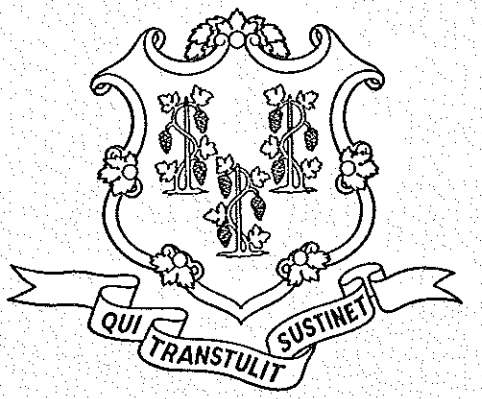
Connecticut General Assembly



Legislative Program Review and Investigations Committee

SUNSET REVIEW

Medical Examining Board

Vol. I-10

January 1, 1980

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements. In 1975 the General Assembly expanded the Committee's function to include investigations and changed its name to the Legislative Program Review and Investigations Committee. During the 1977 session, the Committee's mandate was again expanded by the Executive Reorganization Act to include "Sunset" performance reviews of nearly 100 agencies, boards, and commissions, commencing on January 1, 1979.

The Committee is composed of twelve members, three each appointed by the Senate President Pro Tempore and Minority Leader, and the Speaker of the House and Minority Leader.

This is the first of five annual reviews emerging from the first round of "Sunset" research.

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SUNSET REVIEW 1980

CONNECTICUT MEDICAL EXAMINING BOARD

Vol. I-10

SECTION I

DESCRIPTION OF ENTITY

- Definition and Background
- Structure
- Functions
- Entry Requirements

CONNECTICUT MEDICAL EXAMINING BOARD

The Connecticut Medical Examining Board was reviewed by the Legislative Program Review and Investigations Committee in compliance with the Sunset mandate of P.A. 77-614. The nine criteria outlined in that act (Title 2c, Chapter 28) provided the basis upon which committee decisions were made. These criteria required legislators to address three fundamental questions in evaluating the boards and commissions slated for 1980 Sunset review:

1. Is regulation of the occupation or profession necessary to protect the public from harm?

2. What is the appropriate level of regulation?

3. Who should regulate the occupation or profession and how should it be regulated?

This board-specific report is supplemental to the Sunset Review 1980 - General Report which contains the background, methods, and recommendations of Sunset Review 1980. To appreciate fully the contents of this board-specific report, it is necessary to review and refer to the General Report, particularly the section "Model Legislation" which provides a single statutory framework to be applied uniformly and consistently to all regulated entities under Sunset review.

This specific report contains the following sections:

- Description of entity reviewed;
- Recommendations and discussion for entity reviewed; and
- Entity survey and analysis.

Definition and Background

In the practice of medicine and surgery, physicians diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease (actual or imaginary), and perform surgery.

The potential for serious harm within the broad scope of medical practice is obvious. Physicians, in addition to providing all aspects of medical care, are responsible for supervising other health professionals (e.g., nurses, physician associates and other trained assistants) who perform medical functions. Given the increasing complexity of modern medical care and the growing number of "physician extender" personnel, the need to assure competent medical practice through licensure has become greater over the years.

Until the mid-1800's, regulation of physicians in most states was left to private medical societies.[1] This system proved unsatisfactory, however, when it was discovered that "quackery" was prevalent and the quality of medical education and training varied widely among practitioners.

State licensure of physicians originated to protect the public from quackery, deception, commercial exploitation and professional incompetence by establishing legally enforceable standards for entrance and continuation in the medical profession.

Today, all U.S. states and jurisdictions regulate the practice of medicine through boards of medical examiners, although medical societies as well as hospitals continue to play an important role in policing the profession through their respective peer review functions.

