House
Legislative
Analysis
Section

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HEALTH CARE SANCTIONS

House Bill 4076 (Substitute H-1)
Sponsor: Rep. David M. Gubow

House Bill 4292 (Substitute H-1)
Sponsor: Rep. Sandra Hill

House Bill 4295 (Substitute H-1)
Sponsor: Rep. John Jamian

Committee: Public Health

House Bill 4077 (Substitute H-2)
Sponsor: Rep. David M. Gubow

House Bill 4078 (Substitute H-2)
Sponsor: Rep. Sharon Gire

House Bill 4080 with committee amendment
Sponsor: Rep. Nelson Saunders

House Bill 4289 with committee amendment
Sponsor: Rep. Richard Bandstra

House Bill 4290 (Substitute H-2)
Sponsor: Rep. Michael Goschka

Committee: Judiciary

First Analysis (3-24-93)

THE APPARENT PROBLEM:

There has long been a public perception of the need for better "policing" of "bad" physicians, physicians whose practice endangers the health or safety of their patients. For example, almost ten years ago (in April of 1984) the Detroit Free Press published a week-long series of articles on "bad doctors" which received national attention, and there have been numerous articles in other state newspapers since then. The Michigan legislature has repeatedly addressed this issue over the past 15 years through a series of special or "ad hoc" committees established to study the problem and make recommendations to improve the existing licensing and disciplinary process. For example, the 1975-76 legislature established such a committee ("the Owen committee"), which issued its final report in February of 1977. Many of its findings and recommendations were ostensibly addressed in the Public Health Code revision of 1978. Nevertheless, almost ten years later, the Speaker of the House of Representatives believed it necessary to establish another special committee on medical licensure ("the Evans committee"), which issued its report in December of 1984. In addition, the director of the former Department of Licensing and Regulation commissioned a report by the state Health Occupations Council (which appeared in November of 1983), while the governor--in response to the "medical malpractice crisis" of 1984--appointed a special investigator who issued a final report ("the

Fleming report") on health care provider malpractice and malpractice insurance in December of 1985.

Despite these recurring studies and recommendations, enough problems have persisted that in January, 1989, the Speaker of the House appointed a Special Ad Hoc Committee on Physician Licensure to examine the current physician licensure and discipline process in Michigan and to recommend legislation that might improve this process. The committee's charge specifically did not include looking at such issues as tort reform or affordability and availability of medical malpractice insurance. The committee heard testimony from a number of groups on aspects of physician licensure and discipline. Representatives from the Department of Licensing and Regulation described the current licensing and disciplinary process as well as budget and staffing in the department for the process. Representatives of the Michigan Bar Association described the attorney discipline process. The medical, osteopathic, and podiatric licensing boards (and the three physician professional groups) testified, as did representatives from other professional groups (pharmacists, nurses, and trial lawyers), the attorney general's office, and a major medical insurer. In addition, a number of hospitals testified on the current peer review process. After the committee reviewed testimony and recommendations concerning current practices, it decided to address the licensing and disciplining of all health care professionals, not just that of physicians. The committee decided that the current disciplinary process should be streamlined and made consistent for all of the 15 currently licensed or registered health care professionals, that public participation in the process should be increased, and that participation in the process by licensed health care professionals should be ensured. The present package of bills is a result of the special ad hoc committee's recommendations.

In a related problem, currently if a licensed or registered health professional is found by his or her licensing board to be personally disqualified to practice because of substance abuse or mental incompetence, the board can take a number of disciplinary actions ranging from probation to fines and suspension or revocation of the practitioner's license or registration. However, there are no provisions in law which allow the state to take nondisciplinary action with regard to health professionals who are impaired because of their use of drugs (including alcohol) or because of mental illness. Consequently, legislation has been introduced to allow nonpunitive, treatment-oriented approaches to deal with impaired health professionals.

THE CONTENT OF THE BILLS:

The two major bills in the package, House Bill 4076 and House Bill 4295, would amend the Public Health Code (MCL 333.7104 et al. and MCL 333.16211 et al.) to revise the existing health care professional discipline process and to add a program for impaired providers.

