Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

2009 Sunset Review: Colorado State Board of Medical Examiners

October 15, 2009

Consumer Protection

Department of Regulatory Agencies

Executive Director's Office
D. Rico Munn
Executive Director

Bill Ritter, Jr.
Governor

October 15, 2009

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado State Board of Medical Examiners (Board). I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2010 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….

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

Sincerely,

D. Rico Munn
Executive Director

1560 Broadway, Suite 1550 Denver, Colorado 80202 Phone 303.894.7855
Fax 303.894.7885 Toll Free 800.866.7675 www.dora.state.co.us V/TDD 711

Consumer Protection

Bill Ritter, Jr.
Governor

D. Rico Munn
Executive Director

2009 Sunset Review:
Colorado State Board of Medical Examiners

Summary

What Is Regulated?
Physicians (medical doctors and doctors of osteopathy) and physician assistants.

Why Is It Regulated?
To assure that physicians and physician assistants meet a standard level of competency.

Who Is Regulated?
In fiscal year 07-08, there were a total of 18,434 physician licensees and 1,650 physician assistant licensees.

How Is It Regulated?
The Colorado State Board of Medical Examiners (Board) is housed in the Department of Regulatory Agencies' Division of Registrations (Division). The Board licenses physicians and physician assistants. Applicants for a physician license must have graduated from medical school, passed an examination, obtained at least one year of experience, and be at least 21 years old. Once licensed, physicians must maintain professional liability insurance of at least $500,000 per incident and $1.5 million annual aggregate per year. Applicants for a physician assistant license must have completed a physician assistant educational program, passed an examination and be at least 21 years old.

What Does It Cost?
The Board's fiscal year 07-08 expenditures were $2,033,681, and 9.2 full-time equivalent employees were allocated to staff the Board.

What Disciplinary Activity Is There?
Between fiscal years 03-04 and 07-08, the Board issued 584 disciplinary actions against physicians, and 22 disciplinary actions against physician assistants. Disciplinary actions included revocations, suspensions and letters of admonition.

Where Do I Get the Full Report?
The full sunset review can be found on the Internet at: www.dora.state.co.us/opr/oprpublications.htm.

Key Recommendations

Continue the Board and the Medical Practice Act for nine years, until 2019.
To expect the average consumer to research the credentials of an individual physician to determine competency is both inefficient and unrealistic. The depth of knowledge and level of skill required to practice as a competent physician is more efficiently determined by the state, through the Board.

Transfer all regulatory authority pertaining to emergency medical technicians to the Colorado Department of Public Health and Environment, effective January 1, 2011, create the State Board of Emergency Medical and Trauma Services, and schedule the new board and regulation to sunset in 2015.
Under the current, bi-furcated regulatory system, the Colorado Department of Public Health and Environment (CDPHE) certifies individual emergency medical technicians (EMTs), but the Board, by rule, determines the protocols EMTs may implement in the field. A more efficient system, and one that is utilized across the nation, is to centralize all regulatory authority at CDPHE.

Restate the definition of unprofessional conduct such that failing to properly address the practitioner's own physical or mental condition is unprofessional conduct, and authorize the Board to enter into confidential agreements with practitioners to address their respective conditions.
Current law allows the Board to discipline practitioners for suffering from physical or mental disabilities. Since having such a condition is not unprofessional, but rather failing to limit one's practice to accommodate such a condition is unprofessional, the definition of unprofessional conduct should be revised accordingly.

Major Contacts Made During This Review

Colorado Academy of Family Physicians
Colorado Academy of Physician Assistants
Colorado Association of Medical Staff Services
Colorado Attorney General's Office
Colorado Board of Medical Examiners
Colorado Citizens for Accountability
Colorado Department of Public Health and Environment
Colorado Division of Registrations
Colorado Family Medicine Residencies
Colorado Health Institute
Colorado Hospital Association
Colorado Medical Group Management Association
Colorado Medical Society
Colorado Nurses Association
Colorado Patient Safety Coalition
Colorado Physician Health Program
Colorado Rural Health Center
Colorado Society of Osteopathic Medicine
Colorado Trial Lawyers Association
Commission on Family Medicine
COPIC Companies
Denver Medical Society
Emergency Medical Services Association of Colorado
Rocky Vista University
Shriners Hospitals for Children
University of Colorado Health Sciences Center
U.S. Department of Health and Human Services

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
Colorado Department of Regulatory Agencies
Office of Policy, Research and Regulatory Reform
1560 Broadway, Suite 1550, Denver, CO 80202
www.dora.state.co.us/opr

Table of Contents

Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

Regulation, then, has many positive and potentially negative consequences.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. To facilitate input from interested parties, anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.state.co.us/pls/real/OPR_Review_Comments.Main.

The regulatory functions of the Colorado State Board of Medical Examiners (Board) relating to Article 36 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2010, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of physicians and physician assistants should be continued for the protection of the public and to evaluate the performance of the Board and staff of the Division of Registrations (Division). During this review, the Board and the Division must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly.

Methodology

As part of this review, DORA staff conducted a literature review, attended Board meetings, interviewed Board members and staff, reviewed Board records and minutes including complaint and disciplinary actions, interviewed officials with state and national professional associations, interviewed healthcare providers, reviewed Colorado statutes and Board rules, and reviewed the laws of other states.

Profile of the Professions

Medicine is the art and science of healing. In Western countries, the practice of medicine originated from ancient Greek healers such as Hippocrates and Galen, who used observation of the human body to gain medical knowledge. Although many of the medical theories of the ancient Greeks have been discredited, the basic principle of using observation and logic to heal the human body remains central to modern medicine.

Physicians—doctors, medical doctors, doctors of medicine, medical practitioners, and osteopathic physicians—diagnose and treat human disease or injury.[2] They conduct patient examinations, take medical histories, order and interpret tests, and prescribe medication. Physicians may specialize in family practice, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, dermatology, general surgery, and numerous other specialties.

In the United States, there are two types of medical degrees: doctor of medicine (MD) and doctor of osteopathy (DO).[3] The profession of medicine demands a high degree of education and training. For entry into medical school, applicants are required to have attained at least three years of undergraduate education, including courses in physics, biology, mathematics, English, and inorganic and organic chemistry. Medical school requires four years of study. The first two years of medical school are primarily taught in classrooms and laboratories, and the last two years are taught in clinical or hospital settings. Following medical school, most graduates spend three to six additional years training in a residency program. The length of residency training depends on the requirements of the national board for a particular specialty. For example, family practitioners spend three years training in a residency program while orthopedic surgeons obtain five years of training in a residency program.

Physician assistants are healthcare professionals who practice medicine under the supervision of a physician.[4] They take medical histories, conduct physical examinations, diagnose and treat illnesses, order tests, assist in surgery and prescribe medication. All physician assistants study to be generalists, but under the guidance of the physician they are working with, they may further specialize in internal medicine, pediatrics, surgery, obstetrics and gynecology, dermatology and other areas of medicine.

For entry into a physician assistant program, schools typically require two to four years of undergraduate education and some experience in healthcare.[5] Physician assistant programs are two years long and include instruction in biochemistry, pathology, human anatomy, physiology, microbiology, clinical pharmacology, clinical medicine, geriatric and home healthcare, disease prevention, and medical ethics.

[2] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook.* Retrieved September 17, 2009, from http://www.bls.gov/oco/ocos074.htm
[3] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook.* Retrieved September 17, 2009, from http://www.bls.gov/oco/ocos074.htm
[4] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook.* Retrieved September 18, 2009, from http://www.bls.gov/oco/ocos081.htm
[5] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook.* Retrieved September 18, 2009, from http://www.bls.gov/oco/ocos081.htm

Legal Framework

History of Regulation

Created in 1881, the Colorado State Board of Medical Examiners (Board) protects the public health, safety and welfare by enforcing minimum standards of competency through licensing, investigating complaints, and taking disciplinary action as appropriate.

In 1977, the General Assembly passed Senate Bill 454, directing the Board to promulgate rules outlining the duties and functions of the emergency medical technicians that were regulated by the then, Colorado Department of Health.

In 1984, the Board underwent its second sunset review, which noted four major issues: the expanding role of allied healthcare providers; the Board's jurisdiction over podiatrists; the problems inherent in licensing graduates of international medical schools; and the steep increase in disciplinary actions between 1978 (the date of the Board's first sunset review) and 1984. As a result of the 1984 sunset review, the regulation of podiatrists was removed from the Board's jurisdiction.

Between 1984 and 1994 (the date of the Board's last sunset review), the Medical Practice Act (Act) was amended many times. Some of the amendments include:

- The authorization of professional review committees and their designation as extensions of the Board;
- The statutory creation of a fund for a physician peer assistance health program; and
- The expansion of the definition of unprofessional conduct to include sexual misconduct with patients.

In 1994, the General Assembly authorized the creation of provider networks. In so doing, the General Assembly authorized physicians to form corporations with non-physicians.

The 1994 sunset review of the Board resulted in House Bill 95-1002, which amended the Act to, among other things:

- Enumerate specific grounds for license denial;
- Prohibit a physician from having sex with a patient for six months after the termination of the professional relationship;
- Require physicians to respond to complaints in a timely manner;
- Allow physician assistants to access the peer assistance health program; and
- Require professional peer review committees to report certain information to the Board.

That same year, House Bill 95-1007 was passed, authorizing advanced practice nurses (APNs) to write prescriptions. The bill also authorized Colorado-licensed physicians to enter into collaborative agreements with such APNs to facilitate this goal.

Over the next 15 years, numerous bills were passed that impacted the Act. Some of the more substantive changes include:

- Recognition that alternative medicine may possess a reasonable potential for therapeutic gain;
- Creation of a limited license for doctors affiliated with Shriners Hospitals for Children;
- Increase in the number of public Board members from two to four;
- Requirement that physicians and physician assistants respond to complaints in an honest, materially responsive, and timely manner;
- Amendment of the definition of the practice of medicine to clearly include telemedicine;
- Change in the regulatory scheme for physician assistants from certification to licensure;
- Authorization for the Board to impose fines of not more than $10,000 in lieu of suspension; and
- Clarification that, when physicians form professional corporations, there is no vicarious liability for the negligent acts of the physicians and that there shall be no interference in the exercise of independent medical judgment.