It should be noted that a license from a state medical board grants general authority to practice. Medical and surgical specialty boards, nationally recognized within the medical profession, rather than state licensing boards, certify competence

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[1] Physicians were first licensed in England in the sixteenth century. The first U.S. licensing law was enacted by New Jersey in 1772. For an overview of the medical profession's development see Bradley, J. and Harvey A., Two Centuries of American Medicine, W. B. Sanders Co., 1976.

within a medical specialty (cardiology, obstetrics, etc.). State licensure, however, is an initial requirement for recognition by one of these non-government specialty boards.

In Connecticut, the State Medical Examining Board is responsible for enforcing minimum medical and surgical practice standards through a physician licensure program. Over 11,000 persons held valid licenses to practice medicine and surgery in this state in 1978.

Structure

The composition of the Medical Examining Board was significantly altered with the passage of the "Doctor Disability Act" in 1976. The act, in addition to changing grounds and procedures for disciplinary action, increased board membership from five to nine, provided for diversified backgrounds among the seven physician members and specified that two new members, a lawyer and a public representative, not be connected with medicine. Under the 1977 Reorganization Act (P.A. 614) the board was modified slightly to its present composition of four practicing physicians, one physician who is a full-time UConn Medical School faculty member, one physician who is a full-time Chief of Staff of a Connecticut general care hospital, and three public members.

All members are appointed by the Governor. The Connecticut State Medical Society recommends physicians for the four practicing physician positions, but the Governor is not limited to these nominations.

Functions

The board's role in enforcing minimum standards in the practice of medicine and surgery includes responsibility for the following functions:

- advise and assist the Commissioner of Health Services in establishing regulations concerning operations of the board and the practice of medicine and surgery;
- approve medical schools and annually publish a list of approved schools;
- prescribe the examination required for licensure and supervise its administration;

- hold hearings on complaints concerning physicians and impose disciplinary sanctions; and

- annually report to the Governor and legislature on complaints received, disciplinary actions taken and recommendations to improve monitoring of health care quality.

As noted earlier, the 1976 "Doctor Disability Act" (P.A. 276) revised the board's disciplinary role. Under this act, the grounds for disciplinary action and the board's range of possible sanctions were broadened. The board was also authorized to order physicians to submit to a mental or physical examination as part of a disciplinary proceeding. In addition, provisions of this act require the board to make an annual "complaint" report and mandate certain medical organizations and individuals to report incompetent physicians to the board.

To assist the board in carrying out its expanded duties, provisions were made for the appointment of an executive director, as well as technical and clerical staffing from the department. The medical board was one of the few boards and commissions with separate, full-time staffing. All health regulatory boards within DOHS are now assisted by the centralized services of the Medical Quality Assurance Division.

Requirements for Licensure

The basic requirements for medical licensure in Connecticut include: a minimum age of 18; graduation from an approved medical school and an M.D. degree (or its equivalent); passage of the board's prescribed examination; evidence of good moral character; and two years residency training (or its equivalent) approved by the Liaison Committee on Graduate Medical Education (a nationally recognized approval organization). A $150.00 license fee is also required. All licensed physicians must annually register with the Department of Health Services and pay a $100.00 renewal fee.

The provision that all new applicants for licensure have two years of training as a resident physician was added in 1979 under P.A. 161.[1] Prior to this amendment, only foreign medical graduates were required to have post graduate experience and training.

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[1] Through a technical error, the statutory residency requirement, intended for all candidates, applies only to applicants for licensure through examination. Correction is anticipated during the next (1980) legislative session.

The board accepts the National Board of Medical Examiners' three-part examination ("National Boards") which is required (and administered) by most American medical schools. Nearly all recent American medical school graduates who apply for Connecticut licensure are licensed through endorsement of a National Board Diploma (given upon successful completion of the exam) rather than examination by the board. In addition, applicants who have received a license in another state or in Canada after passing an examination equal to Connecticut's and have practiced lawfully for one year, may be licensed without examination (provided they also meet the other education, training and character standards of this state).

