverse decisions of hospitals and other health care institutions may result in denial of physician staff privileges, reduction of privileges, removal of the physician from the medical staff, or other disciplinary actions. The adverse decisions of medical societies may result in a recommended plan of action to improve the physician's performance or, in the most serious cases, expulsion of the physician from the medical society.

Table 3.2  
Information Reporting Requirements

<i>Statute</i>	<i>Reporting Agency</i>	<i>Receiving Agency</i>	<i>Type of Case</i>	<i>Reporting Requirements</i>
Section 663-1.7 (d), HRS (Act 219, SLH 1976)	Final Peer Review Committee of a medical society, hospital or other health care facility	Board of Medical Examiners	Medical practice and conduct which is contrary to acceptable performance standards.	Report all final adverse decisions and all potential adverse decisions that are superseded by resignation or other voluntary action on board-prescribed form within 30 business days of decision.
Section 671-15, HRS (Act 219, SLH 1976)	Medical Claims Conciliation Panels	Insurance Commissioner, who routes to Board of Medical Examiners	Professional negligence, the rendering of professional services without informed consent, or an error or omission in practice which proximately causes death, injury or other damage.	Report all written advisory decisions on cases which have not been settled or otherwise disposed of to the Insurance Commissioner within 30 days after the completion of a hearing. Insurance Commissioner must forward copies of advisory decisions to the Board of Medical Examiners.
Section 329-44, HRS (Act 152, SLH 1931)	State Court Clerks and Judges	Board of Medical Examiners	Violations of the Uniform Controlled Substance Act.	Report all convictions including a copy of the sentence and opinion of the court or judge.
Section 453-8.7 (c) and (d), HRS (Act 227, SLH 1982)	State Court Clerks	Board of Medical Examiners	Death or personal injury caused by negligence, error or omission in practice or the unauthorized rendering of services.	Report all criminal and civil liability judgments and determinations on board-prescribed form within 10 days of decision.
Section 671-5, HRS (Act 219, SLH 1976)	Insurance Companies and Self-Insured Physicians	Insurance Commissioner, who routes to Board of Medical Examiners	Professional negligence, the rendering of professional services without informed consent, or an error or omission in practice which proximately causes death, injury or other damage.	Report all insurance settlements, arbitration awards, and adjudicated judgments to the Insurance Commissioner within 10 working days. Insurance Commissioner must forward names of physicians to the Board of Medical Examiners.
Section 453-8.7 (a) and (d), HRS (Act 227, SLH 1982)	Uninsured Licensed Physicians	Board of Medical Examiners	Death or personal injury caused by negligence, error or omission in practice or the unauthorized rendering of services.	Report all settlements or arbitration awards of claims or actions for damages on board-prescribed form within 30 days of decision.

While the activities of peer review committees are extremely important in terms of controlling the quality of care provided by physicians, adverse decisions alone have limited impact in protecting the public. A physician who is removed from the medical staff of one hospital may join the staff of another hospital in this or another state. The physician may also choose to practice medicine in a private office without hospital privileges. Similarly, a physician who is disciplined by a medical

society may simply resign from the organization rather than comply with its recommendation.

Act 219, SLH 1976, requires the highest level peer review committees of hospitals, other health care institutions, and medical societies to report to the board all adverse decisions rendered against physicians. In 1982, Act 227 expanded this reporting requirement to include *potential* adverse decisions that are superseded by resignation or other voluntary action bargained for by physicians in lieu of disciplinary action. The board is authorized to review adverse decisions with the objective of determining whether further investigation of a physician's performance is needed. It is required to hold the adverse decision reports in confidence, and they are not available for public inspection or subject to discovery.

Between January 1, 1979 and June 30, 1983, 21 adverse decisions were filed with the board. Until RICO was reorganized in November 1982, the board's policy was to handle the investigation of adverse decision cases on its own or to forward cases to the attorney general's office. Now, adverse decision cases eventually go to RICO for investigation.

*Medical claims conciliation panels (MCCPs).* In order to improve the efficiency of the State's medical malpractice insurance system, Act 219, SLH 1976, established MCCPs to review and render findings and advisory opinions on claims alleging death, injury, or other damage due to professional negligence, a failure to obtain informed consent, or an error or omission in practice. Individuals must file their claims with the MCCPs before they can initiate a suit in state court. The objectives are to reduce the number of medical malpractice suits filed against health care providers and to encourage prompt settlement of claims.

Each panel consists of a chairperson who is experienced in personal injury claims settlements, an active trial lawyer, and a licensed physician. The chairperson is appointed by the Chief Justice of the State Supreme Court, the attorney is appointed by the chairperson from a list of 25 submitted annually by the Supreme Court, and the physician is appointed by the chairperson from a list of 25 submitted annually by the Board of Medical Examiners.

Members of the MCCPs serve for one month on a voluntary basis without compensation. Staff support to the panels is provided by the Department of Commerce and Consumer Affairs (DCCA). The MCCPs may call on other legal, medical, and insurance specialists as needed.

The panels encourage informal resolutions of claims through voluntary disposition or settlement. Claims that are not resolved informally are heard by the panels which then issue written advisory decisions concerning liability and in cases where providers are found to be liable, the panels set forth the amount of damages that should be awarded to claimants. These advisory decisions are non-binding and they may not be introduced as evidence in subsequent court proceedings.

The MCCPs are required to forward copies of their written advisory decisions to the State Insurance Commissioner. In turn, the Insurance Commissioner is required to forward copies of these advisory decisions to all parties concerned, including the board. So far, the written advisory decisions have not been forwarded to the Insurance Commissioner. The responsibility for preparing and distributing copies of the advisory decisions has been undertaken by the executive secretary to the Board of Medical Examiners. To the executive secretary's knowledge, no case filed between January 1, 1979 and June 30, 1983 has been forwarded for investigation.

Between January 1, 1979 and June 30, 1983, 310 written advisory decisions were issued by the MCCPs, including 236 findings of no liability and 74 findings of liability. In addition, 86 claims were closed before a written advisory decision was issued, including 39 claims that were withdrawn, 17 claims that were settled, 17 claims that were dismissed because the statute of limitations expired, and 13 claims that were dismissed due to lack of jurisdiction.<sup>9</sup>

*State court clerks and judges.* Pursuant to Act 152, SLH 1931, state court clerks and judges are required to report to the board any physicians convicted for violations of the Uniform Controlled Substance Act. Pursuant to Act 227, SLH 1982, state court clerks are required to report to the board criminal and civil liability judgments and determinations against physicians found responsible for patient death or personal injury due to professional negligence, the rendering of unauthorized services, or an error or omission in practice. The purpose of this reporting requirement is to assist the board in detecting physicians whose actions may be in violation of the medical practice act.

*Insurance companies and self-insured physicians.* Act 219, SLH 1976, requires insurance companies and self-insured physicians to report to the Insurance

9. Medical Claims Conciliation Panels, Statistical Summary of MCCP Cases.

Commissioner insurance settlements, arbitration awards, and adjudicated judgments that find physicians responsible for patient death, injury, or other damage due to negligence, the rendering of unauthorized services, or an error or omission in practice. The Insurance Commissioner is required to forward the names of physicians involved in these cases to the board for a review of their fitness to practice medicine. According to the Insurance Commissioner's office, copies of closed claim reports are routinely forwarded to the board.

*Uninsured physicians.* Pursuant to Act 227, SLH 1982, uninsured physicians are required to report to the board any settlements and arbitration awards on claims for damages for patient death or personal injury caused by professional negligence, the rendering of unauthorized services, or an error or omission in practice. The purpose of this reporting requirement is to assist the board to detect physicians whose actions may be in violation of the medical practice act and to increase the reporting of medical tort claims.

**Shortcomings in the information reporting system.** The current information reporting system has two major shortcomings that impair the State's ability to identify and discipline physicians whose performance and conduct endanger the public's health, safety, and welfare. The most serious shortcoming is that not all of the reporting systems have been implemented as intended by law. A second problem is the lack of adequate information provided under some of the reporting systems.

*Lack of implementation.* Of the six reporting channels (peer review committees, medical claims conciliation panels, insurance companies, self-insured physicians, court clerks and judges, and uninsured physicians), only the first, involving peer review committees, currently flows into the investigation system.

Act 204, SLH 1982, provides for the separation of the investigation and prosecution functions, which are assigned to the DCCA, from the adjudication and disciplinary action function, which continues to reside with the boards. Specifically, the act states: "Notwithstanding section 92-17 or any other law to the contrary, all boards and commissions placed within the department of commerce and consumer affairs for administrative purposes shall delegate their authority to receive, arbitrate, investigate, and prosecute complaints to the department." Under the

department's organization, the office which is therefore responsible for receiving and investigating complaints is RICO.