In 2004, the General Assembly passed House Bill 1406, which, for the first time, required the Board to make available to the public, information relating to medical malpractice and negligence judgments against physicians and physician assistants. This spirit of disclosure reached a climax in 2007, with the passage of the Michael Skolnik Medical Transparency Act (Skolnik Act). The Skolnik Act requires physicians to disclose considerably more information, and in greater detail, than was required under House Bill 04-1406. Some of the provisions of the Skolnik Act were later clarified in House Bill 09-1188.

Senate Bill 09-026 removed from Board jurisdiction, the regulation of athletic trainers.

Finally, Senate Bill 09-239, the Board of Nursing sunset bill, altered the manner in which APNs with prescriptive authority and physicians interact with one another. Collaborative agreements were replaced by articulated plans, and with them, a greater sense of autonomy was granted to APNs.

Colorado Medical Practice Act

The Colorado Medical Practice Act (Act) can be found at Article 36 of Title 12, Colorado Revised Statutes (C.R.S.). The Act defines the practice of medicine, creates the Colorado State Board of Medical Examiners (Board) and outlines the regulatory requirements for both physicians and physician assistants.

The Act's definition of the practice of medicine is fairly comprehensive and includes:

> Holding out one's self to the public . . . as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, pain, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, telemedicine, the interpretation of tests, including primary diagnosis of pathology specimens, images, or photographs, or any physical, mechanical, or other means whatsoever; . . . Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever[.][6]

Specifically exempted from this definition are, when practiced by a duly registered or licensed practitioner, the practices of midwifery,[7] dentistry,[8] podiatry,[9] optometry,[10] chiropractic,[11] nursing,[12] acupuncture,[13] physical therapy,[14] and other fields of the healing arts.[15]

Also exempted are those physicians who are licensed in another state or U.S. territory who limit their practice in Colorado to only the occasional case or consultation,[16] as well as commissioned medical officers in the U.S. armed forces.[17]

Finally, those who render services in cases of emergency,[18] related to religious worship[19] or in the practice of Christian Science,[20] are also exempt from the Act.

[6] §§ 12-36-106(1)(a) and 12-36-106(1)(b), C.R.S.
[7] § 12-36-106(1)(f), C.R.S.
[8] § 12-36-106(3)(c), C.R.S.
[9] § 12-36-106(3)(d), C.R.S.
[10] § 12-36-106(3)(e), C.R.S.
[11] § 12-36-106(3)(f), C.R.S.
[12] § 12-36-106(3)(j), C.R.S.
[13] § 12-36-106(3)(p), C.R.S.
[14] § 12-36-106(3)(r), C.R.S.
[15] § 12-36-106(3)(m), C.R.S.
[16] § 12-36-106(3)(b), C.R.S.
[17] § 12-36-106(3)(i), C.R.S.
[18] § 12-36-106(3)(a), C.R.S.
[19] § 12-36-106(3)(g), C.R.S.
[20] § 12-36-106(3)(h), C.R.S.

The Governor-appointed, 13-member Board comprises nine physician members and four public members, all of whom are appointed to four-year terms.[21] Of the physician members, seven must hold the degree of doctor of medicine and two must hold the degree of doctor of osteopathy.[22] Additionally, these members must have been licensed and actively practicing medicine in Colorado for the three years immediately preceding their appointments to the Board, and they must have been residents of Colorado for at least five years preceding the appointment.[23]

The Board is authorized to issue licenses, promulgate rules, receive and investigate complaints, take disciplinary action when appropriate, and assist the state's district attorneys.[24] In addition to its general authority to promulgate rules, the Board is specifically directed to promulgate rules pertaining to emergency medical technicians[25] and physicians who have entered into articulated plans with Advanced Practice Nurses with prescriptive authority.[26]

In conducting its business, the Board divides itself into two panels, each of which acts as both inquiry and hearings panel.[27] Under this system, if a complaint is investigated by one panel, it is heard, if referred for formal hearing, by the other panel.[28]

The Board issues several types of physician licenses: training, full, distinguished foreign teaching, temporary and limited. Additionally, the Board licenses physician assistants.

A training license may be issued to any person serving in an approved internship, residency or fellowship in a hospital and who is not otherwise licensed to practice medicine in Colorado.[29] The holder of a training license may practice medicine only under the supervision of a fully licensed physician,[30] may not delegate medical functions to a person who is not a licensed physician and may not supervise physician assistants.[31] An individual may not hold a training license for more than six years in aggregate.[32]

To obtain a full medical license, a candidate must have passed an examination approved by the Board, or a national examination; be at least 21 years old; have graduated from an approved medical school (including osteopathic medical schools); and have completed an internship of at least one year or one year of postgraduate training.[33]

[21] § 12-36-103(1)(a), C.R.S.
[22] § 12-36-103(2), C.R.S.
[23] § 12-36-103(2), C.R.S.
[24] § 12-36-104, C.R.S.
[25] § 25-3.5-203(1)(a), C.R.S.
[26] § 12-36-106.4(4)(a), C.R.S.
[27] § 12-36-118(1)(b), C.R.S.
[28] § 12-36-118(1)(c), C.R.S.
[29] § 12-36-122(2), C.R.S.
[30] § 12-36-122(7)(a), C.R.S
[31] § 12-36-122(7)(c), C.R.S.
[32] § 12-36-122(1), C.R.S.
[33] §§ 12-36-107(1)(c) and 12-36-107(2), C.R.S.

Additionally, if a candidate already holds a license issued by another state or U.S. territory, the Board may issue a full medical license so long as the licensing requirements in the other jurisdiction are not substantially lower than those of Colorado and so long as the other jurisdiction would issue a license to a Colorado-licensed physician on similar terms.[34]

A distinguished foreign teaching license may be issued to a candidate "of noteworthy and recognized professional attainment" who is a graduate of a foreign medical school and who is licensed in a foreign jurisdiction, provided the candidate has been invited by a Colorado medical school as a full-time member of its academic faculty and so long as the candidate's medical practice is limited to that required by the academic position.[35]

A temporary license may be issued to a candidate who is licensed to practice medicine in another state or U.S. territory, has been invited by the U.S. Olympic Committee to provide medical services at the Olympic Training Center in Colorado Springs, and limits his or her practice to that required by the U.S. Olympic Committee.[36] Such licenses are valid for 90 days.[37]

A limited license may be issued to a candidate who is licensed to practice medicine in another state or U.S. territory and has been invited by the administrator of a hospital to provide medical services relative to the treatment of patients of Shriners Hospitals for Children.[38] Such licenses are valid for two years and the fees for such must not be more than half that of the renewal fees charged for a full medical license.[39]

All physicians must maintain professional liability insurance of at least $500,000 per incident and $1.5 million annual aggregate per year.[40] If a physician reports two or more medical malpractice payments to the Board in any given year, then the physician is required to carry double the amount of liability insurance, unless the Board, in its discretion, finds it fair and conscionable to reduce the amount.[41]

A physician assistant license may be issued to anyone who has completed a physician assistant education program; passed a national examination; and is at least 21 years old.[42] Physician assistants do not have a statutory scope of practice. Rather, they work under the authority delegated to them by their respective supervising physicians.[43] A single physician may not supervise more than two physician assistants at any one time without specific approval of the Board.[44]

[34] § 12-36-107(1)(d), C.R.S.
[35] § 12-36-107(3)(a)(I), C.R.S.
[36] § 12-36-107(4)(a), C.R.S.
[37] § 12-36-107(4)(b), C.R.S.
[38] § 12-36-107(5)(a), C.R.S.
[39] § 12-36-107(5)(b), C.R.S.
[40] § 13-64-301(1)(a), C.R.S.
[41] § 13-64-301(3), C.R.S.
[42] § 12-36-106(5)(c), C.R.S.
[43] § 12-36-106(5)(a), C.R.S.
[44] § 12-36-106(5)(b)(I), C.R.S.

The Board may refuse to issue a license, or it may grant a probationary license, to any candidate who 1) does not possess the required qualifications; 2) has engaged in unprofessional conduct; 3) has been disciplined in another jurisdiction; or 4) has not actively practiced for the two-year period immediately preceding the license application or has not otherwise maintained continued competency during such period.[45]

As of January 1, 2008, all applicants for a full physician license had to complete an on-line physician profile, pursuant to the Michael Skolnik Medical Transparency Act. Physicians licensed prior to this date had to complete this profile upon renewal in May 2009. In addition to generic demographic information, physicians must disclose, among other things:[46]

- Any public disciplinary action taken against the physician;
- Any agreement or stipulation entered into by the physician and a licensing agency;
- Any involuntary limitation, reduction, nonrenewal, denial, revocation or suspension of the physician's medical staff membership or clinical privileges;
- Any involuntary surrender of the physician's U.S. Drug Enforcement Administration registration;
- Any final criminal convictions or plea arrangements pertaining to any felony or crime of moral turpitude;
- Any final judgment, settlement or arbitration award that was the result of a medical malpractice claim, paid by the physician or on the physician's behalf; and
- Any refusal by an issuer of medical malpractice insurance to issue a policy to the physician due to past claims experience.

Failure to make the necessary disclosures may result in an administrative fine of up to $5,000.[47]

Additionally, in making the above information available to the public, the Board must make certain disclosures of its own, most of which serve to somewhat mitigate or put into context the required physician disclosures.[48] For example, one statement required of the Board reads, "Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation."[49]

[45] § 12-36-116(1), C.R.S.
[46] § 12-36-111.5(3), C.R.S.
[47] § 12-36-111.5(7), C.R.S.
[48] § 12-36-111.5(5), C.R.S.
[49] § 12-36-111.5(5), C.R.S.