Applicants whose credentials (e.g., diploma or license) are not eligible for endorsement or who have not previously been examined must take and pass the Federation Licensing Examination (FLEX) in order to be licensed in Connecticut. This standardized test, prepared by the Federation of State Medical Boards, and comparable to the "National Boards," was developed primarily for the examination of foreign medical graduates.[1]

Prior to 1979, "approved education" involved completing a program in an American medical school listed in the World Health Organization (WHO) Directory or in a foreign school recognized either by the WHO or the American Medical Association (AMA). Under its new authority to approve schools (P.A. 79-161), the medical board requires that applicants be graduates of U.S. and Canadian schools accredited by the Liaison Committee on Medical Education (the nationally recognized accreditation agency) or graduates of foreign schools listed by the WHO and approved by the board.

The requirements for a youth camp physician license are the same as those for endorsement of credentials (no examination by the board), except the fee is $25.00. In addition, such licenses are valid for a maximum of nine weeks and only entitle the licensee to practice in the youth camp designated in the license application.

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[1] Medical education in many foreign countries is quite different from American medical education. FLEX is designed to determine whether the applicant's educational and clinical background meets U.S. standards.

Applicants for a temporary physician license (to practice solely in any state facility) must pay a $150.00 fee and meet the requirements for endorsement of credentials or have graduated from a WHO listed medical school, received an M.D. or equivalent degree and completed one year of post-graduate experience.[1] In addition, these temporary licenses are valid for a maximum of 12 months. During this period the licensee must apply to take the FLEX examination for permanent licensure.

Clinic (group) permits are issued by the board (under C.G.S. Sec. 33-181) to corporations formed by three or more licensed physicians for the purposes of establishing a medical clinic to provide medical and surgical treatment and promote medical, surgical and scientific research. The initial permit fee is $20.00 and the annual renewal fee is $3.00. To be eligible for a permit, the corporation must be organized according to the statutory provisions concerning medical group clinics. Under these provisions (C.G.S. Chapter 594) all corporation members must be Connecticut licensed physicians and the clinic must: be established for medical treatment and research purposes; be operated in compliance with law and board regulations; and be conducted in the public interest.

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[1] Both the board and DOHS are reviewing this license in light of the new two year residency requirement. As noted earlier technical errors have produced some inconsistencies in licensure requirements.

SECTION II

RECOMMENDATIONS AND DISCUSSION

Recommendations for the Regulation of Medicine and Surgery (Chapter 370)

1. Continue physician license.

2. Continue temporary physician license (state facility only).

3. Terminate temporary youth camp physician license.

4. Terminate clinic (group practice) permit; retain statutory provisions allowing licensed physicians to incorporate (C.G.S. Chapter 594) as a medical clinic.

   Licensure has been found to be the most appropriate level of regulation for the practice of medicine and surgery. However, only two types of licenses--the physician license and the temporary physician license (state facility only)--are needed to protect the public from incompetent medical practitioners. The temporary youth camp physician license and the clinic (group practice) permit are not necessary. Other mechanisms are available to protect the public from harm in these circumstances.

5. Continue the Connecticut Medical Examining Board.

   Retention of this board as currently composed is necessary to provide professional expertise and peer review in the entry and enforcement functions of medical licensure.

6. Eliminate references to homeopathy from the Medical Practice Act (Chapter 370); establish separate licensing statutes for homeopathic medicine and surgery.

   Separation of the statutory provisions for homeopathy from the medical practice act is needed to clarify the distinction between traditional medical practice and homeopathy, and alternative school of practice.

7. Amend Chapter 370 to include Model Legislation standards, procedures, responsibilities, appropriate repealed sections and all other relevant sections.