More specifically, House Bills 4076 and 4295 would:
* increase membership on the existing health care profession boards and add disciplinary subcommittees;
* create a health professional recovery committee and a health care professional recovery program for health professionals impaired by chemical dependency (including alcoholism), mental illness, or substance abuse, and provide some immunity for professionals participating in recovery programs;
* require all licensed health care professionals to report conduct or treatment by other health care professionals that might be a basis for disciplinary action and provide "whistleblower" protections;
* add new requirements for licensure, registration, or specialty certification, and new information requirements for applicants;
* increase health professional license fees to pay for the new disciplinary process and allow for future increases;
* establish a health professions regulatory fund for the fee increases;
* establish a one-year time frame for the disciplinary process;
* require private practices to have pamphlets from the DPH about the disciplinary process available upon request;
* change references from the Department of Licensing and Regulation to the Department of Commerce (which houses the Bureau of Occupational and Professional Regulation);
* remove retirees' limited licenses; and
* eliminate references to the Health Occupations Council.

Health Profession Licensing Boards. The existing health profession boards would continue to set licensure criteria, test applicants, and issue licenses (including license renewals) and to handle license

reinstatements (including retesting) following disciplinary actions. Boards and task forces could not grant licenses, registrations, or certificates to applicants with pending disciplinary actions or under sanctions at the time of application, and if a board or the department discovered that a license, registration, or certificate had been issued to someone with pending disciplinary actions or under sanctions, it, too, could impose appropriate sanctions.

The boards would continue to have a majority of licensees as members, but membership would be increased as follows:

	Public members		Professional members	
	Current:	Proposed:	Current:	Proposed:
Chiropractic	2	4	5	(no change)
Medicine	3	8	11	(no change)
Nursing	2	8	15	(no change)
Optometry	2	4	5	(no change)
Osteopathic Medicine	2	4	5	(no change)
Pharmacy	2	5	6	(no change)
Physical therapy	2	4	5	(no change)
Podiatrists	2	4	3	5
Counseling	2	4	7	(no change)
Psychology	3	4	5	(no change)
Occupational Therapy	2	4	3	5
Sanitarians	2	4	3	5
Veterinarians	2	3	5	(no change)

Disciplinary subcommittees. House Bill 4295 would require the chairs of each of the boards or task forces to appoint one or more disciplinary subcommittees. Smaller boards with fewer than 10 members would have disciplinary subcommittees with three members: one public member and two professionals. Larger boards would have subcommittees with five members: two public members and three professionals. The subcommittee chair would have to be a public member, and all subcommittee decisions would require a majority vote. Decision to impose sanctions would require, in addition, the vote of at least one public member.

Disciplinary subcommittees would impose sanctions for violations of the health code. The bill would allow, in addition to the existing sanctions, the subcommittees to require licensees to pay restitution; to perform community services; to satisfactorily complete an educational program, a training program, a treatment program, or a mental, physical, or professional competence examination (or a combination of those programs and examinations). In hearings or investigations where

a licensee is alleged to be mentally or physical impaired or a substance abuser, disciplinary subcommittees (as well as hearing examiners and, with the subcommittee's approval, the department) could require the licensee to submit to mental or physical examinations. (Currently, only boards and hearings examiners may do this.)

The disciplinary subcommittees would make recommendations to the Department of Commerce regarding the promulgation of rules establishing license reinstatement criteria.

Licensing/licensee revisions. The bill would require applicants for licensure, registration, or specialty certification to include in their application (or renewal) information about:

* any felony convictions;
* any two-year misdemeanor convictions and misdemeanors involving alcohol or controlled substances convictions; and
* any sanctions imposed by similar boards elsewhere.

Physicians (medical, osteopathic, and podiatric) and dentists, in addition, would have to report hospital affiliations for licensure or relicensure.

Any licensee convicted of a two-year misdemeanor, a misdemeanor involving alcohol or controlled substances, or a felony would have his or her license automatically suspended upon notification of the Department of Commerce. The bill also would increase the license revocation period by two years to five years total for convictions involving controlled substances.

Licensees would be required to notify the department of criminal convictions or disciplinary licensing action taken by another state against the licensee within 30 days after the date of the conviction or action.

Licensees whose licenses had been suspended or revoked for more than 60 days would be required to notify, in writing, all their patients of the change in their license status. (For purposes of this notification, a "patient" would be anyone who had been actively treated by the licensee within the immediately preceding calendar year).

Licensees would have to provide, upon patient request, copies of pamphlets from the Department of Commerce explaining how to make a complaint about alleged provider misconduct. (Licensed facilities also would have to display these pamphlets.)