The Board may deny, suspend or place on probation the license of, or issue a letter of admonition to, any licensee it determines has engaged in unprofessional conduct or has otherwise violated any provision of the Act or rules promulgated thereunder.[50] The Board may also issue a confidential letter of concern if the Board determines that a complaint should be dismissed but the Board noticed indications of possible errant conduct that could lead to serious consequences if not corrected.[51]

In lieu of suspending a license, the Board may impose a fine of not more than $10,000.[52] All money collected by such fines is credited to the state's General Fund.[53]

Additionally, the Board may issue a cease and desist order to any licensee that it determines is an imminent threat to the health and safety of the public, or to any person who is practicing medicine without a license.[54]

Unprofessional conduct includes:[55]

- Resorting to fraud, misrepresentation, or deception in obtaining a license, professional liability insurance or privileges at a hospital;
- Procuring, or aiding or abetting in procuring, criminal abortion;
- Having been convicted of an offense of moral turpitude, a felony, or any crime that would constitute a violation of the Act;
- Administering, dispensing, or prescribing any habit-forming drug or any controlled substance other than in the course of legitimate professional practice;
- Having been convicted for violating any federal or state law regulating the possession, distribution or use of any controlled substance;
- Suffering from habitual intemperance or excessively using any habit-forming drug or any controlled substance;
- Aiding or abetting any unlicensed person in the practice of medicine;
- Practicing medicine as the partner, agent, or employee of, or in joint venture with, any person who does not hold a license to practice medicine in this state;
- Violating, or attempting to violate, any provision of the Act;
- Suffering from a physical or mental disability that renders the licensee unable to practice with reasonable skill and safety;
- Engaging in any act or omission that fails to meet generally accepted standards of medical practice;
- Engaging in a sexual act with a patient during the course of patient care or within six months immediately following the termination of the professional relationship;
- Violating any valid Board order or rule;
- Dispensing, injecting or prescribing an anabolic steroid that is intended to increase muscle mass or weight without medical necessity;

[50] §§ 12-36-118(4)(c)(III) and 12-36-118(5)(g)(III), C.R.S.
[51] § 12-36-118(4)(c)(II.5), C.R.S.
[52] § 12-36-118(5)(g)(III), C.R.S.
[53] § 12-36-118(5)(g)(III.5), C.R.S.
[54] § 12-36-118(14)(a), C.R.S.
[55] § 12-36-117(1), C.R.S.

- Dispensing, injecting or prescribing an anabolic steroid unless the steroid is dispensed from a pharmacy pursuant to a prescription order;
- Prescribing, distributing or giving to a family member or to oneself except on an emergency basis, any Schedule II narcotic;
- Failing to report to the Board any adverse action taken by another licensing agency;
- Failing to report to the Board the surrender of a license or other authorization to practice medicine in another jurisdiction;
- Failing to accurately answer the license renewal questionnaire;
- Willfully and repeatedly ordering or performing, without clinical justification, unnecessary laboratory tests or studies;
- Administering, without clinical justification, unnecessary treatments;
- Failing to obtain consultations or performing referrals when failing to do so is not consistent with the standard of care for the profession;
- Ordering or performing, without clinical justification any X-ray or treatment that is contrary to recognized standards of the practice of medicine;
- Falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records;
- Committing a fraudulent insurance act;
- Failing to maintain professional liability insurance;
- Failing to respond in an honest, materially responsive, and timely manner to a complaint submitted to the Board; and
- Advertising in a manner that is misleading, deceptive or false.

The Board must initiate an investigation when it is informed of disciplinary actions taken by a hospital to suspend or revoke the privileges of a physician; disciplinary actions taken as the result of a professional review proceeding; an instance of medical malpractice settlement or judgment; and licensees who have been allowed to resign from hospitals for medical misconduct.[56]

All licensees have the duty to report to the Board any licensee known, or upon information and belief, to have engaged in unprofessional conduct, unless the licensee is treating the other licensee for a mental disability or habitual intemperance and the treating licensee determines that the impaired licensee does not present a danger to himself, herself or others.[57]

The Board may also seek injunctive relief against any person it finds is violating any provisions of the Act.[58]

[56] § 12-36-118(4)(b), C.R.S.
[57] § 12-36-118(3)(a), C.R.S.
[58] § 12-36-132, C.R.S.

A physician who splits fees with another person, or who pays others for referrals may have his or her license suspended or revoked.[59] Such a physician may also be charged with a Class 3 misdemeanor,[60] which is punishable by a fine of between $50 and $750, six months' imprisonment, or both.[61]

In addition to its other powers and duties, the Board may require a licensee to submit to mental or physical examinations if it has reason to believe that such licensee is unable to practice with reasonable skill and safety.[62]

Although technically unrelated to this authority, the General Assembly has authorized the Board to impose a surcharge on all initial and renewal full physician and physician assistant license issuances, to fund a peer health assistance fund.[63] The fund is designed to fund the Peer Health Assistance Program, which, among other things:[64]

- Provides for the education of licensees with respect to the recognition and prevention of physical, emotional, and psychological problems and provide for intervention when necessary or under circumstances which may be established by Board rules;
- Offers assistance to a licensee in identifying physical, emotional, or psychological problems;
- Evaluates the extent of physical, emotional, or psychological problems and refers the licensee for appropriate treatment;
- Monitors the status of a licensee who has been referred for treatment;
- Provides counseling and support for the licensee and for the licensee's family;
- Receives referrals from the Board; and
- Makes its services available to all licensees.

Any person who practices as a physician or as a physician assistant without a license commits a Class 2 misdemeanor,[65] which is punishable by a fine of between $250 and $1,000, between 3 and 12 months' imprisonment, or both,[66] for the first offense, and a Class 6 felony,[67] which is punishable by a fine of between $1,000 and $100,000,[68] between 12 and 18 months' imprisonment and one year of parole, or both, for any subsequent offense.[69]

[59] § 12-36-125(2), C.R.S.
[60] § 12-36-125(1), C.R.S.
[61] § 18-1.3-501(1)(a), C.R.S.
[62] § 12-36-118(9), C.R.S.
[63] § 12-36-123.5(3.5)(b), C.R.S.
[64] § 12-36-123.5(3.5)(c), C.R.S.
[65] §§ 12-36-106(5)(k) and 12-36-129(1), C.R.S.
[66] § 18-1.3-501(1)(a), C.R.S.
[67] §§ 12-36-106(5)(k) and 12-36-129(1), C.R.S.
[68] § 18-1.3-401(1)(a)(III)(A)
[69] § 18-1.3-401(1)(a)(V)(A), C.R.S.

Any person who dispenses or injects an anabolic steroid that is not dispensed from a pharmacy pursuant to a prescription order commits a Class 5 felony, which is punishable by a fine of between $1,000 and $100,000,[70] between one and three years' imprisonment and two years of parole,[71] or both, for the first offense,[72] and a Class 3 felony, which is punishable by a fine of between $3,000 and $750,000,[73] between 4 and 12 years' imprisonment and five years parole,[74] or both, for any subsequent offense.[75]

The Act authorizes physicians to form professional service corporations provided certain requirements are satisfied.[76] Some of the more salient requirements include:

- The corporation is organized solely for the purpose of permitting individuals to conduct the practice of medicine;[77]
- All shareholders of the corporation are Colorado-licensed physicians and are actively practicing medicine;[78]
- Lay directors and officers do not exercise any authority over the independent medical judgment of a licensed physician;[79]
- Licensed physicians remain personally liable if they engage in negligent or tortious conduct—that is the corporation is not vicariously liable for the acts of its physician employees;[80] and
- All employees of the corporation are insured for at least $50,000 per claim and $150,000 annual aggregate per year.[81]

Finally, pursuant to several directives to do so, and in order to clarify numerous statutory provisions, the Board has promulgated a comprehensive set of rules, including those that address:

- Establishment and recognition of peer review committees;
- Emergency medical technicians;
- Physician assistants;
- Prescribing stimulant drugs;
- Financial responsibility standards;
- Continued competency;
- License renewal procedures;
- Misleading, deceptive or false advertising; and
- Responsibilities of physicians who engage in drug therapy management with licensed pharmacists.

[70] § 18-1.3-401(1)(a)(III)(A), C.R.S.
[71] § 18-1.3-401(1)(a)(V)(A), C.R.S.
[72] § 12-36-129(2.5), C.R.S.
[73] § 18-1.3-401(1)(a)(III)(A), C.R.S.
[74] § 18-1.3-401(1)(a)(V)(A), C.R.S.
[75] § 12-36-129(2.5), C.R.S.
[76] § 12-36-134(1), C.R.S.
[77] § 12-36-134(1)(b), C.R.S.
[78] § 12-36-134(1)(d), C.R.S.
[79] § 12-36-134(1)(f), C.R.S.
[80] § 12-36-134(1)(f), C.R.S.
[81] § 12-36-134(1)(g), C.R.S.

Program Description and Administration

All states, U.S. Territories and the District of Columbia regulate the practice of medicine. The Colorado State Board of Medical Examiners (Board) licenses doctors of medicine (MDs), doctors of osteopathy (DOs), and physician assistants. The Board is vested with this authority in order to protect against the unauthorized, unqualified and improper practice of medicine.

The Board consists of 13 members, including seven MDs, two DOs and four members of the public. The Board meets quarterly to address policy issues, rulemaking and the unauthorized practice of medicine. The Board promulgates rules for regulating physicians, peer review, physician assistants, emergency medical technicians and medical directors, unlicensed X-ray technicians, and the delegation of medical functions to unlicensed healthcare providers.

The Board is also divided into two inquiry and hearings panels, Panel A and Panel B. Each inquiry panel meets monthly to provide oversight and to discipline current licensees, and the inquiry panels alternate licensure duty every other year.

Agency Fiscal Information

The Board is housed in the Division of Registrations (Division), within the Department of Regulatory Agencies (DORA). The Division provides administrative and operational support to the Board.

Table 1 illustrates the Board's expenditures and staffing over the past five fiscal years.

Table 1
Board Expenditures and Full-Time Equivalent (FTE) Employees

Fiscal Year	Total Program Expenditure	FTE
03-04	$1,963,922	8.3
04-05	$2,004,587	8.3
05-06	$1,756,025	8.3
06-07	$2,075,121	8.3
07-08	$2,033,681	9.2

The Director of the Healthcare Unit (0.2 FTE Management) oversees the responsibilities of the healthcare section and has been the primary staff member involved with the development and oversight of the Michael Skolnik Medical Transparency Act.

The Program Director (0.9 FTE General Professional VI) oversees all activities of the Board. The Program Director also performs case management activities, researches and drafts rules and policies, supervises staff, and is the primary liaison for Board members, the Office of the Attorney General, external agencies, and media queries.