   Model Legislation addresses and ameliorates previous and potential concerns about regulatory procedures and policies. By providing a single regulatory framework for all boards under the aegis of the Departmenz of Health Services (DOHS), the Model Legislation insures

consistency, objectivity and uniformity in the execution of regulatory functions. Specific areas of concern in medical regulation and the solution offered by the Model Legislation are listed below.

a. Powers and Duties of the Department of Health Services - *Professional board members and others expressed concern about the perceived unilateral control and authority by this single agency after Executive Reorganization. Model Legislation delineates the Commissioner's powers and duties relative to the regulatory boards and provides mechanisms for countervailing powers and board input where necessary.*

b. Powers and Duties of the Boards - *Critics of the boards prior to Executive Reorganization maintained that they had too much authority and lacked a necessary system of checks and balances in their powers and duties. After Executive Reorganization, however, board members and other professionals in particular believed that the board's regulatory role was overly diluted and not clearly specified with respect to the Department of Health Services.*

Model Legislation delineates the board's powers and duties and provides mechanisms to insure professional expertise and input where necessary.

c. Business Practices - *The Committee found that regulation of business practices and statutory restrictions on business practices were not relevant to ensuring and enforcing minimum standards of competence. Such business practices (See Model Legislation - Business Practices) recommended for statutory repeal include the following statutory section:*

- C.G.S. Sec. 20-13c(7) - Advertising restrictions.

d. Entry Requirements - *The Committee found that the medicine and surgery statutes governing entry requirements contained certain qualifications not relevant to determining an applicant's competence. Such requirements* --minimum age and good moral character-- *are recommended for deletion. Model Legislation also provides for an intensive review and revision of entry requirements by the board and the Department of Health Services to bring them in conformance with the principles outlined in the Model Legislation and the current state of the art in the practice of medicine.*

e. Renewal Standards - *The Committee found that standards for licensure renewal required review and revision to bolster the enforcement of continued competence. Model Legislation (Required Reports) provides for such updating.*

f. Grounds for Professional Discipline - *The Committee found a great variance among the statutes in this area. Model Legislation provides grounds for professional discipline which are focused on the delivery of service and quality of care rendered by the practitioner. Application of these grounds to all regulatory boards under the aegis of the DOHS insures a rational and uniform basis for peer review and imposition of disciplinary sanctions.*

g. Receiving and Processing Complaints - *An area of considerable controversy, mechanisms for receiving and processing complaints in the Model Legislation are delineated to provide the professional board with necessary information and input at appropriate stages, while maintaining the separation of powers and duties necessary in this regulatory aspect.*

h. Disciplinary Sanctions - *Model Legislation explicates a range of disciplinary sanctions and requires consistency and uniformity in their application.*

8. Direct the Medical Board and the DOHS to:

- Study the issue of physician's trained assistants (in consultation with the Nursing Board) and;

- Report recommendations to the Public Health Committee during the 1981 legislative session concerning qualifications necessary for practice as a physician's trained assistant, guidelines for physician supervision, and the appropriate and least restrictive mechanism for regulation of all categories of physician's trained assistants (e.g., physician extenders, physician associates, nurse clinicians, nurse practitioners, child health associates, etc.).

Public hearing testimony and Committee staff research revealed that the effective utilization of physician's assistants is hindered by legal ambiguities in definitions and scope of practice. The complexities of the physician's trained assistant issue could not be resolved satisfactorily during the 1979 Sunset process. The Legislative Program Review and Investigations Committee found that further study by health professionals and the legislature is necessary to determine a consistent approach for regulating all types of physician's trained assistants.

SECTION III

ENTITY DATA AND ANALYSIS

ENTITY DATA AND ANALYSIS

Section 2c-6 of Connecticut's Sunset Law mandates that the entity reviewed demonstrate a "public need for (its) reestablishment" and that "it has served the public interest and not merely the interests of the persons regulated." All boards, commissions and departments evaluated in Sunset Review 1980 received a questionnaire which addressed the nine statutorily specified Sunset criteria.

This questionnaire, the primary instrument used to evaluate the entity's "burden of proof," was followed by staff interviews with key board members and members of the professional associations for further clarification and amplification.

The following section contains the questionnaire sent to the Connecticut Medical Examining Board. Where appropriate, Committee staff has edited the agency response without altering or diluting the argument. Committee staff then analysed the agency response. Because of the methodological constraints posed by Sunset evaluation and implementation of Executive Reorganization occurring simultaneously, manageable quantitative data were difficult to obtain. Qualitative analysis, based on relevant information and data derived from a variety of sources, was used primarily in the Committee staff comment. This annotation appears in italics below the agency response.