Licensees who knew that another licensee had acted in a way that would be the basis for disciplinary action or who suspected that another licensee was impaired would be required to report that to the department. A licensee's failure to report when required would not give rise to a civil cause of action for damages, but he or she would be subject to administrative action. Unless the reporting licensee agreed in writing, his or her identity would be kept confidential unless he or she was required to testify in disciplinary proceedings against the subject of the report. Mandatory reporting would not apply in cases in which a licensee gained information of a violation or impairment while in a professional relationship with the licensee to whom the information applied or when the information about a violation was obtained during the course of a peer review. A licensee who, in good faith, reported suspected impairment would not be liable for damages in a civil action or subject to prosecution in a criminal proceeding as a result of his or her reporting.

Licensed medical facilities and agencies. Currently, health facilities with medical staffs are required to report to the appropriate licensing board and to the Department of Licensing and Regulation disciplinary action taken against any member of the medical staff. The bill would require that this reporting be done to the Department of Commerce and include not only disciplinary actions, but restrictions (or surrenders) of clinical privileges. The bill also would require hospitals to provide information on disciplinary actions when such information was requested by the department or a disciplinary subcommittee, or another hospital considering extending staff privileges to the health professional in question.

The bill would provide "whistleblower" protections for hospital employees who reported malpractice of a health professional (or acted as an expert witness in a civil action involving malpractice or in an administrative action) or other reportable violations. Violations would subject the hospital to an administrative fine of up to $10,000 in addition to existing sanctions.

The disciplinary process. Allegations and complaints of misconduct by licensed health professionals would continue to go to the

Department of Commerce, which also would conduct any investigations and hold any compliance conferences. When no agreement was reached at a compliance conference, formal hearings would be conducted by hearing examiners under contract with the department. Discipline hearings and sanctions would be handled by newly created disciplinary subcommittees of each of the existing boards.

Allegations and complaints would continue to come to the department through a variety of mechanisms, including patient complaints, the hospital disciplinary process, the federal data bank, license complaints, professional associations, state courts, and other law enforcement agencies. However, under the bills, all licensed health professional also would be required to report conduct or treatment by other health care professionals that could be the basis for disciplinary action; all licensed health care professionals would have to report felony convictions, two-year misdemeanor convictions, and misdemeanors involving alcohol or controlled substances convictions; and the circuit and recorder's courts would have to report felony and two-year misdemeanor convictions of licensed health professionals within 21 days of sentencing, while district courts would have to report misdemeanor convictions involving alcohol or controlled substances within 21 days of sentencing.

The department (instead of the appropriate board) would review licensees' files, and the bill would add, in addition to the existing review "triggers," the requirement that reviews be done when a licensee was denied participation in a federally funded insurance program, when a licensee reported another licensee under the bill's mandatory reporting requirement, or upon notification of disciplinary actions by boards in other states.

If the department decided that there was reason to believe that the health code had been violated, and with the authorization of the chair of the appropriate board (or, if no approval is given within seven days of requesting authorization, without the chair's authorization) the department would investigate. The statutory mandate to investigate licensees involved in medical malpractice litigation would be shortened from a 10-year consecutive period to a five-year consecutive period (the $200,000 threshold would remain the same). All information gathered in an investigation before a complaint was issued would be confidential.

Within 90 (instead of 45) days after beginning an investigation (rather than simply receiving an allegation), the department would have to issue a formal complaint, conduct a compliance conference, issue a summary suspension, issue a cease and desist order, dismiss the complaint, or put a 30-day extension in the complaint file. The department could create a paralegal unit to help in its work.

The department could schedule a compliance conference at any time to see if a complaint could be settled. The conference could include the licensee, his or her attorney, one member of the department's staff, one member of the appropriate board (but not on the disciplinary subcommittee), and anyone else approved by the department. All records of a compliance conference held before a complaint was issued would be confidential and closed to the public. No one could make transcripts of compliance conferences. If a settlement was not reached at a compliance conference, the complaint would be referred to a hearing.

The department would prepare and serve formal complaints. The department could use a staff attorney, its paralegal unit, or an attorney under contract to draft complaints. Complaints could be mailed (by regular or certified mail) to the licensee, in which case service would be considered effective three days after the date the complaint was mailed. The subject of the complaint would have 30 days from the date of receipt to respond in writing to the complaint. Refusal to accept delivery of a mailed complaint would not affect the validity of the service. A licensee's failure to respond to a complaint within the 30 days would be considered admission to the allegation.