The Enforcement Program Manager (General Professional VI, 1.0 FTE) supervises the enforcement unit, monitors physician compliance with Board actions, prepares disciplinary documents and suspensions, performs case management activities, gathers statistics, and interacts with consumers.

The Office Manger (0.8 FTE Program Assistant II) supervises the Board office and budget, prepares agendas for Board meetings, performs case management activities, supervises the Michael Skolnik Medical Transparency Act staff and licensing unit, handles rulemaking and public notices, and drafts Board minutes.

The Program Specialist (1.0 FTE General Professional II) advises the complaint unit, performs case management activities, prepares the panel agendas, handles complex complaints, and interacts with consumers and physicians.

The Board staff also includes five Administrative Assistants (4.5 FTE) and two Program Assistants (1.6 FTE).

The FTE in Table 1 does not include staffing in the centralized offices of the Division, which include:

- Director's Office;
- Office of Examination Services;
- Office of Expedited Settlement;
- Office of Investigations;
- Office of Licensing; and
- Office of Support Services.

The cost of these FTE is reflected in the "Total Program Expenditures" column of Table 1. The Board pays for these FTE through a cost allocation methodology developed by the Division and DORA's Executive Director.

The Board is cash-funded by the fees it collects for licensure as shown in Table 2. License fees are set each year on July 1.

Table 2
Board Fees
Fiscal Year 08-09

Fee Type	Physician	Physician Assistant
New License	$522	$282
Renewal	$397	$165
Renewal Inactive	$212	Not Applicable
Late Renewal	$15	$15
Reinstatement Active	$412	$202
Reinstatement Inactive	$227	$142
Training	$10	Not Applicable
Distinguished Foreign Teaching	$100	Not Applicable
Temporary	$50	Not Applicable
Limited	$100	Not Applicable

Licensing

The practice of medicine, as it is defined by statute, is restricted to persons who hold a medical license issued by the Board. Other professionals such as chiropractors, nurses and dentists deliver healthcare services, and Colorado does not prohibit these professions from providing healthcare. However, these other professions are limited by their particular scopes of practice.

The titles of “MD,” “DO,” “physician,” and “surgeon” are protected and can only be used by those who are licensed by the Board.

The Board issues the following types of licenses:

- Full physician;
- Physician training
- Distinguished foreign teaching;
- Temporary;
- Limited; and.
- Physician assistant.

Full physician and physician assistant licenses are renewed every other year. Physician training licensees must renew every three years.

An individual applying for a license to practice medicine must complete an application and submit it with the required supporting documentation to the Division's Office of Licensing. A licensing specialist reviews the application and notifies the applicant if is incomplete. Once the application is complete, a licensing specialist evaluates the application to ensure the applicant meets the requirements for licensure. If requirements are met, the license is issued. If not, the licensing specialist notifies the applicant in writing, and the application is kept on file for one year.

Any applications that can not be administratively approved are reviewed by the inquiry and hearings panel that is acting as the licensing subcommittee at that time. These applications include any with a history of disciplinary action, medical malpractice, substance abuse, and foreign medical school graduates.

Table 3 is a summary of the number of licenses for all license types over the last five fiscal years. In non-renewal years, the number of reinstatements typically spikes because physicians who do not renew in time and miss the grace period must reinstate their licenses.

Table 3
Summary of All License Types

Fiscal Year	New – All Methods	Reinstatement	Renewal	Total
03-04	1,540	Not available	1,182	19,578
04-05	1,527	64	15,839	20,834
05-06	1,566	123	1,322	20,501
06-07	1,556	79	16,323	21,812
07-08	1,575	157	1,614	21,360

The number of new licenses granted by the Board has remained constant over the past five fiscal years, contributing to a steady but minimal growth in the total number of licensed physicians and physician assistants.

The figures for the various types of license acquisition do not equal the figures in the "total" column due to a number of circumstances, including computer system anomalies. Many of these anomalies can be attributed to the date on which various reports are pulled, as well as when data is entered into the system.

Table 4 illustrates the number of new physician licenses broken down by graduates of U.S. and non-U.S. medical schools. The spike in international licensees in fiscal year 05-06 may be due to a new data entry system. Previously these numbers were imprecise.

Table 4
Physician Licenses

Fiscal Year	New -- Graduates of U.S. Medical Schools	New -- Graduates of Non-U.S. Medical Schools	Reinstatement	Renewal	Total
03-04	998	12	Not Available*	78	17,147
04-05	932	44	52	15,835	18,142
05-06	944	113	104	49	17,875
06-07	878	128	61	16,260	18,922
07-08	879	119	134	36	18,434

*For fiscal year 03-04, the Division is unable to provide a breakdown of the number of licenses provided by reinstatement because at that time reinstatements were not tracked separately from renewals.

Physicians renew their licenses in odd numbered years only. Their licenses expire on May 31 of the renewal year, but the Division grants them a grace period through July 31 of the renewal year. Thus, there can be some cross-over from one fiscal year to the next, as is exemplified by the renewal figures reported in fiscal years 03-04, 05-06, and 07-08, which represent physicians renewing late.

Table 5 breaks down the number of total physician licenses by active and inactive status. The number of inactive licenses has decreased primarily because physicians with such licenses must demonstrate competency when they reactivate, which can be an arduous and expensive process. As a result, more physicians are choosing to keep their licenses active in order to avoid having to prove continued competency later.

Table 5
Physician Licenses by Status

Fiscal Year	Active	Inactive	Total
03-04	14,795	2,352	17,147
04-05	15,533	2,609	18,142
05-06	15,790	2,085	17,875
06-07	16,828	2,094	18,922
07-08	16,885	1,549	18,434

Table 6 shows the number of physician training licenses issued by the Board over the last five fiscal years. Training licenses are issued for three years to medical school graduates who are participating in a Colorado residency program or internship. As exemplified by the renewal numbers, not all such licensees renew their licenses. This is typically due to the fact that they obtain a full physician license prior to renewing their physician training licenses.

Table 6
Physician Training Licenses

Fiscal Year	New	Renewal	Total
03-04	384	0	1,054
04-05	377	0	1,134
05-06	346	56	1,095
06-07	360	59	1,152
07-08	385	59	1,196

Table 7 demonstrates the number of distinguished foreign teaching licenses issued by the Board over the last five fiscal years. In fiscal years 03-04 and 04-05, this license type was titled "temporary visiting professor," before legislation was passed that changed the license type to "distinguished foreign teaching physician."

Table 7
Distinguished Foreign Teaching Physician Licenses

Fiscal Year	New	Renewal	Total
03-04	2	0	4
04-05	4	2	8
05-06	3	1	10
06-07	3	3	13
07-08	4	1	15

A distinguished foreign teaching physician license is valid for one year. The low number of renewals can be attributed to several factors. Many of these licensees come to Colorado to teach for a single academic term and then leave the state. Alternatively, many of those who stay in Colorado obtain a full medical license prior to renewing this license.

Table 8 shows the number of temporary licenses issued by the Board over the last five fiscal years. This type of license is a 90-day permit issued to physicians who are licensed elsewhere and are practicing medicine in Colorado at the invitation of the U.S. Olympic Committee. This license-type does not renew or reinstate.

Table 8
Temporary Licenses

Fiscal Year	Original
03-04	6
04-05	9
05-06	10
06-07	9
07-08	9

The Board also issues a limited license to physicians who are employed by the Shriners Hospitals for Children (Shriners Hospital). These physicians are also licensed by another state. They provide treatment and evaluations to patients of Shriners Hospital who live in Colorado and are under the age of 21. The license fee is reduced for this license type because Shriners Hospital provides pediatric specialty care to children at no cost. The Board has only issued four of these licenses to date, and the renewal numbers are included with the other license types in Table 3.

Table 9 shows the number of physician assistants licensed by the Board during the previous five fiscal years. Physician assistant licenses are valid for two years, renewing on January 31 of even numbered years only.

Table 9
Physician Assistant Licenses

Fiscal Year	New	Reinstatement	Renewal	Total
03-04	126	Not available	1,097	1,311
04-05	124	10	0	1,471
05-06	131	18	1,215	1,471
06-07	157	17	0	1,652
07-08	158	22	1,511	1,650

The number of new physician assistant licenses granted by the Board has increased marginally over the last five fiscal years, contributing to a small but steady growth in the total number of licensed physician assistants.

Table 10 provides a breakdown of the total physician assistant licenses by active and inactive status.

Table 10
Physician Assistant Licenses by Status

Fiscal Year	Active	Inactive	Total
03-04	1,156	155	1,311
04-05	1,297	174	1,471
05-06	1,368	103	1,471
06-07	1,516	136	1,652
07-08	1,584	66	1,650

A physician assistant works under the license and within the scope of the agreement with his or her supervising physician. A physician assistant may not practice without a supervising physician. Upon licensure, a physician assistant has 180 days to register a supervising physician before his or her license becomes inactive. When a supervising physician inactivates his or her license, a physician assistant has 180 days to register a new supervising physician before his or her license becomes inactive.

The decrease of physicians with inactive licenses is reflected in the physician assistant licensing data as well.

Table 11 illustrates the number of physician assistants, licensed by the Board over the past five fiscal years, who are licensed pending a supervising physician. They have 180 days to register a supervising physician before their license becomes inactive.

Table 11
Physician Assistants Pending Supervising Physician

Fiscal Year	New	Reinstatement	Renewals	Total
03-04	12	Not available	7	51
04-05	36	2	0	65
05-06	22	1	2	37
06-07	21	1	0	52
07-08	21	1	8	50

Renewal figures can be attributed to physician assistants whose licenses were in pending status at the time of license renewal.

Examinations

One of the qualifications necessary to obtain a medical license in Colorado is passage of a national examination. Physician assistants are required to pass the national certifying examination developed by the National Commission on the Certification of Physician Assistants (NCCPA). Physicians are required to pass Step 3 of the United States Medical Licensing Examination (USMLE), sponsored by the Federation of State Medical Boards of the United States and the National Board of Medical Examiners, or the Comprehensive Osteopathic Medical Licensing Examination-USA (COMLEX-USA), administered by the National Board of Osteopathic Medical Examiners.