1. WOULD THE TERMINATION OF LICENSING REQUIREMENTS FOR YOUR PROFESSION SIGNIFICANTLY ENDANGER THE PUBLIC HEALTH, SAFETY, OR WELFARE? PLEASE EXPLAIN.

Yes, the termination of licensing requirements would significantly endanger the public health, safety and welfare. The licensing procedures as now defined are at a bare minimum and essential for quality control protection of the public in matters concerning medical care. The termination would remove even the minimal protection the public now has under the current statute.

Medical practice involves the full range of health care from diagnosis to all forms of treatment including surgery. Physicians, in directing and providing all aspects of medical care, perform functions and make decisions which directly impact a patient's life, health and safety. Competent medical care demands special skills and knowledge. The risks to the public health, safety and welfare from unqualified practitioners is obviously significant. In the United States, entry to the medical profession requires, at a minimum, eight years of intensive education and training and passage of a rigorous examination. All 50 states and every U.S. jurisdiction licenses physicians to insure a minimum level of competence among practitioners of medicine and surgery.

2. COULD THE PUBLIC BE ADEQUATELY PROTECTED BY ANOTHER STATUTE, OFFICE, OR PROGRAM? IF SO, WHICH ONE(S)?

There is not an existing statute that could protect the public as the laws are now written.

Under the current regulatory structure, the Connecticut Medical Examining Board consisting of physician and public members, shares responsibility with the Department of Health Services for implementing the state's physician licensure program. During an interview, the board chairman agreed with staff that certain regulatory functions, e.g. processing and approving applications, investigating complaints (provided a physician is consulted) could be adequately handled by department staff. However, the board maintained, during interviews and in public hearing testimony, that questions of competence and quality of care require professional expertise for fair and thorough review.

In addition, medical care becomes more complex each year as new research findings, highly technical procedures and experimental medications are introduced. Entry and practice standards should be frequently reviewed and periodically revised to reflect the continual growth and change within the medical profession. Physician input is vital to the effectiveness of this process.

The staff recognizes a valid need for professional expertise in complaint adjudication as well as in the development of medical licensure requirements. Approval of foreign medical schools, since they are not subject to a uniform accreditation process, is another regulatory area requiring advice from the medical establishment. The current board structure provides an efficient way of regularly involving both physician input and a public interest viewpoint in entry and enforcement functions of state regulation.

3. COULD THE PUBLIC BE ADEQUATELY PROTECTED BY A LESS RESTRICTED METHOD OF REGULATION THAN THE CURRENT LICENSING REQUIREMENTS, SUCH AS CERTIFICATION OR REGISTRATION? PLEASE EXPLAIN.

No. The public would not be adequately protected with a less restricted method of regulation. The current law, as noted above, is permissive as it stands and is a bare minimum of adequacy for public protection. Thus, [less] restricted methods and regulations certainly will fall far below the minimum for assurance to the public.

Licensure is the only regulatory mechanism for assuring initial and continued competence according to legally enforceable standards. As the most restrictive method of regulation, it can provide the greatest degree of public protection and should be instituted when incompetence poses significant danger to the public health, safety and welfare. Given the high potential for serious harm involved in medical care, the large, diverse patient population served and the broad scope of medical practice, licensure is the most appropriate level of regulation for the practice of medicine and surgery.

However, one type of temporary license--the youth camp physician license--and the clinic (group practice) permit issued by the board are recommended for termination. Youth camps in the state are not required to employ licensed physicians. Therefore, this special licensure category is unnecessary. Under provisions of the medical clinic statutes (C.G.S. Chapter 594) only licensed physicians may form a corporation for group medical practice and research purposes. Individual physicians remain liable for disciplinary action. This adequately protects the public from incompetence. The board was not aware of its responsibilities related to group practice clinics and does not oppose elimination of the permit requirement.