However, adverse decisions resulting from peer review are sent to the board, not the department. The cases are reviewed by the board's executive secretary who then sends them to RICO. Even though it might be argued that peer review decisions are not technically "complaints," we believe that these cases should go directly to RICO. Neither the board nor its agent, the executive secretary, should be involved in cases which the board might subsequently have to adjudicate.

Closed claim reports of insurance companies and self-insured physicians pertaining to insurance settlements, arbitration awards and adjudicated judgments should also be channelled to RICO. Under current procedures, closed claim reports are forwarded by the Insurance Commissioner to the board, but there is no evidence of investigations being initiated. According to the board's executive secretary, approximately 100 closed claim reports have been filed with the board.

Reporting channels from the courts, concerning physicians convicted of violating the Uniformed Controlled Substance Act and physicians with criminal or civil liability judgments, have not been implemented at all. The department should make the necessary arrangements with the courts to receive the required reports.

As for the advisory decisions of the MCCPs, these were reported to be under the review of the medical advisory committee to determine which cases should be forwarded for investigation. No cases had been forwarded at the time we reviewed this aspect. As we discuss in a later section of this chapter, it is questionable whether this is a responsibility which should be assigned to the medical advisory committee. Like other reporting sources, advisory decisions of the MCCPs should be directed to RICO.

Our concluding observation on this matter is that consumer complaints are but one source of information for the initiation of investigations. Other sources, including peer review decisions, insurance reports, MCCP advisory decisions, and court decisions and judgments, are also important to the investigations process, provided that the investigations office has timely access to these sources of information. Consequently, just as the Legislature has clarified that the responsibility for receiving, investigating, and prosecuting complaints rests with

DCCA, it would also be appropriate for the Legislature to clarify that the department (and therefore, its investigative arm, RICO) should be the recipient of not only complaints but also the information from these other sources.

*Insufficient information.* The quality of information conveyed in some of the reporting systems is inadequate for decisionmaking. In order to enhance the department's ability to investigate cases, some statutory amendments should be made.

Section 453-17, HRS, authorizes the director of DCCA to subpoena patient records relating to adverse peer review decision cases. However, DCCA does not have access to non-patient records that are used by peer review committees to arrive at their decisions. RICO has reported that it has had to close two adverse decision cases due to its inability to subpoena peer review committee records. In order to enhance the department's ability to investigate these cases, Section 453-17, HRS, should be amended to authorize the director to subpoena evidence that is used by peer review committees to arrive at their decisions. This provision will enable the department to investigate cases which involve physician performance not recorded on patient records, such as drug addiction or alcohol abuse. This will also give RICO investigators more information about the nature of complaints and facilitate their investigation.

Under Section 671-5, HRS, the Insurance Commissioner receives information on medical tort claims that have been settled, arbitrated or adjudicated to final judgment. The information which insurance companies and self-insured providers are required to submit is specified by statute, including such information as a summary of the facts of each case; the date and amount of settlement, arbitration award, or judgment; funds expended for defense and plaintiff costs; and the actual dollar amount of award received by the injured party. However, the Insurance Commissioner is only required by law to forward the *names* of the physicians involved. To facilitate any investigation that might ensue, the Insurance Commissioner should be required to forward the same information that is received from the insurance companies and self-insured providers.

**Medical advisory committee.** Section 453-8.5(a), HRS, requires the director of DCCA to establish a medical advisory committee to serve as consultants to the Board of Medical Examiners in its review of physicians referred for possible

disciplinary action. As originally intended by the department, which recommended the establishment of the medical advisory committee, the committee was to provide the means by which investigators could consult with specialists in their investigation of medical malpractice cases.<sup>10</sup> The Board of Medical Examiners also supported the idea of a committee and stated in legislative testimony that: "Due to the technical nature of a medical malpractice case, it is essential that the investigators assigned to such a case be able to consult with experts in the pertinent field of medicine. The Medical Advisory Committee would constitute a pool of experts with whom the investigators could consult."<sup>11</sup>

The board is required to submit annually to the director the names of 25 physicians who have agreed to serve on the medical advisory committee. The director may appoint physicians from this list to advise in the investigation of individual medical cases. Each designated physician is to serve on the committee until the investigation of the case has been concluded.

In early 1983, the board submitted to the director the names of 38 physicians representing 17 medical specialty fields who agreed to serve on the medical advisory committee. It has been reported that orientation sessions were held in the Spring for new committee members. Some physicians have already assisted RICO in its review of medical malpractice cases.

At the present time, the medical advisory committee's role and functions are unclear. The former chairman of the board asked one committee member to chair a special subcommittee. According to this physician, the purpose of the subcommittee is to review MCCC cases in order to identify patterns of practice that may pose problems in the medical profession, to identify physicians with problems, and to ascertain why these problems exist. The physician expects that the subcommittee will report back to the board with recommendations for an educational program that is designed to eliminate or reduce problem areas in medical practice in the State.

On the other hand, the board's executive secretary believes that the special subcommittee's job is to review MCCC cases and recommend which ones should be

10. Department of Regulatory Agencies, Justification Sheet, House Bill No. 3140, February 3, 1982.

11. Testimony on House Bill No. 3140 submitted by the Board of Medical Examiners to the Honorable Russell Blair, Chairman, House Committee on Consumer Protection and Commerce, and the Honorable Yoshiro Nakamura, Chairman, House Committee on Judiciary, March 2, 1982.

forwarded to RICO for investigation. According to the executive secretary, subcommittee members come to the office, pick up case files, and review them individually. He assumes that at some point in time, the subcommittee will get together and draw up its recommendations. It is questionable whether members of the medical advisory committee should be involved at all in recommending cases for investigation, especially when they might be called upon at some later time to provide expert advice in the investigation or serve as consultants to the board in disciplinary actions.

While committee members should not be involved in making recommendations for investigation, they could perform a valuable role in providing expert advice to department investigators. This would be the role originally intended by the department and the board in supporting the committee's establishment. Additionally, and as the law now provides, committee members would be available for expert consultation with the board in its adjudication of disciplinary cases. Since the medical advisory committee only recently came into being, the department has an early opportunity to clarify the role of the committee and prevent any further confusion over its functions.

In order to ensure that members are fully briefed on the role and functions of the medical advisory committee, DCCA should develop an information sheet for each member describing the committee's purpose, the roles and responsibilities of committee members, and the procedures that will be used to carry out the committee's work. In addition, in order to preserve the objectivity of the committee's work, the department should implement a policy of deleting the names of physicians involved in cases under review. This will avoid placing committee members in a potential conflict of interest situation should they know the physicians who are the subject of a departmental investigation.

**Processing of consumer complaints by RICO's intake unit.** In late 1982, an intake unit was established in RICO's Honolulu investigations office. The functions of the intake unit are to log and track all consumer complaints filed with the department; to receive and review Oahu consumer complaints; to determine whether the department has jurisdiction over these complaints; to refer consumers to appropriate governmental agencies that do have jurisdiction; to attempt to resolve

disputes; and to forward for investigation those cases which point to a violation of the State's regulatory laws.

The intake unit has contributed positively to the overall management of consumer complaints filed with the department. Cases are now routinely logged and tracked on a timely basis. Consumers with complaints that fall outside the department's jurisdiction are referred to the appropriate governmental agency, or to civil proceedings. Many minor disputes are informally resolved by intake specialists without the need to forward cases for investigation. However, there is a need to clarify the role of the intake specialists.

The intake specialists see their job as serving as a buffer between the public and RICO. They advise consumers that the department's role is to take action against the licenses held by respondents rather than to recover money or to compel the payment of damages. They refer consumers with civil cases to private attorneys and they attempt to resolve informally disputes which they feel they can handle.

According to the intake specialists, there is an informal two week period during which they are authorized to handle consumer complaint cases. Cases not resolved within two weeks are supposed to be forwarded for investigation. The intake specialists do not appear to be following the two week policy for medical cases. Thirty-three consumer complaints relating to the practice of medicine were filed by patients, their families, and physicians between November 29, 1982 and May 31, 1983. As of September 6, 1983, 14 had been forwarded for investigation and the remaining 19 were handled at the intake office. Sixteen cases handled by intake were closed but 10 of the 16 had been held over two weeks, including four cases that took more than 50 days to resolve. In addition, three cases were still open at intake on September 6, 1983 after 111, 163 and 212 days.

The intake specialists lack clearcut guidelines about what types of consumer complaints they may handle and what types of cases should be forwarded for investigation. According to the intake specialists, they will forward for investigation cases which they "feel" they cannot handle, cases which are too complicated, and cases where there are two diverse stories.