The NCCPA gives the Physician Assistant National Certifying Examination (PANCE) to graduates of physician assistant programs certified by the Accreditation Review Commission on Education for the Physician Assistant. PANCE is a six-hour, multiple-choice, computerized examination, comprising 360 questions. The examination questions are developed by physician assistants and physicians to test basic medical and surgical knowledge. Examinations are given at over 200 Pearson VUE testing centers throughout the country. Colorado has three testing centers, one each in Greenwood Village, Westminster, and Pueblo. Examinations may be taken most days throughout the year, except on major holidays and the last two weeks of the year. The registration fee is $425.

Table 12 illustrates the number of NCCPA examinations taken in Colorado by first-time test takers and the pass rates.

Table 12
NCCPA Examination

Fiscal Year	Examinations	Pass Rate (%)
03-04	103	97
04-05	93	96
05-06	121	97
06-07	112	96
07-08	115	98

The pass rates of the physician assistants taking the NCCPA examination in Colorado is consistently high, averaging 97 percent over the last five fiscal years.

The USMLE Step 3 is developed by medical educators and practicing physicians to test whether medical school graduates have the basic medical knowledge and clinical skills essential for the unsupervised practice of medicine. The USMLE Step 3 comprises multiple-choice questions and computer-based simulations. The examination fee is $690. Examinations are given at Thompson Prometric testing centers throughout the United States and its territories. Colorado has four testing centers, one each in Greenwood Village, Longmont, Grand Junction, and Colorado Springs. Examinations are scheduled throughout the year, except on major holidays and the first two weeks of the year. In order to be eligible for the USMLE Step 3, a medical school graduate must have obtained either an MD or a DO degree and have successfully completed both USMLE Steps 1 and 2. Step 1 measures basic science knowledge, and Step 2 tests clinical knowledge and clinical skills. Typically, medical students take Steps 1 and 2 during the second and fourth years of medical school respectively. Step 3 is taken after graduation, typically at the end of the first year of residency training.

Table 13 shows statistics for the USMLE Step 3 examinations taken in the United States and Canada by both first-time and repeat test takers. Examination statistics specific to Colorado were not available.

Table 13
USMLE Examination U.S./Canada
Step 3 MD/DO

Calendar Year*	Written Examinations	Pass Rate (%)
2004	17,685	94
2005	16,992	94
2006	17,461	94
2007	17,591	95
2008	18,262	94

* The time frame for this data is not an exact calendar year. It is generally January 1 of each year through mid-February of the following year. For example, 2004 is January 1, 2004 through February 16, 2005.

The pass rates of the USMLE examination taken in the U.S. and Canada is consistently high, averaging 94 percent over the last five fiscal years.

Graduates of osteopathic medical schools may take the USMLE Step 3 or the COMLEX-USA Level 3 for licensure. COMLEX-USA Level 3 is designed to assess the osteopathic medical knowledge and clinical skills necessary to practice medicine without supervision. The examination is an eight-hour test, and the fee is $650. In order to be eligible for the COMLEX-USA Level 3, an osteopathic medical school graduate must have obtained a DO degree and have successfully completed both COMLEX-USA Levels 1 and 2. Like the USMLE, osteopathic students typically complete Levels 1 and 2 in their second and fourth years of school. Level 3 is taken after graduation, typically during the first year of residency training.

The National Board of Osteopathic Medical Examiners did not provide data for the COMLEX-USA Level 3 examination.

Complaints/Disciplinary Actions

The Board receives complaints from patients and their families, medical professionals, and other governmental or law enforcement agencies. The Board may initiate a complaint on its own initiative. All complaints are reviewed by one of the inquiry panels of the Board. If the Board finds that the licensee has violated the Medical Practice Act (Act) or the Board rules, the Board is authorized to take the appropriate disciplinary action.

Table 14 illustrates the types of complaints filed against physicians.

Table 14
Physician Complaints

Nature of Complaints	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Standard of Practice	668	699	680	607	632
Physical/Mental Disability	30	34	45	30	22
Stipulation/Order Violation	8	13	8	8	32
Failing to Report Adverse Action	1	1	4	3	6
Sexual Misconduct and Boundary Violations	14	6	17	12	24
Substance Abuse	25	18	25	22	8
Inappropriate Prescribing	27	14	15	13	13
Criminal Conviction	4	5	3	2	2
Application Fraud/Misrepresentation	4	2	13	7	14
Aiding/Abetting Unlicensed Practice	1	2	3	1	2
Insurance Fraud/Abuse	9	5	10	6	2
TOTAL	**791**	**799**	**823**	**711**	**757**

Over the past five fiscal years, the bulk of the complaints filed against physicians pertained to standard of practice issues, i.e. cases where it is alleged that a reasonable or prudent physician would consider the care to be substandard. Substance abuse, inappropriate prescribing and disability are the next largest complaint types.

If the Board determines that a complaint is within its jurisdiction and credible, it will initiate an investigation and send a letter requesting that the physician respond to the complaint. The Board may also request copies of patient records, direct the Division staff to interview witnesses, or send the case out to be reviewed by an expert.

If a complaint is a violation of the Act, then the Board may pursue sanctions necessary to protect the public including: revocation or suspension of a license, probation or practice limitation, a stipulated agreement, or a letter of admonition. If a complaint does not violate the Act, then the Board may dismiss the complaint. In cases where the Board uncovers conduct that does not rise to the level of unprofessional conduct but should not be dismissed outright, then the Board may send a letter of concern.

Over the last five fiscal years, 15 percent of the physician complaints filed or received by the Board resulted in disciplinary action by the Board, and 17 percent of physician complaints resulted in letters of concern, effectively dismissals.

Table 15 illustrates the final agency actions taken by the Board against physician licenses over the last five fiscal years.

Table 15
Physician Final Agency Actions

Action	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Revocation/Surrender/ Voluntary Relinquishment	6	4	3	3	7
Suspension	17	22	9	23	26
Probation/Practice Limitation	52	65	47	40	44
Letter of Admonition	29	24	29	52	32
License Denied/Application Withdrawn	4	4	2	3	1
Fine	0	5	3	3	2
Other	1 (Licensing Agreement)	7 (3 Injunctions) (4 Stipulations)	4 (Injunctions)	4 (3 Injunctions) (1 Cease and Desist)	7 (1 Injunction) (6 Stipulations)
Total Board Actions	**109**	**131**	**97**	**128**	**119**
Dismiss	511	613	569	519	488
Letter of Concern	143	132	145	129	115
Total Dismissals	**654**	**745**	**714**	**648**	**603**

Forty-five percent of the Board actions resulted in practice limitation or probation of a licensee, and 25 percent of the Board actions resulted in letters of admonition. Sixteen percent of the Board actions against physicians resulted in suspension of a license, and four percent resulted in revocation.

Table 16 illustrates the complaints filed against physician assistants over the last five fiscal years.

Table 16
Physician Assistant Complaints

Nature of Complaints	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Standard of Practice	19	32	17	22	16
Physical/Mental Disability	4	1	6	3	2
Stipulation/Order Violation	0	1	0	0	2
Failing to Report Adverse Action	0	1	0	0	0
Sexual Misconduct and Boundary Violations	0	0	0	2	0
Substance Abuse	3	1	3	3	1
Inappropriate Prescribing	3	0	2	2	0
Criminal Conviction	3	1	0	0	0
Application Fraud/Misrepresentation	0	1	0	0	1
Aiding or Abetting Unlicensed Practice	1	3	0	0	0
TOTAL	**33**	**41**	**28**	**32**	**22**

The rate of complaints against physician assistants is consistently low. Like complaints against physicians, the most common type of complaint against physician assistants pertains to standard of practice. Complaints regarding disability, substance abuse and inappropriate prescribing make up the next most significant groups of complaint types filed against physician assistants.

Over the past five fiscal years, the Board dismissed 85 percent of complaints against physician assistants. Table 17 illustrates the final agency actions taken against physician assistant licenses.

Table 17
Physician Assistants Final Agency Actions

Type of Action	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Revocation / Surrender / Voluntary Relinquishment	0	1	0	0	1
Suspension	0	0	0	0	1
Probation / Practice Limitation	1	1	2	3	2
Letter of Admonition	0	1	1	4	1
License Denied	0	0	0	1	0
Fine	0	0	0	0	1
Licensing Agreement	0	1	0	0	1
TOTAL BOARD ACTIONS	**1**	**4**	**3**	**8**	**7**
Dismiss	19	28	19	20	15
Letter of Concern	3	14	6	8	3
TOTAL DISMISSALS	**22**	**42**	**25**	**28**	**18**

Over the past five fiscal years, about half of Board actions taken against physician assistants resulted in practice limitation or probation, and a quarter resulted in letters of admonition. Three percent of actions against physician assistants resulted in suspension of a license, and eight percent resulted in revocation.

The Board is authorized to impose a fine in lieu of suspending a license. Typically, fines are imposed for violations such as practicing while a license is lapsed, improperly delegating medical services to unlicensed healthcare providers, and boundary violations. Table 18 reflects the amount of fines collected by the Board. It does not reflect the fines imposed.

Table 18
Fines Paid or Collected

Fiscal Year	Number	Total
03-04	0	$0.00
04-05	5	$20,000
05-06	3	$6,500
06-07	3	$8,000
07-08	2	$6,000

Note: Fining authority was added to the Medical Practice Act, effective August 6, 2003.

Table 19 demonstrates the number and types of complaints received against physician training licensees over the last five fiscal years.

Table 19
Training Licensees Complaints

Nature of Complaints	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Standard of Practice	4	8	1	5	7
Physical/Mental Disability	1	5	2	3	0
Failure to Report Adverse Action	0	0	0	2	0
Substance Abuse	1	2	1	2	0
Stipulation/Order Violation	0	0	0	1	0
Application Fraud/Misrepresentation	0	0	1	1	0
TOTAL	**6**	**15**	**5**	**14**	**7**

Training licensees receive a very low rate of complaints compared to physicians and physician assistants. As seen with the other license types, the most common complaint against a training license has to do with standard of practice. Disability and substance abuse complaints make up the next most common complaints filed against training licensees.

Table 20 shows the final agency actions taken by the Board against physician training licensees over the last five fiscal years. On average, 15 percent of Board complaints resulted in disciplinary action against training licensees.