When no agreement was reached at a compliance conference, formal hearings would be conducted within 60 days by hearing examiners under contract with the department. The hearings examiner would determine whether there was a violation of the health code, and would prepare recommended findings of fact and conclusions of law to be sent to the appropriate disciplinary subcommittee for final decision and action. (The hearings examiner would not recommend or impose penalties.) The licensee would have to be present, and could be represented by legal counsel. The department would be represented by the attorney general's office (though not by the same assistant attorney general assigned to provide legal counsel to the board or the disciplinary subcommittee), and a member of the

appropriate board also could be present. A licensee who failed to appear for scheduled hearings could be subject to civil contempt proceedings, would be considered as an admission to the charges, and would result in an entry of default. Licensees could be granted one continuance.

A disciplinary subcommittee would have to meet, to impose a penalty, within 60 days after receiving recommended findings of fact and conclusions of law from a hearings examiner. When imposing a penalty, the subcommittee would review the hearings examiner's findings of fact and conclusions of law and the record of the hearing. It would use as its standard of proof the preponderance of the evidence, and it could request the hearings examiner to take additional testimony or evidence on a specific issue or could revise the findings of fact and conclusions of law as it felt necessary. The subcommittee would be advised by an independent special assistant attorney general who would not be the same assistant attorney general who represented the department before the hearings examiner. A disciplinary subcommittee also could take action against a licensed health professional based on disciplinary action in other jurisdictions.

The compliance conference, the hearing before the hearings examiner, and final disciplinary subcommittee action would have to be completed within one year after the department initiated the investigation.

Final decisions of disciplinary subcommittees could be appealed by right to the court of appeals.

Impaired health professionals. The bills would create a health professional recovery committee in the Department of Commerce. Each existing health professions board (and the physician's assistants task force), in consultation with the appropriate professional association, would appoint one professional member who had education, training, and clinical expertise in the treatment of people with addictive behavior or mental illness. The director of the department, who would serve as an ex officio member (without a vote), would appoint two public members, one of whom had specialized training or experience, or both, in treating people with addictive behavior. Appointed members could not, at the time of appointment, be a member of a health professions board or task force. Members would serve for two year terms.

The health professionals recovery committee would be required to establish the general components of a "health professionals recovery program" (defined in the bill as "a nondisciplinary, treatment-oriented program for impaired health professionals") and a mechanism for monitoring health professionals who might be impaired due to substance abuse, chemical dependency, or mental illness. The Department of Commerce would hire qualified consultants to help the committee to administer the recovery program, and the committee, in consultation with these consultants, would be required to develop and implement criteria for identifying, assessing, and treating or referring for treatment (when appropriate and with the health professional's consent) health professionals who might be impaired. In addition, the committee would be responsible for developing and implementing ways of evaluating continuing care or aftercare plans for impaired professionals. Finally, the committee would be required to submit annual reports on the status of the program, (including statistical information on the level of participation in the program of each health profession), to each board and the physician's assistants task force. The reports also could include recommendations for improving the program.

If a recovery program consultant believed a health professional to be impaired, the consultant would be required to report this to the health professional recovery committee (either orally or in writing), and the committee then would require the consultant to proceed to determine whether or not the health professional actually was impaired. If the consultant believed that the health professional might pose a threat to the public health, welfare, or safety, the consultant would have to immediately report this to the department. If the department agreed and determined that the health professional in question had violated the public health code, the department could begin the disciplinary process.

Health professionals whom the consultant had determined were impaired could be accepted into the recovery program if they acknowledged their impairment and voluntarily agreed to participate in an approved treatment plan and agreed, as determined by the recovery committee, either to stop practicing or to limit their practice.

The identity of someone participating in an approved treatment program would be confidential and not subject to disclosure under the Freedom of

Information Act (Public Act 442 of 1976) unless he or she failed to satisfactorily complete the program or lied about successfully completing the program. The identity of anyone who gave the recovery committee or the department information about the suspected impairment of a health professional also would be confidential. If the recovery committee determined that a health professional had successfully completed a treatment plan prescribed under the recovery program, the department would destroy all records regarding the impairment of the health professional five years after the committee's determination.