A related problem is that the intake specialists have no guidelines on what priorities to place on different types of complaints. The intake specialists report

that they place high priority on cases where a large number of calls come in on one licensee and on cases that involve a lot of money. They rarely get calls relating to bodily harm and personal injury, and when they do, they tend to refer complainants to the MCCPs. As of September 6, 1983, only four of ten complaints alleging medical malpractice that were filed between November 29, 1982 and May 31, 1983, had been forwarded for further investigation. Six cases were closed at intake. Of these six, one was a case in which no violation was found and one case was withdrawn; however, no determination of whether malpractice had occurred was made in the other four cases.

The net effect is that medical complaint cases are not being handled efficiently and responsively. Under the current setup, nearly every type of medical complaint case can be investigated at intake and, in the absence of any operational time limit, intake specialists may hold on to these cases indefinitely. Cases that merit concern should be forwarded for investigation rather than to the MCCPs as not all complainants are interested in filing a civil suit against the physician. Referral to the MCCPs does not relieve RICO of its responsibility to investigate charges of incompetent physicians.

RICO should review the roles and responsibilities of the intake specialists and establish more definitive guidelines for their handling of consumer complaints in general and consumer medical complaints in particular. Among these guidelines should be higher priorities for complaints alleging medical malpractice and unprofessional conduct that cause death, permanent disability, or temporary disability to patients. These cases should be forwarded for complete investigation.

### **Board Organization and Operations**

Improvements can be made in the board's organization and operations to enable it to carry out more effectively its responsibilities for administering new programs and overseeing existing programs. These include providing the board with more staff support and making funds available to the board for various activities. In addition, the board needs to conduct its business with greater objectivity and promote greater public participation in its work, in keeping with the spirit of the Sunshine Law.

**Staff support.** In 1976, Act 219 authorized the director of the department to hire a civil service-exempt executive secretary to staff the board. Act 219 also established the MCCPs to hear cases involving claims against physicians and placed these panels within the department for administrative purposes. When the new executive secretary was hired for the board, the responsibility for organizing and administering the MCCPs was also assigned to the board's executive secretary.

The number of cases filed with the MCCPs has steadily increased over the last several years, from 56 in 1977 to 113 in 1982. The backlog of cases has also increased over the same period, from 28 to 69. The executive secretary estimates that he devotes 80 percent of his time to MCCP business. This involves the scheduling of hearings, getting two lawyers and a physician to agree to sit on each panel, and holding hearings. The assignment of both board and MCCP responsibilities to one executive secretary has detracted from adequate support to the board.

When Act 219, SLH 1976, was passed it authorized the director of the department to hire a civil service-exempt executive secretary to administer the board. This provision was added because it was anticipated that amendments to the medical practice act would increase the board's workload since it would have greater responsibilities in reviewing and evaluating physician medical practices. The director testified that the board would not be able to fulfill its responsibilities with its current staffing of a part-time executive secretary who was also responsible for four other boards.<sup>12</sup> Licensing fees for physicians were raised from \$7.50 to \$75.00 to enable the department to hire a full-time executive secretary as well as other necessary staff.

Assigning responsibility for the MCCPs to the board's executive secretary has had the effect of returning the staffing of the board to the same level as it was prior to passage of Act 219, SLH 1976. With the new programs which have been established, the board currently does not have adequate staffing to enable it to carry out its many duties and responsibilities.

12. Testimony on House Bill No. 2700 submitted by the Department of Regulatory Agencies to the Honorable Dennis Yamada, Chairman, House Committee on Consumer Protection and Commerce, and the Honorable Donald Nishimura, Chairman, Senate Committee on Judiciary, March 2, 1976.

In addition to the problem of workload, the combination of board and MCCP functions in one executive secretary creates a potential for conflict of interest if the executive secretary becomes involved in deciding which cases warrant investigation by the department. If a case were forwarded for investigation and returned to the board for disciplinary action, participation by the executive secretary at the board's meeting could raise questions concerning objectivity.

The executive secretary has also expressed concern that wearing both hats makes it extremely difficult at times to keep the two functions separate. The business of the panels is supposed to be entirely separate from the business of the board. Yet, an inadvertent discussion of an MCCP case with the board might jeopardize future prosecution of the case.

In order to provide the board with more adequate staff support to carry out its many program responsibilities, and to remove the potential for conflict of interest, responsibility for the MCCPs should be transferred to a staff person in the director's office who is not associated with the board.

**Financial support.** During the past ten years, new responsibilities assigned to the board and DCCA under the medical practice act require the expenditure of funds for program development and implementation. These include such activities as the establishment of certification programs for physician's assistants and emergency ambulance personnel, and the establishment of standards for informed consent. In addition to these new program responsibilities, the board must oversee the current physician licensing program to ensure that its standards and application procedures are adequate.

Members of the board have expressed their frustration that the board has not received the financial support needed to effectively carry out its responsibilities. For example, board members say that they cannot attend annual meetings of the Federation of State Medical Boards to keep up-to-date with developments in national medical licensing programs, and they are not able to publish annual newsletters to inform licensees about new requirements and board activities.

More importantly, members of the board have pointed out that when they were given the responsibility to administer the new certification program for emergency ambulance personnel, no additional funds were made available for carrying out this

activity. They have adopted national certification standards for this group of health care personnel which include a requirement that applicants pass written and practical qualifying examinations. However, as the department has not budgeted for these new examinations, which are fairly expensive, the board has had to request other state agencies to administer the qualifying examinations using funds provided by the Department of Health.

Similarly, the board received no additional funds when it was given the responsibility for developing standards for informed consent. When the first set of standards were developed in 1979, they were circulated only to hospitals and health care facilities in the State. The board has now developed specific standards governing surgical treatment of breast cancer, including coverage of alternative forms of treatment, but it has found that there may not be funds for disseminating these standards. The board is seriously considering *not* distributing the standards to licensed physicians due to the expense involved in mailing them out. This would seriously impair the effectiveness of this program and negate legislative intent.

The department should plan and budget for the various board programs as part of the routine program planning and budgeting cycle so that the board has sufficient financial resources to carry out its program. And on a matter vital to public health and welfare, the department should make funds available to distribute the informed consent standards for treatment of breast cancer so that physicians will be cognizant of their responsibilities and breast cancer patients will be adequately informed of the alternative forms of treatment.

**Greater objectivity and public participation in the board's activities.** We find that board operations could be improved by making some changes that would promote objectivity and public participation. For example, meetings of the board are held in private conference rooms at the Hawaii Medical Association instead of in public places. According to the executive secretary, this is because public places tend to be closed at night when the board holds its meetings. Also, no minutes are taken of executive sessions held by the board, although Section 92-9, HRS, does not exempt executive sessions from the requirement of keeping minutes. The executive secretary says that this is *not* done because the board does not take any action during executive sessions. Minutes taken during regular board meetings do not reflect fully the substance of the discussions. For example, they do not always identify the

reasons for entering into executive sessions (a specific requirement of Section 92-4, HRS), the numbers of complaint cases that are reviewed by the board, or the substance of the board's decisions on complaint cases. And, copies of meeting notices and agendas are not routinely mailed to members of the public upon request. According to the executive secretary, this is not done because everyone knows that the board holds its regular monthly meetings on the third Wednesday of each month.

In order to conform with the intent of the Sunshine Law, the board should adopt policies and procedures that encourage objectivity and public participation in its activities. These would include holding board meetings in public places, taking minutes of executive sessions, taking more thorough minutes of regular meetings to record the substance of board deliberations, and routinely mailing copies of meeting notices and agendas to members of the public upon request.