Table 20
Training Licensee Final Agency Actions

Type of Action	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Revocation / Surrender / Voluntary Relinquishment	0	0	0	0	0
Suspension	0	0	0	0	0
Probation / Practice Limitation	0	0	1	1	0
Letter of Admonition	0	2	1	0	1
License Denied	0	0	0	0	0
Fine	0	0	0	0	0
Other	0	0	0	0	0
TOTAL BOARD ACTIONS	**0**	**2**	**2**	**1**	**1**
Dismiss	4	12	6	4	9
Letter of Concern	0	1	0	2	0
TOTAL DISMISSALS	**4**	**13**	**6**	**6**	**9**

Over the past five fiscal years, 50 percent of Board actions resulted in letters of admonition against training licensees, and 30 percent resulted in probation. The Board did not suspend or revoke any training licenses during this period.

Table 21 shows the complaints received and the actions taken by the Board concerning the unlicensed practice of medicine.

Table 21
Unlicensed Practice of Medicine

Actions	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Complaints Received	12	8	14	11	15
Complaints Dismissed	6	5	9	9	16
Injunctions Obtained	0	3	4	3	1
Cease and Desist Orders*	N/A	N/A	N/A	1	0
Total Actions	**0**	**3**	**4**	**4**	**1**

* Cease and desist authority was granted to the Board effective July 1, 2006.

Over the past five fiscal years, the Board has investigated a handful of unlicensed practice of medicine cases. The majority of these have been dismissed. Over the past five fiscal years, the Board has dismissed about 75 percent of the unlicensed practice cases and has obtained injunctions in about 20 percent of the cases. The Board has only filed one cease and desist order since receiving the authority in 2006.

Colorado Physician Health Program

The Colorado Physician Health Program (CPHP), a nonprofit organization founded in 1986, is the peer health assistance program selected by the Board to provide services to Colorado physicians. CPHP provides assistance to physicians who have health problems that could affect the safety of their medical practice.

All physician assistant and full physician licensees are required to pay a surcharge to fund the program, although all license types may avail themselves of the services offered by CPHP. In 2009, the two-year surcharge was $122. The surcharge pays for evaluation, assessment, treatment referral, drug and alcohol monitoring, and client support of physicians and physician assistants. Any necessary treatment is paid for by the individual. The largest source of revenue for CPHP is generated by the peer assistance surcharge fund. In fiscal year 07-08, the surcharge fund made up 76 percent of CPHP revenue.

A practitioner may be referred to the program by the Board, by his or her workplace, by his or her training program, or a practitioner may self refer. A practitioner who self refers is not reported to the Board unless he or she does not follow the practice limitations and treatment recommended by CPHP, and CPHP determines that he or she is no longer safe to practice. A practitioner who is required by the Board to attend CPHP must sign a confidentiality waiver so that CPHP may release information to the Board.

Self referrals make up the largest source of new referrals to CPHP. In fiscal year 07-08, 37 percent of new clients were self referred. Board referrals make up the second largest source at 13 percent. Table 22 demonstrates the percentage of different license types referred to CPHP by the Board.

Table 22
Board Referrals to CPHP
Fiscal Year 07-08

Type	Percent
Active Physician Licensees	48
Applicants	40
Training Licensees	9
Active Physician Assistant Licensees	3

Center for Personalized Education for Physicians

The Center for Personalized Education for Physicians (CPEP) is a nonprofit organization created in 1990 to attend to physician performance concerns. If the Board identifies a physician who may have deficits in his or her clinical competency, the Board may refer the physician to CPEP as a condition of licensure in order to ensure the competent practice of medicine. A physician who has been out of practice for some time may be referred to assess clinical competence. A physician may also be referred in order to evaluate the clinical capabilities of a physician with health concerns including recovery from substance abuse, a disabling illness or injury, or neurological concerns.

CPEP is not funded by the state, nor is it funded by state license fees. The cost of the assessment, education and evaluation is paid for by the individual.

Michael Skolnik Medical Transparency Act

In 2008, the Board implemented the Michael Skolnik Medical Transparency Act (Skolnik Act). To comply with the Skolnik Act, all physicians holding a full medical license in Colorado must create a physician profile in which they disclose the following information about their practice:

- Name, aliases, current address, telephone number;
- Information regarding all medical licenses ever held;
- Current board certifications and practice specialty or specialties;
- Affiliations with hospitals and healthcare facilities;
- Current ownership interests in healthcare related businesses;
- Current healthcare related employment contracts;
- Public disciplinary actions against a medical license;
- Agreements and stipulations to temporarily cease medical practice;
- Involuntary hospital or healthcare facility privileging actions dating back to 1990;
- Involuntary surrender of a U.S. Drug Enforcement Administration registration;
- Criminal convictions or plea arrangements for felonies and crimes of moral turpitude dating back to initial licensure in any state or country;
- Judgments, settlements and arbitration awards for medical malpractice claims dating back to 1990; and
- Refusal by an insurance carrier to issue medical liability insurance.

The physician profile is available for the public to view online at www.dora.state.co.us/pls/real/PRR_SEARCH_GUI.show_page. By the end of the renewal period in 2009, all physicians in Colorado with an active license to practice medicine should have complied with the Skolnik Act.

The information posted in the physician profile is created by the licensed physician and is not verified by the Board. If the Board receives information that the physician profile is not accurate or complete, the Board will take action to obtain compliance.

The physician profiles include a disclaimer which states: "Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence." The disclaimer advises consumers to consider other factors when viewing the malpractice history of a physician.

The public has been able to access the physician profiles required by the Skolnik Act since August 2008. Between that date and September 30, 2009, the Skolnik website received 100,156 visitors, including physicians entering their profiles, or an average of 7,154 visitors per month. If the months of April, May and June 2009 are excluded, since this is when most physicians were counted as visitors when entering their profiles, the monthly average is 4,900 visitors.

Analysis and Recommendations

Recommendation 1 – Continue the Colorado State Board of Medical Examiners and the Medical Practice Act for nine years, until 2019.

The Medical Practice Act (Act), which can be found at section 12-36-101, *et seq.*, Colorado Revised Statutes (C.R.S.), creates the Colorado State Board of Medical Examiners (Board) and provides the statutory framework for the regulation of physicians and physician assistants.

There are at least two tests to apply to determine whether continuation is warranted: historical and statutory.

Historically, regulation of various professions is premised on the proposition that the public is unable to determine the qualifications and competency of the profession at issue. Ironically, physicians are the profession most often used to exemplify this question.

Physicians generally spend at least eight years in school before entering their residency programs, which last at least three years. There are hundreds of medical schools in the U.S. and abroad, plus thousands more residency programs.

Additionally, most physicians go on to become certified by one or more national specialty boards. There are dozens of such boards, many with subspecialties.

To expect the average consumer to research the credentials of an individual physician to determine competency is both inefficient and unrealistic. The depth of knowledge and level of skill required to practice as a competent physician is more efficiently determined by the state, through the Board.

Although physician assistants spend less time in school and do not complete residency programs, the degree of specialization makes it difficult for a consumer to determine individual competency.

Therefore, from this historical perspective, the Board and its regulation of physicians and physician assistants should be continued.

The first sunset criterion asks whether regulation is necessary to protect the public health, safety and welfare. To answer this question, it is necessary to explore what physicians and physician assistants do that could harm consumers.

Physician and physician assistants diagnose and treat human bodies. The process of diagnosing can run the spectrum from visual observation, to palliation, to highly technical, invasive procedures. Similarly, treatment can be highly complex and invasive, depending on the diagnosis. Treatment can involve ordering the patient to rest, writing a prescription or performing surgery.

Is regulation of the individuals who perform such tasks necessary to protect the public? It is. Without regulation, there is no way to determine that those who perform such services are at least minimally competent.

Therefore, regulation is necessary, and the Board is the ideal state body to perform this function.

The Board comprises physicians and members of the public. Physicians possess the expertise necessary to evaluate complaints, interpret medical records, and assess whether a particular practitioner has engaged in unprofessional conduct. Public members seek to ensure that the Board is not self-serving to the profession and that the public interest is maintained.

Additionally, the Board was recently ranked as sixth best in the nation by a consumer advocacy group.[82]

Therefore, the Board is the ideal vehicle through which the state can regulate the practice of medicine.

In addition to the issues that were explored during the course of this sunset review that resulted in recommendations, many more were explored that did not result in recommendations. At least one of these merits attention here.

In order to obtain a full physician license in Colorado, a candidate must have, among other things, "completed either an approved internship of at least one year . . . or at least one year of postgraduate training approved by the Board."[83]

In short, the candidate must have acquired at least one year of experience, either in an internship or a residency program.

Some argue that this is insufficient to adequately prepare an individual to practice medicine safely. Rather, the Act should require, some argue, one of the following:

- Three years of experience;
- Completion of a residency program; or
- Enrollment in a residency program.

None of these is justified.

[82] Sidney Wolfe, M.D., and Kate Resnevic, "Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007," April 22, 2008. Retrieved July 8, 2009, from www.citizen.org/documents/medicalboardtable.pdf

[83] § 12-36-107(2)(c), C.R.S.

The purpose of regulation is to protect consumers by ensuring that practitioners are minimally competent. When discussing physicians, this becomes a tricky issue.

Given that Colorado licenses physicians but not specialists, and given the wide array of medical specialties, what is minimally competent?

To answer this, it is logical to look at complaint and disciplinary data, as well as the requirements of other states.

Although Board staff does not track the level of experience of the physicians against whom complaints are filed and disciplinary action is taken, based on observation, it does not appear that physicians with less overall experience get into trouble any more frequently than those with more experience.

Additionally, experience alone does not determine whether a candidate gets a license. A license candidate must still pass the U.S. Medical License Examination (USMLE). Thus, there is an objective measure of competency.

Finally, only 15 U.S. jurisdictions require more than one year of experience, whereas 53 require only one year.[84] Therefore, the vast majority of U.S. jurisdictions have also concluded that one year of experience is sufficient to ensure minimal competency.

Similarly, completion of a residency program is also unjustifiable.

Depending on the medical specialty, some residencies are three years long and some can be five or even seven years long. Thus, basing licensure on the completion of a residency program would, necessarily, impose different statutory requirements on different candidates, based on their specialties. This would be difficult to administer and runs counter to Colorado's long-held philosophy of regulating physicians, not specialists.