Anyone (whether someone providing or undergoing treatment) who intentionally lied about a health professional's successfully completing a treatment program (when he or she had not) would be guilty of a felony.

Fee increases and health professions regulatory fund. The bills would increase license fees of licensed health professionals to pay for the new disciplinary process, with the amount of the fee increase varying for the various health professionals. All fees would be deposited into a newly created health professions regulatory fund. The bill also would move the license fees back under the code (instead of the State License Fee Act, where they currently are).

House Bill 4076 also would let the Department of Commerce increase license fees at the beginning of each state fiscal year for that year. The percentage of the increase couldn't be greater than the average percentage wage and salary increase granted for that fiscal year to the department's classified civil service employees, and the increased fees would be used as the basis for calculating future fee increases.

Money from the health professions regulatory fund could be used by the Department of Commerce to carry out its duties under the bill.

The proposed license fee increases would be as follows:

	Current fee:	Proposed fee:
Drug dispensing license	$50	$75
Chiropractors	$50	$90
Counselors	$50	$55
Dentists	$40	$90
Dental assistants	$5	$10
Dental hygienists	$10	$20
Medical doctors	$40	$90
Nurses	$10	$20
Optometrists	$40	$90
Osteopathic physicians	$40	$90
Pharmacists	$10	$30
Pharmacies	$25	$50

Physical therapists	$25	$50
Physician's assistants	$25	$50
Podiatrists	$50	$90
Psychologists		
Full doctoral	$40	$90
Masters limited	$30	$60
Sanitarians	$30	$50
Occupational therapists	$55	$60
Veterinarians	$25	$50
Veterinary technicians	$10	$20

Other provisions. The bill also would establish a "nurse professional fund" to be used to further nursing education and to promote and advance the nursing profession. Two dollars of every annual license fee would go to the fund, which also could receive gifts and other money as provided by law. The bill would specify that the Department of Commerce could use not more than one-third of the fund each year for each of three purposes: to establish and operate a nurse continuing education program, for research and development studies to promote and advance the nursing profession, and to establish and operate a nursing scholarship program. Within two years after the bill's effective date, the department would be required to promulgate rules regarding expenditure of money from the fund, including rules governing the continuing education program and rules establishing eligibility criteria for participation in the scholarship program.

The Department of Commerce would be required to annually report to the legislature and to each board and task force on disciplinary actions taken during the preceding year. Within two years after the effective date of the bills, the department would have to submit a public report to the legislature on the effectiveness of the bills. That report would have to include a review and evaluation of the disciplinary process and the reporting requirements, and any recommended administrative or statutory changes. The department also would have to provide annually to each county clerk and the Library of Michigan a list of licensees who were disciplined and indicate if an appeal were pending. The state library would distribute the list to depository libraries, where it would be open to public inspection and would provide information about any disciplinary action taken against a licensee in the last three years.

Tie-bar. Both bills are tie-barred to each other, to House Bill 4292, which would amend the peer review act (Public Act 270 of 1967, MCL 331.532) to allow the release of certain peer review information, and to House Bills 4077, 4078, 4080, 4289, and 4290.

House Bill 4077 would amend the Open Meetings Act (MCL 15.267 and 15.268) to exempt from disclosure compliance conferences (held prior to issuance of a complaint) held under House Bill 4295. The bill is tie-barred to House Bills 4076 and 4295.

House Bill 4078 would amend the Freedom of Information Act (MCL 15.243) to generally exempt from disclosure information regarding an investigation or compliance conference (as conducted under House Bill 4295). Not exempted would be information pertaining to the fact that an allegation had been made (along with the date of the allegation), that an investigation was underway, that no departmental complaint had been issued, and that an allegation had been dismissed. The bill is tie-barred to House Bills 4076 and 4295.

House Bill 4080 would amend the Administrative Procedures Act (MCL 24.285 and 24.315) to exempt final decisions or orders rendered under the new health professionals' disciplinary process (set up by House Bill 4295) from the act's provisions for judicial review. The bill also would require that findings of fact and conclusions of law included in a final decision or order issued in a contested case hearing be placed in separate captioned sections. The bill is tie-barred to House Bills 4076 and 4295.