### ***Recommendations***

*We recommend the following:*

1. *Chapter 453, HRS, be reenacted to continue the regulation of medicine and surgery. In reenacting the statute consideration should be given to the following changes:*
  - deleting the term "physician-support personnel;"*
  - establishing a mandatory licensing program for physician's assistants;*
  - authorizing only certified and licensed health care professionals to practice medicine under the direction and control of physicians;*
  - deleting the requirement that foreign medical graduates pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination and have three years of work experience and requiring instead that they be certified by ECFMG and have one year of graduate medical training to be eligible for the state board examination;*
  - recognizing graduates of the American Medical Association's Fifth Pathway Program on the same basis as ECFMG certified foreign medical graduates;*
  - requiring the Board of Medical Examiners to delegate to the Department of Commerce and Consumer Affairs its authority to receive and review information reported pursuant to all the statutory reporting requirements*

*relating to medical malpractice and misconduct and authorizing the director to subpoena evidence used by peer review committees in arriving at their adverse decisions. Section 671-5(b), HRS, should also be amended to authorize the Insurance Commissioner to forward to the department copies of closed claim reports pertaining to insurance settlements, arbitration awards, and adjudicated judgments.*

2. *The department clarify the role of the medical advisory committee as a source of expert advice to the department and the board on investigations and disciplinary cases and develop an information sheet on the committee's roles, responsibilities, and functions and the procedures that will be used to carry out the committee's work.*

3. *The board amend its rules to: (a) specify the level of supervision that is required for the practice of medicine by licensed and certified health care professionals working under the direction and control of physicians; and (b) set clear guidelines for declaring areas of absence or shortage of physicians and to remove county medical societies from making these determinations.*

4. *The department improve its application process by making a more thorough check on the disciplinary history of all applicants for regular and limited and temporary licenses and by revising the application instructions to conform them with existing statutes and rules.*

5. *The department adopt policies clarifying the roles and responsibilities of intake specialists in the Regulated Industries Complaints Office and the procedures they should follow in handling complaints.*

6. *The director of the department assign responsibility for administering the medical claims conciliation panels to a member of the director's staff who is not associated with board activities. In addition, the director should budget for the special needs of the board to enable it to carry out its statutory responsibilities and make funds available for the distribution of informed consent standards for the treatment of breast cancer.*

7. *The board promote greater public participation in its activities by holding meetings in public places, taking adequate minutes, and routinely forwarding meeting notices and agendas to the public upon request.*



## Chapter 4

### EVALUATION OF THE REGULATION OF EMERGENCY AMBULANCE PERSONNEL

This chapter contains our evaluation of the regulation of emergency ambulance personnel by the Board of Medical Examiners. It includes our assessment of the board's regulatory operations and our recommendations for improvement.

#### Summary of Findings

We find that:

1. There is a potential danger to the public in the practice of medicine by emergency ambulance personnel, and they should continue to be regulated.

2. The board has not examined the adequateness and appropriateness of its standards for certification, and it has failed to define the scope of practice and the level of supervision needed.

3. The board has not assumed independent control over certification but has allowed other agencies to participate substantively in the certification process. This has led to inefficiency and conflict of interest.

4. The board needs additional expertise to develop and administer an effective and efficient certification program for emergency ambulance personnel.

#### Need for Regulation

The practice of medicine by emergency ambulance personnel is potentially dangerous to public health and safety. Emergency ambulance personnel diagnose and treat a wide variety of routine and serious medical emergencies while working under the direct or indirect supervision of physicians. In effect, they practice medicine on acutely ill or injured patients. An incorrect diagnosis or incompetent medical treatment may result in loss of life or temporary or permanent disability. Inadequate medical care may also result in emotional distress and economic hardship to patients and their families.

Because of the potential dangers in delivering emergency medical services and because consumers cannot choose who will treat them during medical emergencies, the State must ensure that emergency ambulance personnel are qualified to practice and that they are competent in their medical duties. In 1982, all states regulated emergency ambulance personnel.<sup>1</sup>

## **Regulatory Standards**

**Background on board responsibilities.** In 1973, Act 111 amended the medical practice act to permit physician-support personnel, including emergency ambulance personnel, to practice medicine under the direction and control of physicians. In order to protect the public's safety, Act 111 required the board to adopt rules setting standards governing the medical education and training of these personnel. These standards were to be at least equivalent to national standards.

In the same year, Act 56 designated the Department of Health (DOH) to be solely responsible for the coordination of a statewide emergency medical services program. This legislation authorized the director of health to adopt rules and standards relating to emergency care personnel and to indicate what would be required in the way of licensing, certification, or registration for these personnel.

The board did not adopt rules setting standards for the medical education and training of emergency ambulance personnel. However, in 1976, DOH issued rules establishing minimum requirements for certifying emergency ambulance personnel and requiring DOH licensed ambulance services to employ only certified personnel. DOH recognized two types of emergency ambulance personnel: the emergency medical technician (EMT) who would be qualified to deliver basic life support services, and the mobile intensive care technician (MICT) who would be qualified to deliver basic and advanced life support services.

In order to qualify for DOH certification, EMTs and MICTs were required to complete state approved training courses and pass state registry examinations. DOH rules did not specify the content of state approved training courses and, in the absence of standards set by the board, DOH recognized applicants who had

<sup>1</sup> U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 182.

completed training courses administered by the Hawaii Medical Association—Emergency Medical Services Program as qualified for certification.

In 1978, Act 148 made DOH responsible for establishing, administering, implementing, and maintaining a comprehensive emergency medical services system for the State. This legislation also made the board responsible for certifying emergency ambulance personnel. The certification function was placed under the board to ensure that medical standards for qualifying emergency ambulance personnel would be uniform throughout the State, and to give supervising physicians assurance and confidence that these personnel received proper medical training. In order to qualify for board certification, Act 148 requires applicants to pass board recognized training courses or board recognized examinations or meet other standards set by the board. It also provides that certified individuals must meet continuing education requirements set by the board.

The Hawaii Medical Association (HMA) supported transferring the certification program from DOH to the board for several reasons. It noted that regulatory functions are properly the domain of the board and the Department of Regulatory Agencies (now the Department of Commerce and Consumer Affairs), and that individuals who perform acts which constitute the practice of medicine should be formally regulated by a board composed of physicians. It also testified that placing the certification function under the board would resolve an apparent conflict of interest in which DOH was employing emergency ambulance personnel and simultaneously certifying its own personnel.

The Department of Regulatory Agencies testified against transferring certification responsibilities to the board, noting staffing constraints. Consequently, Act 148 authorized DOH to continue to certify emergency ambulance personnel according to its own standards if the board failed to establish a certification program.

The board finally adopted rules governing the certification of emergency ambulance personnel in December 1982, some nine years after it was first required to set standards for their medical education and training and five years after it was mandated to set standards for their certification.

Despite this long period of gestation, the board's rules lack substance. They do not define the scope of practice for the different types of emergency ambulance personnel recognized by the board or the level of supervision needed. The board has not acted independently to set clear and specific standards for the medical education

and training of these personnel. Instead the board relies on DOH to set state education and training standards, and therefore, in effect, the board has abdicated its responsibility over certification standards. The DOH education and training standards are restrictive, and there is no assurance that these standards are appropriate and valid in preparing emergency ambulance personnel for competent practice.

**Scope of practice.** The board's rules state that EMTs and MICTs shall be certified as competent to perform (under appropriate supervision) those duties and functions specifically delegated to them by a supervising physician. However, the rules do not define the scope of practice for EMTs and MICTs or the level of supervision that is reasonably necessary to ensure the safe and effective practice of medicine by these personnel.

Emergency ambulance personnel deliver two types of emergency medical care. Basic life support services include such medical procedures as the management of shock, the maintenance of oral airways, and first aid. Advanced life support services include more sophisticated medical procedures such as cardiac monitoring and the intravenous administration of drugs. In general, EMTs are trained in the delivery of basic life support services and MICTs are trained in the delivery of advanced life support services.

In the absence of rules delineating the scope of practice for emergency ambulance personnel, there is a danger that they may practice medicine beyond their competency. For example, under the board's rules, EMTs may perform any advanced life support procedure delegated to them by a supervising physician, even though they may not have been trained to perform at this level of care. Such advanced life support functions as cardiac defibrillation (the use of electric shock to restore normal heart rhythm) and the administration of drugs contain considerable risk to patients if performed improperly.<sup>2</sup>

In addition, in the absence of guidelines defining the level of supervision that is appropriate for the delivery of basic and advanced life support services, there is a possibility that these services will be rendered without adequate medical direction

2. Committee on Emergency Medical Services, National Research Council, *Emergency Medical Services at Midpassage*, Washington, D.C., National Academy of Sciences, 1978, p. 41.

and control. For example, the performance of even a basic life support procedure such as the administration of oxygen without adequate medical supervision can lead to death if a patient has a common respiratory disease such as emphysema.<sup>3</sup>

To ensure public protection, the board should adopt rules defining the scope of practice for EMTs and MICTs and the level of medical supervision that is appropriate for the delivery of basic and advanced life support services.

**DOH training standards.** The board has adopted the following requirements for certification of emergency ambulance personnel: (1) fulfill the requirements of the National Registry of Emergency Medical Technicians and (2) complete a state approved training program or its equivalent to be determined by DOH which includes a practical skills examination or a period of observation or both. There are no board standards relating to the content of state approved training programs. Instead, the board allows DOH to set standards for these training programs.