4. DOES YOUR BOARD OR COMMISSION HAVE THE EFFECT OF INCREASING THE COSTS OF GOODS OR SERVICES TO THE PUBLIC EITHER DIRECTLY OR INDIRECTLY? PLEASE EXPLAIN THE BASIS FOR YOUR ANSWER.

No. The facts can support the statement quite the reverse of increasing costs of goods and services to the public. If allowed to function adequately, the board could have the effect of saving costs of medical services far in excess of the cost of operating the board. Inappropriate use of medications, hospital resources, tests, etc. are many times an indication of physician incompetence. The Board of Medical Examiners is charged through its statutory authority to detect such incompetence. More staff and more attention to this aspect of the board's function would be very cost-effective.

The board, through its licensing program, does contribute indirectly to the costs of medical care. Scholarly research has demonstrated that professional licensing, because it is exclusionary, creates and has the economic impact of a monopoly.[1] *Entry to the medical profession also requires a substantial investment in an expensive, lengthy education and training program. In economic theory, the costs incurred to meet medical licensing requirements will be reflected in the fees physicians charge. While many factors beyond the control of the board are involved in the high cost of medical care, the board's licensing function has an effect on both the availability and cost of physician services.*

5. IF YOUR BOARD HAS THE EFFECT OF INCREASING COSTS, IS THE ADDITIONAL COST JUSTIFIED THROUGH PUBLIC BENEFITS ATTRIBUTABLE TO THE ACTIONS OF THE BOARD? PLEASE EXPLAIN.

The board does not have the effect of increasing costs. Indeed the board by virtue of licensure fees has income to the state far in excess of the costs to the state for function of board.

It is true that physician licensure fees generate far more revenue for the state than the amount expended for medical board operations (over $1.1 million vs. about $89,000 in FY 78). Licensing, however, raises the cost of professional services. Neither the increased costs due to physician licensing nor its attributable benefits, e.g. protecting the public from the significant harm of incompetence and reducing unnecessary or inappropriate medical services, can be

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[1] For an excellent overview of recent literature on the topic, see Simon Rottenberg, A Review of the Progessional Literature on Occupational Licensing, conference paper, Crotonville, New York, April 28, 1978.

easily quantified. Therefore, it would be difficult to prove whether the social benefits of medical licensure outweigh its social costs in dollar terms. On a more qualatative basis, increased costs seem justified, given that the risks of incompetent medical practice include serious, irreversible physical harm and death.

6. IS THE EFFECTIVENESS OF YOUR BOARD OR COMMISSION HAMPERED BY EXISTING STATUTES, REGULATIONS OR POLICIES, INCLUDING BUDGET AND PERSONNEL POLICIES. IF SO, PLEASE BE SPECIFIC IN YOUR ANSWER.

The effectiveness of the board is hampered by the existing statutes, regulations and policies, including budget and personnel policies. The staff supporting the Executive Director of the Medical Examining Board is inadequate to the task of processing the applications, establishing the examination procedure, following up with proper investigation of patient complaints and the myriad of other activities for which the board is responsible. There are too few investigators; there is too long a delay processing applications. Fees generated by the board in licensing, applications, etc. should be applied to perfecting the protection of the public. There are wholly inadequate funds and staff to begin to approach the matter of monitoring a physician's function and physician rehabilitation.

The current medical practice act (Chapter 370) contains inconsistencies and outdated, erroneous and vague sections that impede effective implementation. According to one board member, "There is need to clean up and codify many of the definitions and exclusions of the present law which has grown like Topsy over the decades."

Two sections in particular have important policy implications and need immediate attention and revision. A recent amendment (P.A. 79-161) requiring residency training inadvertantly established dual standards for licensure through examination and licensure through endorsement. The two years of post-graduate experience as a resident physician was intended to apply to all new licensure candidates.