House Bill 4289 would amend the Revised Judicature Act (MCL 600.2507). At present, the act allows the secretary of state, the auditor general, the state treasurer, and the attorney general to search each other's offices and the offices of the clerk of any court of record and of any register of deeds for any documents necessary to the discharge of their duties, and to obtain certified copies of those documents without charge. The bill would amend the act to allow the director of the Department of Commerce to request without charge searches and copies of such records (including those pertaining to criminal matters and to medical malpractice) from the secretary of state, the auditor general, the state treasurer, registers of deed, and the clerks of any court of record (including the supreme court and the probate court) or municipal court. The bill is tie-barred to House Bills 4076 and 4295.

House Bill 4290 would amend the Code of Criminal Procedure (MCL 769.1 et al.) to require the Department of Commerce to be notified when a health professional was convicted of a felony or an alcohol- or drug-related misdemeanor. Within 21 days after the conviction, the clerk of the court would report the conviction to the department on a form furnished by the department. Whether a person convicted of one of these offenses was a health professional would have to be noted in the presentence investigation report. At sentencing, the court would check whether the conviction had been reported as required; if not, the court would order the report to be made immediately. The bill is tie-barred to House Bills 4076 and 4295.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

As the fifteen-year history of special legislative committees and other state agency reports on health care professional regulation suggests, adequately disciplining, or otherwise protecting the public from, "problem" health care providers has been an ongoing problem. Part of the problem has been the result of underfunding of the agencies charged with overseeing and investigating the practice of health care professionals. Despite the fact that, as public testimony over time has pointed out, revenue from health care professional licensing fees would be able to adequately fund oversight and investigatory activities, these fees have gone into the state general fund and have not been dedicated to regulating and disciplining the licensees paying the fees. Another ongoing problem in regulating health care professionals has been what one committee report called the "interminability of the investigative and disciplinary process." Even when allegations are brought against a licensed or registered health care professional (and evidence exists which suggests that incompetent professionals are underreported), the amount of time the process takes, and the uncertain outcome, often mean that clearly incompetent health care professionals wind up being able to continue to practice, much to the detriment of the public health and safety. For example, reportedly one physician has continued to practice for seven years while appeal of disciplinary action against him remains pending.

In recent years, the legislature has taken some steps to correct parts of the many problems involved in this complex question. For example, the ease with which prescription drugs can be illegally diverted has long been identified as part of the overall problem, and the legislature responded by passing a package of legislation known as the "triplicate prescription" program, designed to address this very issue. The legislature also enacted a comprehensive malpractice litigation package which included addressing the issue of medical malpractice, and continues to work on this issue in the current session.

This package of bills would continue to move toward addressing the problem provider, both by adequately funding the disciplinary process and by streamlining the process so that it would, ideally, take no longer than a year to complete. The bills would ensure both public and professional

participation in the process and would provide plenty of opportunity for informally settling allegations while at the same time ensuring that due process and the full protection of the law would be in operation. In addition, House Bills 4076 and 4295 would provide a humane and potentially cost effective way of dealing with health care professionals who were chemically or mentally impaired, by creating a treatment alternative to the disciplinary process.

Against:

Although the proposed disciplinary process appears very promising, given the current uncertainty over the state budget it would appear to be unwise to remove money from the general fund and to earmark this money for a specific program.

Response:

According to a number of state and national studies, the diversion of licensing revenues from their intended purpose (namely, to regulate the professions and thereby protect the public health and welfare) has been an on-going problem and has been an important factor in the failure of the regulatory system to adequately protect the public from "bad" (incompetent, impaired, or even criminal) health care practitioners. By putting license fees into a health professions regulatory fund for the Department of Commerce to use to carry out its disciplinary duties, the bills would go a long way toward addressing regulatory problems resulting from inadequate funding.

Against:

House Bills 4290 and 4295 would allow appeal from a final decision by the health professionals disciplinary board to the court of appeals by "right," which is to say, appeal would be automatically granted if desired. But part of the problem with the present system is that it can be manipulated by unethical health professionals who seek only to delay as long as possible judgments fairly made against them concerning their unethical or unsafe professional practice. The bill should allow appeal only by leave of the court, which would tend to discourage such deliberately frivolous appeals, since only appeals that had legal merit would be accepted by the courts. (And even if the court of appeals did reject an appeal, there would always be recourse to the supreme court.) The bill already provides plenty of opportunities for health care professionals to respond with the full protection of the law to allegations brought against them. Unless appeal is by leave, instead of by right, the disciplinary process will continue to drag on to the detriment of public health and safety.