The board's failure to set standards for state approved training programs means that there has been no independent validation of these standards since emergency medical services training began in the State. The DOH training standards are based on curricula developed by HMA in the mid-1970s and subsequently endorsed by DOH. DOH now contracts with the University of Hawaii to train EMTs and MICTs according to these standards.

The board and DOH are assigned different roles in the State's emergency medical services system. The role of the board is to set minimum levels of training that are reasonably necessary to qualify emergency ambulance personnel for the safe and effective delivery of emergency medical services. The role of DOH is to provide training for emergency ambulance personnel and, as administrator of the state system, to employ qualified personnel to deliver medical care.

It is not appropriate for the board to allow DOH to set training standards for certification. It was specifically to avoid the potential for conflict of interest of DOH that the regulatory program was transferred to the board. The effect of allowing DOH to continue to set training standards is that the standards in Hawaii are among the most stringent in the nation.

3. Interview with Andrew Schwartz, M.D., October 3, 1983.

It can be argued that it is better to err on the side of safety. However, a report by the Committee on Emergency Medical Services of the National Research Council specifically points to the falseness of this "more is better" assumption. It says that there may well be a point in the development of an emergency medical services system at which expenditures for additional training and recruitment may be less cost effective than expenditures for other programs.<sup>4</sup> It should also be noted that more training is not better if it results in a shortage of trained personnel. This is what has happened in Hawaii where there is a shortage of emergency ambulance personnel. This shortage is particularly acute in the City and County of Honolulu which has approximately 20 vacancies for MICTs.

In Hawaii, the independent review and validation of State training standards for emergency ambulance personnel has yet to be done. We find that the current DOH training standards are restrictive when used for purposes of certification.

**Training standards for EMTs.** The board requires EMTs to fulfill certification requirements set by the National Registry and to complete a state approved training program or its equivalent to be determined by DOH. The DOH training standards for EMTs are much higher than national standards and standards set by other states.

National Registry certification standards require EMTs to pass a state approved training course that is based on a national curriculum issued by the U.S. Department of Transportation. This curriculum consists of a minimum of 81 hours of training in a variety of basic life support skills. It is being revised and the minimum number of training hours is expected to be increased to 110 or 120 in the near future.

In 1982, the National Registry found that 52 of 54 jurisdictions surveyed based their EMT training course on the national curriculum. The number of training hours ranged from 81 to 200.<sup>5</sup> Hawaii had the highest number of training hours in the survey. The DOH standards require EMTs to pass a training course consisting of 100 hours of classroom instruction and 100 hours of clinical training, more than double that currently required by the National Registry. In practice, DOH's

4. Committee on Emergency Medical Services, National Research Council, *Emergency Medical Services at Midpassage*, p. 598.

5. Teri Tatman, *1982 NREMT Basic Registration Poll*, The National Registry of Emergency Medical Technicians, Columbus, Ohio, September 1982, p. 2.

contract with the University of Hawaii for EMT training courses specifies even longer training—a minimum of 315 hours, more than triple the National Registry requirement.

**Training standards for MICTs.** The board also requires MICTs to fulfill certification requirements set by the National Registry and to complete a state approved training program or its equivalent to be determined by DOH in order to qualify for board certification. The DOH training standards are different from national standards and the standards set by other states in several respects.

National Registry certification standards require paramedics (or MICTs, as they are called in Hawaii) to pass a state approved training course that is based on a national curriculum issued by the U.S. Department of Transportation. This curriculum consists of 15 modules of training in a variety of advanced life support skills.

According to a 1982 survey conducted by the National Registry, DOH training standards differ from the national curriculum.<sup>6</sup> It has been reported that DOH's standards include some but not all of the training modules contained in the national curriculum. In addition, DOH's standards require more extensive instruction in such skills as cardiac monitoring and the management of diving injuries. Many of the differences between the two curricula are due to the fact that the State's MICT training course was developed before the national curriculum was issued.

The National Registry found that 49 states and the District of Columbia offered paramedic training programs in 1982. Forty-four states and the District of Columbia based their training programs exclusively on the national curriculum. Two states based their training programs on the national curriculum and added training requirements to meet local needs. Only three states—Hawaii, Kansas, and California—reported that their training programs were not based on the national curriculum.<sup>7</sup>

The board should assume direct responsibility for setting independent training standards for the certification of EMTs and MICTs. It should consider basing these

6. The National Registry of Emergency Medical Technicians, *EMT-Paramedic Training Sites in the U.S.A. and Territories*, Columbus, Ohio, 1982, p. 4.

7. *Ibid.*

standards primarily on National Registry requirements as do almost all the other states. This should ensure a reasonable minimum level of qualification for the safe and effective practice of medicine by EMTs and MICTs.

There may be some ways in which Hawaii's emergency medical needs are unique and appropriate training should be required to meet local needs. The board should identify the additional skills needed for Hawaii practice, set clear and specific training standards for these skills, and develop a certification examination to test competency in these skills.

### **Regulatory Operations**

**Review of training credentials.** The board will certify applicants who present evidence that they have met National Registry requirements and passed DOH approved training courses. When applicants who are not graduates of DOH approved training courses apply to the board for certification, they are sent to DOH for review and approval of their training credentials. DOH sends a detailed questionnaire to each applicant's training agency asking about the number of hours of training given in specified subject areas. When the questionnaires are returned, applicants who have training deficiencies are sent to the appropriate training agency to make up their deficiencies. The training agency administers a practical skills examination to identify additional weaknesses in their training. It then requires applicants to take training courses to make up any deficiencies that are uncovered. At the end of each training course, applicants are required to pass comprehensive final examinations.

This procedure is time consuming and makes it virtually impossible for graduates of non-DOH approved training courses to become certified. DOH and the training agencies do the screening and actually decide who is eligible for certification. The present approach is particularly disturbing because there is only one MICT training program in the State and this program has absolute control over who becomes eligible for board certification.

In order to enhance the efficiency and equity of its certification program, the board should assume direct and independent responsibility for reviewing and approving the training credentials of all applicants. If the board establishes National Registry standards as the primary basis for certification, all that will be

necessary is for applicants to present evidence that they have fulfilled national requirements. The board can develop procedures and tests to determine whether applicants have fulfilled any additional State requirements that are needed to meet local needs.

**Conflict of interest in training and testing.** In order to fulfill National Registry requirements, applicants must pass written and practical qualifying examinations. The written portion of the EMT and paramedic examinations are developed and graded by the National Registry. The practical portion of the examinations are developed by the National Registry and graded by local examiners.

The board established its requirement in December 1982, that applicants must meet National Registry certification standards but it failed to make the National Registry examination available in Hawaii. This created serious problems when the first class of MICT candidates applied for board certification in April 1983. They found that they could not qualify for certification as no testing agency had been authorized to administer the paramedic examination.

The board asked HMA to serve as the interim testing agency for this examination. The board's request created a serious conflict of interest because it put HMA, the training agency, in charge of examining its own students for purposes of certification. In addition, designation of HMA as the interim testing agency for the National Registry paramedic examination meant that the training agency acquired full copies of the national written and practical examinations. Although HMA expressed its conflict of interest concerns to DOH and DCCA and the issue was reviewed by the board, HMA was advised to proceed with the conduct of the examination.

After administering the first national paramedic examination, HMA declined to serve as the testing agency due to its continuing concerns about conflict of interest. The board then asked the Employment Training Office (ETO) of the University of Hawaii to serve as the testing agency for fiscal year 1983-84. This request also creates a conflict of interest situation because ETO is in charge of providing and conducting the state training program for MICTs. It has contracted with HMA to assist in the training, and plans are for ETO to assume full responsibility for the training program in 1984.

In order to avoid any conflict of interest, the board and the department should assume direct responsibility for administering the National Registry examinations in Hawaii.

**Temporary certification procedure.** Under the current statutes, emergency ambulance personnel may not practice medicine until they have been certified by the board. This is a problem for applicants who have met the board's training requirements, but cannot begin employment until they have taken and passed the national examination. This is especially difficult for MICT candidates who graduate at different times of the year or whenever they complete their internship.

Because the practical portions of the National Registry examinations are expensive to administer and require a great deal of administrative time to set up, it is not cost-effective to conduct the examinations whenever an EMT class graduates, or whenever an MICT completes the training program. DOH reports that fewer than 100 EMTs, and between 20 and 30 MICTs, become eligible to take the examinations each year. It would appear reasonable to schedule the paramedic examination once or twice a year, and to schedule the EMT examination somewhat more frequently.

In order to enable qualified applicants to enter practice, and to enable the board to schedule examinations on a cost-effective basis, the statutes should be amended to permit emergency ambulance personnel who meet the board's training requirements to obtain temporary certification until the results of the first available examination are issued.