The so-called "physician assistant amendment" (P.A. 71-717) which allows doctors to delegate responsibility for medical services to R.N.'s, L.P.N.'s and physician's trained assistants who are under their control, supervision and responsibility also needs clarification. No where in statute or regulation is the term physician's trained assistant defined, although in practice it includes certain midlevel health professionals with special academic and practical training (physician associates, nurse clinicians, nurse practitioners, physician extenders, child health associates, etc.). Public hearing

testimony revealed that the legal ambiguities surrounding the "physician assistant amendment" have hampered full utilization of new categories of care givers who can safely extend the services of physicians in a cost-effective manner.

7. WHAT STATUTES AND REGULATIONS IMPINGE DIRECTLY ON THE OPERATIONS OF YOUR BOARD? PLEASE LIST OR ATTACH COPIES.

Public Act 77-614, (An Act Concerning the Reorganization of the Executive Branch of State Government) changed the operation of the Connecticut Medical Examining Board in that the board is no longer involved in the initial stages of complaint receipt and investigation. The board feels that their involvement at this early function is desirable in that many of the complaints will deal with medical terminology which a lay investigator will be unfamiliar with. As such, a mechanism should be developed which will address all concerns.

The Model Legislation's process for receiving and investigating complaints addresses concern for peer review by providing for input from a physician member of the board.

8. TO WHAT EXTENT HAVE QUALIFIED APPLICANTS BEEN PERMITTED TO ENGAGE IN THE PROFESSION(S) OR OCCUPATIONS(S) LICENSED BY YOUR BOARD? PLEASE COMMENT ON WAITING PERIODS, DELAYS, PAPERWORK, ETC.

Qualified applicants to the medical profession are forced to wait inordinate lengths of time before licensing and registration can be carried out by the board. The large numbers of individuals applying for examination in our state because of permissive legislation have caused a significant waiting period. A limited number of exams can be given and qualified people have had to wait as much as a year to be assigned an examination time so they can be licensed by our board. This particularly applies to foreign graduates but other physicians have experienced inordinate delays. The board is restricted from offering a wide enough variety of temporary limited licensure to allow qualified applicants to proceed engaging in their profession.

The new licensure requirement (two years of post graduate, residency training) effective since October, 1979 under P.A. 161 has reduced from 500 to 50 the number of applicants eligible for examination and ameliorated this problem.

Connecticut's physician licensure requirements are consistent with those of other states. All states require completion of approved medical education, passage of the National Board's examination or the comparable FLEX exam (except Florida) for foreign medical graduates. The majority of states also require at least one year of post graduate training. While Connecticut now requires two years of residency training, the national trend is toward increasing the years of clinical experience required for licensure.

Connecticut also endorses licenses from states with equivalent requirements. The uniformity of licensure standards along with national accreditation of medical schools and national examinations has facilitated interstate mobility of licensed physicians.

9. WHAT ACTIONS HAS YOUR BOARD OR COMMISSION TAKEN TO INSURE COMPLIANCE WITH FEDERAL AND STATE AFFIRMATIVE ACTION POLICIES AND TO ENCOURAGE ACCESS BY WOMEN AND MINORITIES INTO YOUR PROFESSION?

Since our board is not involved in recruitment and there are no restrictions to application for examination, other than educational background, there is no mechanism in which the board can encourage access by women and minorities into the profession.

The staff found no evidence of noncompliance with affirmative action policies by the board.

10. WITHIN THE PAST FIVE (5) YEARS, WHAT CHANGES IN STATUTE, RULES OR REGULATIONS HAS YOUR BOARD OR COMMISSION RECOMMENDED WHICH WOULD BENEFIT THE PUBLIC AS OPPOSED TO LICENSEES?

The board has recommended piecemeal regulations, such as opposing removal of the residency [post graduate training as a resident physician] requirement, etc. The board has placed in the legislative machinery this year suggestions for further reassurance to the public of qualified personnel applying, the proper use of the limited staff and resources of the board and more effective quality control of the physicians selected.