Response:

Allowing appeal only by leave would constitute an unacceptable infringement on an individual health professional's right of access to his or her day in court. As it now stands, House Bill 4295 fairly balances health providers' due process rights and protection of the public from "bad" practitioners.

Against:

House Bills 4290 and 4295 would require courts to notify the Department of Commerce within 21 days when a health professional was convicted of a felony or an alcohol- or other drug-related misdemeanor. This requirement would pose a number of difficulties for courts. For one thing, information on a person's occupation, when it is obtained, typically is obtained after more than 21 days has passed; for most courts, meeting the 21-day deadline would necessitate either more staff or a significant revision of procedures. In addition, generally the information on an offender's occupation is provided by the offender; there may not be sufficient assurance that offending health professionals will be reported to the department as planned. Finally, the bill may be too narrow in applying the reporting requirement to "convictions." To ensure timely reporting of all offenders in question, the reporting requirement should be triggered by guilty pleas and "no contest" pleas in addition to convictions.

For:

It is widely recognized today that people who are chemically or mentally impaired need help, not punishment. While the public continues to need protection from health professionals whose impairment can result in unsafe professional practices, these impaired professional also deserve help, not punishment. Nevertheless, right now, the only legally recognized way of dealing with chemically or mentally impaired health professionals is punitive: a practitioner who is identified as being impaired is offered not rehabilitation, but possible loss of his or her livelihood and professional standing. Several problems result from the lack of legislation allowing rehabilitation as an alternative to punishment. First, the threat of loss of licensure or regulation encourages impaired professionals to stay "underground" as long as possible (and encourages professional peers to avoid reporting their impaired colleagues), which means there can be a dangerously long period of time in which the professional practices legally but perhaps unsafely.

Secondly, an impaired health professional who has already sought treatment and who is ready to safely return to practice, can still receive ("after the fact") a psychologically devastating sanction against his or her license or registration. Thirdly, given present budget constraints and lowered staffing of state investigative agencies, an investigation can take from 18 to 24 months or longer, during which time the health care professional can continue to practice and pose a possible threat to public safety. And finally, given the shortage of health care professionals generally (and some professionals, such as nurses, in particular), the existing process can remove from practice many practitioners who could receive treatment and who could return to safe practice under supervision and monitoring.

Several states (including Ohio, Florida, Texas, New York, Massachusetts, and California) already have legislation that supports the treatment and rehabilitation of highly trained but impaired health professionals. It is time for Michigan to join these state in this enlightened approach to the problem of impaired professionals.

The non-punitive alternative for impaired health professionals, as well as the mandatory reporting requirements, should improve the identification of chemically dependent or mentally ill health professionals, while the promotion of interventions that could lead to treatment may significantly reduce the amount of time that a health professional may practice while impaired.

The bills would protect the public from potential harm from impaired health professionals, would recognize the potential for rehabilitation of health professionals who are chemically dependent or mentally ill, and would not interfere with disciplinary actions against impaired professionals who chose not to take this alternative to the disciplinary process.

Against:

A number of health professions already have recognized the problems of chemical dependency and mental illness that some of their members face, and have set up special committees or task forces to help their impaired colleagues. While there should be a legally recognized way for the state to take non-punitive action to help impaired health professionals, this should in no way weaken or interfere with the professions' existing--and in some cases long-standing--efforts to help their own.

Response:

Thorough the bills do not require the disciplinary subcommittees to refer impaired professionals back to their professional associations, they nevertheless provide another -- and a guaranteed -- way to help impaired professionals.

For:

Several bills would make changes in a number of laws that would allow the rest of the package of bills to be carried out, in terms of both legal and administrative procedures. For example, the proposed amendments to the Freedom of Information Act and the Open Meetings Act would protect the confidentiality of compliance conferences, which would help facilitate informal resolutions to complaints against health professionals while allowing reasonable public access to information pertinent to protecting the health and safety of health care patients and clients.

POSITIONS:

The Michigan Dental Association supports House Bills 4076 and 4295. (3-23-93

The Michigan Association of Osteopathic Physicians and Surgeons supports the concept of the bills. (3-23-93)

The Department of Commerce has no position on the bills at this time. (3-23-93)

The Michigan Optometric Association does not yet have a position on the bills. (3-23-93)

The Michigan Podiatric Medical Association has not yet taken a position on the bills. (3-23-93)