**Board organization and operations.** The field of emergency medicine is a new and highly specialized branch of medicine that is constantly changing and expanding. Many of the board's duties and responsibilities with regard to the certification of emergency ambulance personnel deal with technical matters with which only specialists are fully knowledgeable. For example, deciding on the supervisory relationship between emergency physicians and emergency ambulance personnel requires a detailed knowledge about the medical control issues inherent in an emergency medical services system. Similarly, establishing standards for the training of emergency ambulance personnel requires a detailed knowledge about emergency medical practice.

At present, the board lacks sufficient time and expertise in the field of emergency medicine to be able to develop an adequate certification program for emergency ambulance personnel.

We suggest that a committee of practicing emergency physicians and emergency ambulance personnel be established to assist the board in developing and implementing its certification program. This should ensure that sufficient attention is paid to this important regulatory activity and that professionals with substantive knowledge of the field of emergency medicine are involved in the certification program. It should also provide the board with additional resources necessary to assume direct responsibility for administering the certification examinations. This is the approach taken in regulating podiatrists under Chapter 463E, HRS, which delegates to a committee of not less than three licensed podiatrists all duties except the adoption of rules and proceedings relating to revocation and suspension of licenses.

### ***Recommendations***

*We recommend that:*

1. *Chapter 453, HRS, be reenacted to allow for the continued regulation of emergency ambulance personnel. In reenacting the chapter, consideration be given to the following changes:*

- *Permitting emergency ambulance personnel who meet the board's training requirements to obtain temporary certification until the results of the first available National Registry examination are issued.*
  - *Authorizing the board to delegate most of its duties and responsibilities relating to the certification of emergency ambulance personnel to a committee of practicing emergency physicians and emergency ambulance personnel.*
2. *The Board of Medical Examiners amend its rules to:*
- *Define the scope of practice for emergency ambulance personnel and the level of supervision that is necessary to ensure the safe and effective practice of medicine by these health care personnel.*

- Set clear and specific certification standards for emergency ambulance personnel. In doing so, the board should consider using primarily National Registry standards. The board should also identify what additional skills may be necessary for Hawaii practice, set standards covering these skills, and develop a local examination to test applicants' competency in the additional skill areas.*
  
- 3. With the establishment of specific certification standards by the board, the Department of Health amend its training requirements to make them consistent with the certification standards.*
  
- 4. The board assume direct responsibility for reviewing the training credentials of all applicants and administering the national certification examinations.*

---

APPENDIX

RESPONSES OF AFFECTED AGENCIES

---



## COMMENTS ON AGENCY RESPONSES

A preliminary draft of this Sunset Evaluation Report was transmitted on December 13, 1983 to the Board of Medical Examiners and to the Department of Commerce and Consumer Affairs for their review and comments. A copy of the transmittal letter to the board is included as Attachment 1 of this Appendix. A similar letter was sent to the department. The responses from the board and the department are included as Attachments 2 and 3. We comment first on the board's response and then on the department's.

The board agrees with some of the recommendations in the report but disagrees with others. The board agrees that:

- . there should be mandatory regulation of physician's assistants although the board calls for "certification" rather than "licensing;"
- . the term "physician-support personnel" should be deleted from the statutes and the practice of medicine under the direction and control of physicians should be limited under Chapter 453 to only certified physician's assistants and emergency ambulance personnel;
- . the authority to receive and review information reported pursuant to all the statutory reporting requirements relating to medical malpractice and misconduct should be delegated to the department;
- . the Insurance Commissioner should be authorized to forward to the department copies of closed claim reports pertaining to insurance settlements, arbitration awards, and adjudicated judgments;
- . the department should clarify the role of the medical advisory committee;
- . the board's rules should specify: (1) the level of supervision that is required for the practice of medicine by certified physician's assistants and emergency ambulance personnel; and (2) set clear guidelines for declaring areas of absence or shortage of physicians and remove county medical societies from making these determinations;

- . the department should make a more thorough check of the disciplinary history of all applicants for licensure and revise the physician application instructions;
- . the department should clarify the role of the intake specialists in the Regulated Industries Complaints Office;
- . the director of the department should assign the responsibility for administering the medical claims conciliation panels to a member of the director's staff who is not associated with the board, and the director should budget for the special needs of the board to enable it to meet its statutory responsibilities.

The board does not agree with our recommendations that foreign medical graduates should be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and have one year of graduate medical training to be eligible for the state board examination, and that graduates of the American Medical Association's Fifth Pathway Program should be recognized on the same basis. The board contends that Hawaii should maintain its higher standards because the lower standards would promote "mediocrity." We believe that the issue here is the establishment of such standards as will adequately protect the public. Forty-three states and the District of Columbia require foreign medical graduates to be certified by the ECFMG, and 46 states recognize the Fifth Pathway Program certificate. There is no evidence that more restrictive standards are needed in Hawaii.

The board responded to our recommendation that it promote greater public participation by holding meetings in public places by saying that it has had difficulty securing public meeting rooms for evening meetings. There are numerous public meeting rooms available for evening use in public libraries and in the State Capitol when the Legislature is not in session.

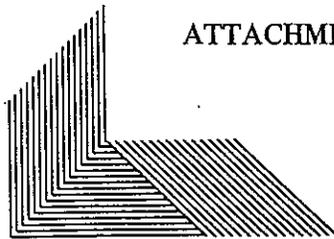
With respect to emergency ambulance personnel, the board agrees to amend its rules to define the scope of practice and the level of supervision necessary. However, the board opposes the granting of temporary certification to these personnel prior to the release of results from the National Registry examinations as this might place the public in danger. However, it must be noted that the board now grants temporary licenses to *physicians* in similar circumstances.

The board disagrees that it should delegate most of its duties and responsibilities relating to the certification of emergency ambulance personnel to a committee. It prefers instead to retain complete authority over the certification program and consult with specialists as needed. This would be a viable alternative if the board intends to apply itself to developing and operating the certification program. Otherwise, the board should establish a committee similar to that established for podiatrists pursuant to Chapter 463E. We would not have made this recommendation if we had found that the certification program was being adequately conducted. The board agrees that it will assume direct responsibility for reviewing the training credentials of all applicants and for administering the National Registry examinations as necessary funds and staff are made available. The board did not respond to our recommendation that it set clear and specific certification standards for emergency ambulance personnel and that it consider using primarily National Registry standards.

The department responded to several findings in the areas of enforcement and board operations. It agrees with some of our recommendations but notes areas of disagreement which it says may only be one of degree. The department states that the information reporting system relating to possible medical malpractice and misconduct is operating effectively but that statutory changes could be made to improve the quality of information conveyed. The department also states that the medical advisory committee is functioning as intended but agrees that an information sheet should be drafted to define the role of the committee. The department says that it has taken steps to clarify the role of intake specialists in the Regulated Industries Complaints Office. Finally, the department says that it will consider the potential conflict of interest in assigning medical claims conciliation panel responsibilities to the board's executive secretary when it studies whether internal adjustments can be made to allocate more staff time to the board.

ATTACHMENT 1

THE OFFICE OF THE AUDITOR  
STATE OF HAWAII  
465 S. KING STREET, RM. 500  
HONOLULU, HAWAII 96813



CLINTON T. TANIMURA  
AUDITOR

December 13, 1983

*COPY*

Dr. Ben K. Azman, Chairman  
Board of Medical Examiners  
Department of Commerce  
and Consumer Affairs  
State of Hawaii  
Honolulu, Hawaii 96813

Dear Dr. Azman:

Enclosed are 10 preliminary copies, numbered 4 through 13, of our *Sunset Evaluation Report, Medicine and Surgery*. These copies are for review by you, other members of the board, and your executive secretary. This preliminary report has also been transmitted to Dr. Mary G. F. Bitterman, Director, Department of Commerce and Consumer Affairs.

The report contains our recommendations relating to the regulation of medicine and surgery. If you have any comments on our recommendations, we would appreciate receiving them by January 12, 1984. Any comments we receive will be included as part of the final report which will be submitted to the Legislature.

Since the report is not in final form and changes may possibly be made to it, access to this report should be restricted solely to those officials whom you might wish to call upon to assist you in your response. We request that you exercise controls over access to the report and ensure that the report will not be reproduced. Should you require additional copies, please contact our office. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the assistance and cooperation extended to us.