Additionally, most physicians already complete a residency, just not before obtaining their licenses. All national specialty certification boards require the completion of a residency to become certified. Most hospitals require the completion of a residency to be credentialed. Most insurance companies require physicians in their provider networks to have completed a residency.

In the end, then, the marketplace has already addressed this issue, just in a post-licensure manner. Therefore, the state need not require more experience to ensure minimal competency.

Furthermore, either requiring three years of experience or the completion of a residency would likely have dire consequences on the supply of physicians in Colorado.

[84] Figures exceed 54 because some U.S. jurisdictions have different requirements for medical doctors than for doctors of osteopathy.

The average physician debt coming out of medical school is between $150,000 and $225,000, depending on where the physician went to school, as well as other factors. Most residents, however, earn only about $50,000 per year. Thus, residents are under a tremendous amount of financial stress.

To address this, many residents "moonlight;" they work outside of their residency programs. A physician may moonlight in any number of settings: urban or rural hospitals; urgent care facilities or even the office of a rural healthcare provider who goes on vacation.

Thus, moonlighting serves several vital goals: it reduces the resident's financial stress; it provides greater access to healthcare for Colorado consumers; and it provides broad-based experience exposure for the resident.

Additionally, some residency directors maintain that moonlighting is part of the educational experience of a residency program. The resident is forced to practice independently, but can always seek help from the residency preceptors.

Nationally, a physician shortage of 40,000 primary care providers is projected for 2025.[85] Since Colorado already has a high number of underserved areas, this shortage can be expected to impact Colorado particularly hard.

Requiring the completion of a residency to obtain a license can be expected to impact the ability of Colorado's residency programs to recruit high quality physicians because those residents will not be able to start paying down their sizable debt and they will not be able to practice independently.

Since all family practice residency programs include a rural rotation, rural areas of the state will see reduced access to healthcare. Residents working on a rural rotation must be able to practice independently, so that they can, for example, write prescriptions without having to find another physician to co-sign.

Further, the rural rotation exposes the physicians to rural practice. This experience can serve to convince many of them that they can handle the unique stresses of rural practice. This makes them more likely to return to such areas after they complete their residency programs.

Indeed, access to healthcare is such an important issue that several recommendations in this sunset report are designed to remove unnecessary regulatory barriers so that more physicians can safely remain in practice longer.

Therefore, requiring the completion of a residency program to obtain a license would present an unnecessary barrier to entry and could actually harm Coloradans by limiting access to healthcare.

[85] Cheryl Preheim, "Fewer doctors choosing primary care," 9News.com. Retrieved on December 3, 2008, from www.9news.com/news/article.aspx?storyid=105106&catid=188

Finally, some argue that Colorado should simply require candidates for full medical licenses to merely be enrolled in residency programs. This, too, is unworkable.

A candidate could enroll, obtain a license, and then resign from the residency program the next day. Nothing would have been achieved.

Additionally, the issuance of a license signifies that the state deems the practitioners competent to practice. Requiring an educational component after issuance nullifies this premise.

For all of these reasons, the General Assembly should retain the current requirement of one year of experience.

The General Assembly should continue the Act and the Board for nine years, until 2019. Nine years is an optimal time frame given that the last sunset review of the Board occurred in 1994. This goes a long way in explaining why this sunset report contains 27 statutory recommendations.

Recommendation 2 – Schedule Colorado's system of professional review committees for sunset in 2012.

Professional review committees, sometimes referred to as hospital or peer review committees, are authorized by Colorado law, "to review and evaluate the quality and appropriateness of patient care provided by the professional conduct of any physician licensed under [the Act]."[86]

In authorizing professional review committees, the General Assembly recognized that the Board,[87]

> . . . cannot practically and economically assume responsibility over every single allegation or instance of purported deviation from the standards of quality for the practice of medicine . . . and that an attempt to exercise such oversight would result in extraordinary delays in the determination of the legitimacy of such allegations and would result in the inappropriate and unequal exercise of its authority to license and discipline physicians. . . .

As a result, the General Assembly declared professional review committees to be an extension of the Board.[88]

Thus, the role of professional review committees in the regulation of physicians and in ensuring the safe delivery of medical services to Coloradans cannot be overstated.

[86] § 12-36.5-104(1), C.R.S.
[87] § 12-36.5-103(1), C.R.S.
[88] § 12-36.5-103(3)(a), C.R.S.

However, the statutes that directed the completion of this sunset report specified the Act, which can be found in Article 36 of Title 12, C.R.S., and made no mention of the statutes authorizing professional review committees, which can be found in Article 36.5 of Title 12, C.R.S.

Therefore, although an intricate part of the regulation of physicians, professional review committees fall outside the scope of this sunset report.

This is unfortunate since these committees play such a vital role in ensuring Colorado consumers are protected. Similarly, since professional review committees are not part of this or any other sunset report, the statutes authorizing them have not undergone any kind of comprehensive review since they were enacted in 1989.

Therefore, the General Assembly should schedule Article 36.5 of Title 12, C.R.S., to repeal effective July 1, 2012, so that a sunset review can be conducted in 2011.

Recommendation 3 – Transfer all regulatory authority pertaining to emergency medical technicians to the Colorado Department of Public Health and Environment, effective January 1, 2011, create the State Board of Emergency Medical and Truama Services, and schedule the new board and regulation to sunset in 2017.

Emergency medical technicians (EMTs) do not practice medicine. They practice under more restrictions than physician assistants in that they cannot write prescriptions and they have no high level medical treatment decision-making authority. They implement pre-approved protocols.

There are three levels of EMT, each with increasingly higher amounts of training, and thus, ability:

- Basic;
- Intermediate; and
- Paramedic.

For a complete description of what each level of EMT may perform, please see Appendix A.

For the most part, EMTs are regulated by the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division (CDPHE). CDPHE approves EMT training programs, certifies EMTs and disciplines EMTs when appropriate.[89]

[89] §§ 25-3.5-201 and 25-3.5-203(1), C.R.S.

However,

> The duties and functions of [EMTs], including the acts that they are authorized to perform subject to the medical direction of a licensed physician, shall be regulated by the rules adopted by the [Board].[90]

In short, the Board establishes the scope of EMT practice, but CDPHE enforces it. While this bi-furcated systems works, by all accounts, it could be more efficient and could better protect the public.

During the Board's quarterly meetings, one of the more time consuming tasks is approving waivers to the Board's rules regarding EMTs. These waivers are typically submitted by the medical directors, who are physicians, of the various agencies that employ EMTs and typically entail a request to allow EMTs to engage in certain activities that are not otherwise authorized by Board rule. The Board rarely denies these waivers.

In large part, these waivers are rarely denied because they have already been vetted and approved by CDPHE's *ad hoc* Medical Direction Committee (MDC), which is composed of four physicians active in emergency medical services (EMS) medical direction, and four licensed or certified healthcare professionals active in EMS. Thus, a group of EMS physicians and other experts have already refined and approved the waiver request before the request goes to the Board.

Since the Board meets only quarterly, this can result in a delay for waivers to be implemented. Many waivers are necessary to implement new technologies or practices. Thus, a delay in waiver approval could cost lives.

An additional concern, and perhaps a more important one, is the competency of the Board to promulgate the EMT rules and to approve the waivers of those rules. Emergency medicine is a specialty and involves technologies, protocols and practices that can be dramatically different from other medical specialties. A neurosurgeon, for example, would know little about emergency medicine.

In individual conversations with Board members, representatives of the Department of Regulatory Agencies (DORA) discerned concern on their part as to whether they are, as individual practitioners, competent to approve or deny waivers. In large part, Board members do not understand the intricacies of the waiver requests or the practices involved with them.

This is not a concern with respect to the Board's evaluation of complaints, however, because the Board routinely secures the services of appropriate experts.

Given that the current system is inefficient and may not represent the best way to ensure public protection, two solutions are obvious: transfer all regulatory authority to the Board or to CDPHE.

[90] § 25-3.5-203(1)(a), C.R.S.

EMTs are individuals. DORA and the Board have the institutional expertise and the infrastructure necessary to regulate individuals. On the other hand, these individuals are already largely regulated by CDPHE and the certification process is a vital component of the statewide system development responsibilities managed by CDPHE. Although some EMTs do not work in the prehospital or emergency room setting, the vast majority do. Under current law, CDPHE is responsible for regulatory oversight of the emergency medical and trauma services system in Colorado, within which most EMTs work.

The Board, and most programs in DORA, are cash funded, meaning that the direct and indirect costs of regulation are paid for through the imposition of license and other fees. However, according to CDPHE, approximately half of all EMTs are volunteers. As a result, the regulatory program administered by CDPHE is cash funded not through license fees, but by a $2-assessment already imposed on all motor vehicle registrations through the Highway Users Tax Fund. By this mechanism, CDPHE is currently able to provide EMT certifications at no cost to applicants, although this may change if this Recommendation 3 is adopted. Regardless, if regulation were to be moved to the Board or DORA, this practice is more likely to end.

Further, CDPHE has nearly 40 years of institutional expertise in the various aspects of emergency medical and trauma services oversight.

Additionally, at least 35 other states regulate their EMTs through a single agency, so in transferring authority to CDPHE, Colorado would not be blazing new territory and would be consistent with proven statewide regulatory systems across the country.

Finally, a report by the American College of Surgeons Committee on Trauma recently found great merit to this proposal and recommended that Colorado adopt this model.[91]

In the final analysis, then, it makes more sense to transfer authority to CDPHE. In doing so, however, the expertise provided by the MDC should be formalized by the creation of a new State Board of Emergency Medical and Trauma Services (BEMTS). The BEMTS should be authorized to act as a fully constituted regulatory body such that it is authorized to issue EMT certifications, receive and investigate complaints, take disciplinary action and promulgate rules.

To facilitate a smooth transition, full regulatory authority should be transferred to CDPHE and the BEMTS on January 1, 2011, and to ensure that this new process is working as intended, it should be scheduled to sunset in 2017, with a sunset review to be conducted in 2016.

Finally, the Act should be clarified so as to exempt from the practice of medicine, those EMTs who are properly certified by the BEMTS and who are working pursuant to BEMTS-promulgated rules.