The board initiated legislation (P.A. 79-161) to establish a new requirement (two years of training as a resident physician) for licensure since, as one board member stated, large numbers of "marginally trained physicians from other countries" were requesting

and achieving Connecticut licensure "without benefit of residency training in this or any country." A period of post graduate training is now thought to be necessary to practice competent medicine and until passage of P.A. 161, Connecticut was one of the few states without a training requirement. One board member noted that virtually all American medical graduates go on to take at least three years of residency training in a specialty anyway.

11. WHAT HAS YOUR BOARD OR COMMISSION DONE TO ENCOURAGE PUBLIC PARTICIPATION IN THE FORMULATION OF YOUR RULES, REGULATIONS AND POLICIES.

The board has not promulgated any regulations. It is functioning under the statutes. The rules are peculiar to the medical education and do not lend themselves to the public comment.

Despite a number of significant statutory amendments to the Medical Practice Act, regulations related to these statutes have not been updated, revised or promulgated since 1975.

Under the 1977 Reorganization Act, the Commissioner of DOHS has responsibility for promulgating all regulations with the board's advice and assistance and in accordance with the Uniform Administrative Procedures Act (C.G.S. Chapter 54). Public participation in the formation of regulations is required by the UAPA, and the Commissioner will be responsible for insuring that this requirement is met. The LPR&IC has also recommended that all boards and DOHS review their regulations for continued relevance, conformance with the provisions of the model legislation and submit recommendations for amendment or repeal during the 1981 legislative session.

12. WHAT HAS BEEN YOUR PROCESS THROUGH DECEMBER 31, 1978 TO RESOLVE PUBLIC COMPLAINTS CONCERNING PROFESSIONALS REGULATED BY YOUR BOARD OR COMMISSION?

[Board's executive director provided flow chart of process]...The new legislative action beginning January 1st will change many of the past processes. The statutes in the past have added four individuals to the board for detection and dealing with incompetent physicians. The board is used as a reporting mechanism that includes peer review through the County Medical Society, public hearings, etc. according to the administrative procedures act.

The board's complaint process underwent major revision in 1976-77 with the passage of the Doctor Disability Act (P.A. 76-276). Increased and improved enforcement activities were a direct result of

the legislative changes in grounds, sanctions, board composition and staffing according to the board's executive director. Prior to implementation of P.A. 76-276, the board had revoked one license and suspended another over a five year period. There was no accurate record of complaints filed or action taken and the discussion of only five cases appeared in nearly two years of board minutes (2/19/75) through 11/10/76).

In contrast, during calendar '78, the board, under the "doctor disability" system, received 215 written complaints, investigated 150 and suspended six licenses. All complaints are logged with sources noted and all disciplinary actions are taken in accordance with the provisions of Chapter 54 (the Uniform Administrative Procedures Act).

The centralized complaint process established by DOHS under the 1977 Reorganization Act incorporates many positive features of the medical board's "doctor disability" system. The major difference is the separation of responsibility for receipt and investigation (vested with DOHS) and responsibility for adjudication (remains with the boards).

13. WITHIN THE PAST FIVE (5) YEARS WHAT STATUTES, RULES, OR REGULATIONS HAS YOUR BOARD OR COMMISSION PROPOSED OR ADVOCATED TO PROTECT YOUR PROFESSION FROM THE LICENSURE OF UNQUALIFIED PERSONS?

Public Act 76-276 [The "Doctor Disability Act," discussed in #12 above] was passed which added consumers to the board membership, mandated a diverse representation of the medical community to the board, and required the reporting to the board by physicians, medical associations, and health care facilities of any physician who might be practicing medicine and surgery without reasonable skill and safety.

The board has also initiated a legislative proposal [P.A. 79-161, discussed in #10 above] in the current General Assembly which would institute a hospital residency requirement before one would be eligible for examination and licensure in Connecticut. This should better insure the quality of those physicians who apply for certification by this board.

SECTION IV

APPENDIX

Bibliography

Staff reviewed the following sources in addition to the information gathered from interviews, public hearings, special meetings, and the board and the Department of Health Services files.

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