Sincerely,

Clinton T. Tanimura  
Legislative Auditor

Enclosures

ATTACHMENT 2



GEORGE R. ARIYOSHI  
GOVERNOR

MARY G. F. BITTERMAN  
DIRECTOR  
BANK EXAMINER  
COMMISSIONER OF SECURITIES  
INSURANCE COMMISSIONER

STATE OF HAWAII  
OFFICE OF THE DIRECTOR  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

DONALD D.H. CHING  
DEPUTY DIRECTOR

1010 RICHARDS STREET  
P. O. BOX 541  
HONOLULU, HAWAII 96809

January 9, 1984

RECEIVED

JAN 10 10 15 AM '84

GFC OF THE AUDITOR  
STATE OF HAWAII

The Honorable Clinton T. Tanimura  
Legislative Auditor  
Office of the Auditor  
465 South King Street, #500  
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

The Board of Medical Examiners discussed your preliminary Sunset Evaluation Report, Medicine & Surgery at its meeting on December 21, 1983.

Since most of the Board members are relatively "new" (three members were appointed in 1983; two members, including the chairman, in 1982; one in 1981; two in 1980; and one in 1978), the individual members found the report to be most informative with regard to background information and past Board actions. Despite disagreement with certain recommendations in Chapters 3 and 4, it was generally felt that the first three chapters were very well written, although Chapter 4 contains some inconsistencies which we will comment on later.

We have the following comments to make on the recommendations in Chapter 3.

1. The Board agrees that Chapter 453, HRS, be reenacted to continue the regulation of medicine and surgery.
  - a. The Board agrees that the term "physician-support personnel" be deleted. Past Boards did not define the term "physician-support personnel" because of the apparently numerous and diverse types of personnel involved (nurse practitioners, nurses, physician's assistants, medical office assistants, ambulance personnel, cytology technicians, orthopedic technicians, etc., to name but a few). The present Board feels that there are only three categories of non-physicians who can be truly described as

practitioners of medicine under the direction and control of physicians: physician's assistants, nurse practitioners (who are regulated by other statutes) and emergency ambulance personnel. All the other categories, such as nurses and medical office assistants, do not practice medicine themselves, but merely assist the physician in his practice of medicine. Thus, the vague term "physician-support personnel" can be deleted and replaced by the more specific terms "physician's assistants and emergency ambulance personnel".

- b. The present Board feels that certification of physician's assistants should be mandatory. However, a licensing program is redundant, since the supervising physician has to be licensed, and also assumes full responsibility for the actions of the physician's assistant. This is one example where the costs of licensing physician's assistants would outweigh the benefits (see item 6 one page 1-3 of your report), and the taxpayer should be spared the burden of unnecessary costs.
- c. Your report condemns the term "physician-support personnel" as being overly broad, but then promptly uses instead the term "health care personnel," which is equally vague. Only certified physician's assistants and certified emergency ambulance personnel should be authorized to practice medicine under the direction and control of physicians.
- d. The Board of Medical Examiners (including the two lay members) is unanimous in its opposition to your recommendation to lower the licensing standards for foreign medical graduates. It is the responsibility of the Board to provide assurance to the citizens of this State that each physician licensed to practice medicine can do so with reasonable skill and safety, even at the entry level. The foundation of this quality medical practice is the medical school. Because of the uniform accreditation process in this country, a base-line of competence is assured. Unfortunately, this is not true on a worldwide basis.

The Honorable Clinton Tanimura  
Page Three  
January 9, 1984

Most state medical boards have traditionally accepted schools that attained listing in the World Health Organization Directory of foreign schools. Generally, this means that a listed school is recognized by the government of the country in which it is located. However, the "Introduction" in the W.H.O. Directory states: "-----it is intended to be no more than a general guide to medical education in the various countries." It goes on to state, "More detailed information on training programs should be obtained directly from the schools themselves-----" Because the status quo does not seem to allow boards to fulfill their responsibilities to the people they serve, the Federation of State Medical Boards has formed the Commission to Evaluate Foreign Medical Schools. The Commission was charged with developing a process to collect data about foreign medical schools upon which the state licensing boards could base their decisions of acceptance. The Commission was successful in designing such a process, but failed in its attempt to implement that process, since recent lawsuits have challenged their authority to act on behalf of state boards.

Besides concerns about the quality of the basic education provided by schools outside the United States accreditation processes, there now seems to be a need for concern related to the veracity with which some schools generate the very documents upon which boards base their licensure decisions.

Cetec University, located in the Dominican Republic, has been shown, by the California Board, to accept transfer credits from non-existent and non-certified medical schools, and to be using the credits to grant advanced standing in their program of up to three and one half years. In many cases the official transcripts make no reference to the use of course work from another institution in granting the M.D. degree. Cetec has also been found to accept training in other fields, unrelated to medicine, in lieu of required course work and converting it to standard medical curriculum.

and awarding the M.D. degree. The California Board further states, "It is routine for Cetec to certify full time attendance in medical school-----for students that have never set foot in the Dominican Republic."

Until a nation-wide mechanism is developed to ascertain that all foreign medical graduates have received their medical education from a curriculum that meets the statutory requirements of comparability to that basic medical education provided by schools in this country, the Hawaii Board feels that the best way to avoid becoming a dumping ground for physicians who are inadequately trained in programs outside this country, is for Hawaii to maintain the present high licensing standards for foreign medical graduates. Lowering the standards would at best promote mediocrity, and at worst create a danger to the health, welfare and safety of the public.

- e. The Board also unanimously opposes recognizing graduates of the Fifth Pathway Program for exactly the same reasons, since once again foreign medical schools are involved. The report in essence argues that Hawaii should lower its standards because many other states have lower standards. This type of reasoning makes sense only to those who believe in mediocrity. It should be emphasized that many states use their lower standards to obtain physicians for unattractive areas of their states. Since Hawaii is so beautiful, there is, in general, no shortage of physicians in this State. After all, Hawaii is a special place, and its people should be protected from the rising tide of mediocrity.
- f. While the Board agrees to delegate to the Department of Commerce and Consumer Affairs its authority to receive and review information reported pursuant to all the statutory reporting requirements relating to medical malpractice and misconduct, the Board feels that the Director of the Department should be authorized to subpoena only the hospital patient records used by peer review committees in arriving at their adverse decisions. It must be emphasized that of the

six reporting channels described in your report, only the one involving peer review committees currently flow into the investigation system (page 3-16). The peer review system is working, and it is important not to upset the delicate balance that currently prevails. The Board does agree that the Insurance Commissioner should be authorized to forward to the Department copies of closed claim reports pertaining to insurance settlements, arbitration awards, and adjudicated judgments.

2. The Board agrees with recommendation no. 2.
3. The Board agrees with recommendation no. 3, except that the term "licensed and certified health care professionals" should be replaced by the terms "certified physician's assistants and certified emergency ambulance personnel." The term "health care personnel" is ambiguous.
4. The Board agrees with recommendation no. 4.
5. The Board agrees with recommendation no. 5.
6. The Board wholeheartedly agrees with recommendation no. 6.
7. The Board of Medical Examiners meets at 7:00 in the evening of the third Wednesday of each month (unlike other Boards, which meet in the daytime, according to the executive secretary). The evening meetings are necessary since physicians have such busy schedules during the day. Evening meetings also promote greater public participation, since the majority of the public also work during the day. The State Capitol is locked during the evenings, and the executive secretary has stated that he has experienced great difficulty in the past in obtaining a public meeting room. The Board will be happy to use any meeting room that can be made available to the Board for its use in the evening, including the office of the Legislative Auditor, if he should care to offer it!!

The executive secretary states that he sends seven copies of the Board's agenda to the Lieutenant Governor's office each month, to be distributed

throughout the State as meeting notices to the public. He also states that he sends copies of the agendas, meeting notices and minutes to anyone who requests them.

The Board finds nothing in the report to support the insinuation that the Board does not promote objectivity. It can only conclude that the staff member of the Legislative Auditor's office who wrote the report, was piqued by not being allowed to sit in on the executive sessions when sensitive and confidential matters were discussed.

Finally, the Board notes that the Legislative Auditor's letter of December 13, 1983 accompanying the report, requests that access to the report be restricted, and that we "exercise controls over access to the report and ensure that the report will not be reproduced". Since the meetings of the Board are public meetings, and since the publicly-distributed agenda did state that the Legislative Auditor's report will be discussed at the meeting of December 21, 1983, we submit to you that your office's request to prevent public access to the report does negate the intent of the Sunshine Law.

The Board of Medical Examiners has the following comments on your recommendations in Chapter 4.

1. The Board agrees that Chapter 453, HRS, be reenacted to allow for the continued regulation of emergency ambulance personnel.
  - a. However, the Board strongly opposes the granting of temporary certification of emergency ambulance personnel prior to the release of the results of the National Registry examination. The emergency room physician who is communicating with the EMT or MICT out in the field, has a right to assume that the EMT or MICT is capable of carrying out his orders in the management of the acutely ill or injured patient. This assumption cannot be made until the individual's skills and capabilities are proven by passing the National Registry examination, as a minimum standard.

Your report is inconsistent. On page 4-1 of your report, you state, "Emergency ambulance personnel

diagnose and treat a wide variety of routine and serious medical emergencies while working under the direct or indirect supervision of physicians. In effect, they practice medicine on acutely ill or injured patients. An incorrect diagnosis or incompetent medical treatment may result in loss of life or temporary or permanent disability. Inadequate medical care may also result in emotional distress and economic hardship to patients and their families." And yet you recommend the temporary certification of ambulance personnel who have not yet passed the National Registry examination, thereby creating a potential danger to the public by allowing the practice of medicine by individuals who have not yet proven their competency and skills. The Board feels that the public should not be placed in danger, simply to increase the number of employed ambulance personnel.

- b. The Board does not intend to delegate its duties and responsibilities relating to the certification of emergency ambulance personnel to a committee of practicing emergency physicians and emergency ambulance personnel. Certainly the field of emergency medicine is specialized and changing and expanding. But what branch of medicine is not specialized and changing? Is not cardiovascular medicine? Or neurosurgery? Or radiology? Does the complexity of medical specialists justify the abdication of the Board's responsibilities and the multiplication of bureaucracy by the creation of a committee for each and every field of medicine? The present Board intends to consult with the relevant specialties whenever the need arises, but it does not intend to abrogate its statutory responsibilities.
2. The Board plans to amend its rules to define the scope of practice for emergency ambulance personnel and the level of supervision that is necessary to ensure the safe and effective practice of medicine by these ambulance personnel.
3. Whatever the certification standards the Board sets for emergency ambulance personnel, the Department of

Health should not be forced to amend their training requirements. Just as the Board of Medical Examiners has no right to tell the University of Hawaii Medical School how to set their academic standards, by the same token the agency that provides and conducts the training program for emergency ambulance personnel (be it the Department of Health, or the Employment Training Office, or the University of Hawaii), should be allowed the independence to set its own standards, even though these standards may be higher than your report would like.

Your report chides the Department of Health for making the training standards for emergency ambulance personnel "among the most stringent in the nation" (page 4-5). The Board of Medical Examiners feels that high standards are something to be proud of. The sensible long-range solution to the shortages of MICTs in Honolulu is to train more MICTs that meet the current high standards, rather than to lower the standards (which is what your report suggests) and endanger the public.

4. The Board will assume direct responsibility for reviewing the training credentials of all applicants and administering the national certification examinations the moment the necessary funds and staffing are made available. Your report on page 4-1 states, "The Board has not assumed independent control over certification but has allowed other agencies to participate substantively in the certification process." Chapter 4 of your report is not objective in the sense that it failed to mention the fact that the Board was never provided the necessary funds and staffing in order to effectively carry out its added responsibilities in administering the new certification program for emergency ambulance personnel. These "other agencies" did have the financial resources that the Board never received.

The Honorable Clinton Tanimura  
Page Nine  
January 9, 1984

We appreciate your consideration of our comments. The Board of Medical Examiners appreciates the opportunity of having our comments included as part of your final report which will be submitted to the Legislature.

Sincerely,

*BK Azman M.D.*

BEN K. AZMAN, M.D.  
Chairman  
Board of Medical Examiners

ATTACHMENT 3

GEORGE R. ARIYOSHI  
GOVERNOR



DONALD D. H. CHING  
Acting Director  
Commissioner of Security

STATE OF HAWAII  
OFFICE OF THE DIRECTOR  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS  
1010 RICHARDS STREET  
P. O. BOX 541  
HONOLULU, HAWAII 96809

RUSSEL S. NAGATA  
DEPUTY DIRECTOR

January 4, 1984

RECEIVED

JAN 6 8 20 AM '84

OFF. OF THE AUDITOR  
STATE OF HAWAII

The Honorable Clinton Tanimura  
Legislative Auditor  
Office of the Auditor  
465 South King Street, #500  
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

Thank you for the opportunity to respond to your "Sunset Evaluation Report, Medicine and Surgery." The department's response will be detailed below, while the Board of Medical Examiners will submit a separate document. The department will address only those comments which it has direct responsibility for.

Page 3-1 lists three findings which directly relate to the department.

"5. Statutory provisions that require various agencies and individuals to report medical malpractice and unprofessional conduct by physicians are not being effectively implemented, and some are not being implemented at all. In addition, some of the reporting requirements and the information made available are inadequate.

6. The role of the medical advisory committee is confused, and it does not appear to be functioning as intended by statute.

7. The board does not have sufficient staffing and budget support to carry out effectively its many duties and responsibilities. This is due in part to the fact that the executive secretary to the board devotes most of his time to administering the medical claims conciliation panels."

With respect to finding no. 5, the department disagrees that the reporting process which funnels possible unprofessional or malpractice information into the department is not being effectively implemented. However, we agree that some of the information made available is inadequate. Of the six reporting channels mentioned, the peer review committee, medical claims conciliation panels, and drug abuse enforcement are the most important sources of information about errant doctors. As of November 30, 1983, seventy-two complaints have been filed against physicians compared to only twenty-nine for the previous year. Of these seventy-two cases, an overwhelming majority have been cases where another private or public disciplinary agency have already determined that some sanction against a physician was necessary. These cases represent extremely serious actions which demanded immediate departmental action. In the drug abuse area alone, contrary to your finding, the Department of Health's Investigation and Narcotics Control Section routinely refer their investigation reports directly to the Regulated Industries Complaints Office's (RICO) legal staff bypassing intake and investigation. With respect to the receipt of adverse peer review reports, the board's secretary automatically refers them to RICO without review.

Our disagreement with the report may just be one of degree. We believe that the reporting system is adequate but can be made more effective with some statutory changes. One of the statutory changes not mentioned in the report is the requirement that medical records also be submitted with the MCCP's advisory decisions, closed claim reports of insurance companies, and reports of self-insured physicians. With respect to the recommendation that non-patient adverse peer review decision records be made available to RICO investigators, a word of caution should be raised. A vital component of the information reporting system is a viable adverse peer review process. Allowing total access to the inner workings of the adverse peer review committees may inhibit the willingness of doctors and hospital staff to freely express themselves. Careful thought should be given before enlarging RICO's investigatory powers.

With respect to finding no. 6, the department disagrees that the medical advisory committee is not functioning as intended by statute. As you are well aware, the adverse peer review reports are deemed confidential by statute. Even the staff person assigned to draft the sunset report was not able to review each adverse report and subsequent investigation file. If the staff person reviewed the over thirty adverse peer review files, she would have discovered that the advisory committee was indeed performing the expert opinion role as originally intended by the department and the board. The staff person would have discovered that the advisory committee was routinely consulted by an investigator on almost every adverse peer review decision report.

The department agrees that an information sheet should be drafted to define the role of the committee. However, we do not believe that the sunset report's emphasis on the functions of a "special subcommittee" should detract from the fact that the advisory committee is primarily providing expert advice to the RICO investigators.

The department agrees that the role of RICO's intake specialists should be clarified. When the staff person conducted her research this past summer, the intake office had only been in existence for half-a-year and lacked a clear understanding of the various medical complaint cases. However, since October clear guidelines on responsibilities and priorities have been established. Most importantly, the intake specialists are now well aware that complaints alleging medical malpractice or unprofessional conduct that cause death, permanent disability, or temporary disability to patients are of high priority.

Finally, the department agrees with finding no. 7 that the board does not have sufficient staffing. Given the state's serious budgetary condition, additional staffing will be difficult to obtain. However, the department will study whether departmental assignment adjustments can be made to devote more staff resources to the board of medical examiners. Although the executive secretary does not sit in on MCCP discussions or get involved on deciding which cases get referred for investigation, the potential conflict of interest aspect will be considered when the department studies whether internal adjustments can be made to allocate more staff time to the board.

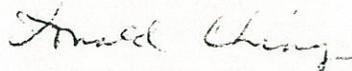
Although the department does not agree with all of the findings of the sunset report, the areas of disagreement may only be one of degree. The department is confident that if

The Honorable Clinton Tanimura  
Page Four  
January 4, 1984

a subsequent update of the report is done today, a number of concerns would be resolved. Suggested statutory changes, internal policy implementation, and staff adjustments are all matters which the department is willing to review and refine.

We thank your staff for the thoroughness of the research and the many recommendations which can only prove useful in improving the board's responsiveness to the public and the profession.

Sincerely yours,



Donald Ching  
Acting Director