[91] American College of Surgeons Committee on Trauma, "Trauma System Consultation, State of Colorado," May 17-20, 2009, p. 20.

Recommendation 4 – Change the name of the Board to the "Colorado Medical Board," and repeal any references to "examination by the board."

The current name of the Board dates back to a time when the Board conducted state licensing examinations. Today the Board relies on a national examination, the USMLE, sponsored by the Federation of State Medical Boards and the National Board of Medicine.

Not only is the term "medical examiner" obsolete as to the function of the Board, it is misleading. A "medical examiner" is a physician who performs autopsies and investigates the cause and circumstances of death. The Board's office is at times mistaken for a coroner's office. A more accurate and appropriate name would be the Colorado Medical Board.

All references in statute should be changed from the "Colorado State Board of Medical Examiners" to the "Colorado Medical Board." Furthermore, as the Board no longer conducts licensing examinations, any references to "examination by the board" should be repealed.

Recommendation 5 – Increase the size of the Board by three members and create a licensing panel to address issues pertaining to licensing and unlicensed activities.

The 13-member Board meets, as a full board, on a quarterly basis. Issues pertaining to unlicensed activity are addressed by the full Board, in open session, on a quarterly basis.

The Board has divided itself into two inquiry and hearings panels – Panel A and Panel B. Complaints are assigned to one panel, which oversees the ensuing investigation and determines the disciplinary action to be taken, if any, in closed session. Should the case go to hearing, the other panel reviews the Administrative Law Judge's Initial Decision and any Exceptions, and makes the final determination.

One of the panels also acts as a licensing subcommittee, which reviews those applications that involve non-routine matters, in open session. The two panels rotate, on an annual basis, which panel will serve as the licensing subcommittee. So, for example, Panel A acts as licensing subcommittee for one year, and the next year, Panel B performs this task.

This system has worked relatively well until recently, when panel packets have grown in length from approximately 800 pages per month, to over 1,200 pages per month. Similarly, panel meetings typically run five to seven hours for the panel that serves as licensing subcommittee, and four to five hours for the other panel.

Although the number of complaints has not increased markedly, the length of the records requiring panel review have. As a result, the workload of the Board has increased dramatically over the last decade.

Some may argue that a four to six hour meeting does not represent undue hardship. However, the time it takes to read and understand the complaint files that are reviewed in these meetings greatly exceeds the length of an individual meeting itself. Therefore, it is logical to conclude that, as the workload continues to increase, it will become increasingly difficult to retain and recruit Board members.

Two solutions are readily apparent: create a third inquiry and hearings panel, or create a stand-alone licensing panel.

In creating a third inquiry and hearings panel, the General Assembly would have to increase the size of the Board so that there could be three panels of six. In addition to this, staff time would also increase as there would be a third meeting for which to prepare each month. Thus, the costs and logistics involved in creating a third panel argue against this alternative. A 19-member Board would likely be unwieldy.

A stand-alone licensing panel, on the other hand, could be considerably smaller since licensing issues tend to be more straightforward than the types of issues that arise during the course of investigating a complaint. As a result, a licensing panel could consist of only three members: an MD, a DO, and a public member. This would mitigate the increase in Board size, but would still entail some additional staff time for preparations.

In order to maintain a sense of Board unity, members could rotate their service on the licensing panel such that once a year, or once every couple of years, those members serving on the licensing panel would rotate onto one of the inquiry and hearings panels, and vice versa. This would also give the licensing panel members the broader perspective that is occasionally needed in making licensing decisions. Regardless, the Board should be granted sufficient flexibility to make this system work.

Additionally, the licensing panel should process matters relating to unlicensed practice. The sanction involved in a matter involving unlicensed practice could be the issuance of a cease and desist order. However, the Board's authority to issue cease and desist orders is contained in section 12-36-118(14)(a), C.R.S., which requires confidentiality. However, unlicensed people are not otherwise entitled to the confidentiality provisions of the Act.

Therefore, the General Assembly should create a separate provision for the issuance of cease and desist orders such that when they apply to a licensee, the process is confidential, but when they apply to someone other than a licensee, the process is open. Doing this will help to clarify the boundaries of the new licensing panel.

For all these reasons, the General Assembly should increase the size of the Board by three (adding an MD, a DO, and a public member) and create a licensing panel to address issues pertaining to licensing and unlicensed activity.

Recommendation 6 – Clarify that the Director of the Division of Registrations possesses the on-going obligation and authority to promulgate and repeal, as appropriate, rules pertaining to Advanced Practice Nurses with prescriptive authority.

Following the 2008 Sunset Review of the Board of Nursing (BON), the General Assembly passed Senate Bill 09-239 (SB 239). Among other things, SB 239 directed the Board and the BON to promulgate rules implementing various new statutory provisions governing the relationship between physicians and Advanced Practice Nurses (APNs) with prescriptive authority.[92]

Although not explicitly stated in the directive to the two boards, the intent was that the two boards would implement rules that complement, rather than conflict with, one another. In the event the boards fail to accomplish this task by July 1, 2010, the Director of the Division of Registrations (Division Director) is directed, on July 2, 2010, to implement rules that, "supersede and replace the rules of the two boards" regarding this issue.[93]

However, SB 239 failed to address two important scenarios. If the Division Director is forced to promulgate rules, and the two boards pass complementary rules subsequent to this, no provision is made for the Division Director to rescind his or her rules in favor of the new board rules.

Conversely, if the boards accomplish their task by July 1, 2010, but one of them subsequently amends those rules such that they are no longer complementary of the other's, it is questionable whether the Division Director has the authority or obligation to pass superseding rules.

In other words, neither the Act nor the Nurse Practice Act makes it clear that the Division Director has an on-going obligation, and the accompanying authority, to ensure that the rules of the two boards regarding APNs with prescriptive authority remain complementary of one another.

Taken to its logical conclusion, this process could result in absurd results whereby, for example:

- The boards promulgate complementary rules after the statutory deadline, but the Division Director's rules must remain in place forever because there is no provision for the Division Director to repeal or amend his or her rules; or
- The boards promulgate complementary rules by July 1, 2010, thus nullifying the Division Director's authority to act on July 2, 2010, but then either or both boards promulgate conflicting rules on July 3, 2010.

[92] §§ 12-36-106.4(4)(a) and 12-38-111.6(4.5)(f)(I), C.R.S.
[93] §§ 12-35-106.4(4)(b) and 12-38-111.6(4.5)(f)(II), C.R.S.

Both of these scenarios, but particularly the latter, result in situations that are clearly contrary to the intent of the General Assembly in creating this statutory scheme. The General Assembly went to great lengths to ensure that the rules governing physicians and APNs with prescriptive authority are complementary to ensure that the remainder of the provisions enacted in SB 239 are complied with.

Therefore, the General Assembly should amend both the Act and the Nurse Practice Act to clarify that the Division Director has the on-going obligation and authority to ensure that the rules of the two boards on this issue remain complementary.

Recommendation 7 – Repeal the requirement that Board members who are physicians must have resided in Colorado for five years before their respective appointments to the Board.

Physicians appointed to the Board are required by statute to have been residents of Colorado for the five years immediately preceding their appointment to the Board.[94] A restriction like this could preclude highly qualified physicians from serving on the Board.

The Board is relied on to make important decisions that impact the livelihood of practitioners and the health of the public. Having qualified physicians on the Board is imperative. Serving on the Board is not an easy task. Board members are typically busy professionals who work long hours, and by serving on the Board they agree to take time out of their schedules to attend Board meetings, to read through vast amounts of materials every month, and to make weighty decisions concerning the conduct of their peers.

Additionally, this restriction prevents, for example, a world-renowned physician with 20 years of experience who may have moved to Colorado two years ago, from serving on the Board for another three years.

Considering all this, a restriction limiting membership on the Board based on residency in the state has very little merit and should be repealed.

Recommendation 8 – Repeal the requirement that the Governor consult with professional associations when appointing members of the Board.

The Governor is required by statute to consult with the professional associations for physicians and osteopathic physicians when appointing members of the Board.[95] Although it is common practice for governors to consult with professional associations when making an appointment, it is unusual to place such an obligation on the Governor in statute. Typically, the Governor may choose whether to consult with a private professional association.

[94] § 12-36-103(2), C.R.S.
[95] § 12-36-103(2), C.R.S.

Additionally, the statute does not require the Governor to appoint anyone selected by the associations. The Governor is merely required to consult with them. So it is at best a specious requirement.

Finally, this requirement is inconsistent with other practice acts, including, but not limited to dental,[96] nursing,[97] chiropractic,[98] and podiatric.[99]

For all these reasons, the General Assembly should repeal this requirement.

Recommendation 9 – Repeal the requirement for notice and a hearing when the Governor removes a member of the Board.

The Governor appoints the members of the Board, and members serve at the pleasure of the Governor. However, section 12-36-103(3), C.R.S., requires notice and a hearing for the Governor to remove a member of the Board for neglect of duty, incompetence, or unprofessional or dishonorable conduct.

As members serve at the pleasure of the Governor, any requirement for notice and a hearing is unnecessary. Moreover, the requirement is inconsistent with other practice acts, including, but not limited to, dental,[100] nursing,[101] chiropractic,[102] and podiatric.[103]

Recommendation 10 – Repeal the office of the secretary from the Board officers.

Section 12-36-103(4), C.R.S., requires the Board to elect a president, vice president and a secretary. Under the current Board structure, the secretary has no duties. Any duties that might have once been performed by the Board secretary are performed by the Board staff. As the role of secretary is obsolete, the requirement for the Board to elect such an officer should be repealed. Additionally, any references to the Board secretary throughout the statute should also be repealed.

[96] § 12-35-104(1)(a), C.R.S.
[97] § 12-38-104(1)(a), C.R.S.
[98] § 12-33-103(1), C.R.S.
[99] § 12-32-103(1), C.R.S.
[100] § 12-35-104(1)(a), C.R.S.
[101] § 12-38-105, C.R.S.
[102] § 12-33-103(1), C.R.S.
[103] § 12-32-103(1), C.R.S.

Recommendation 11 – Create a pro bono license type, to be provided at a reduced fee, for those physicians who provide healthcare for free, or who work for organizations that provide healthcare to patients for free.

Colorado provides a limited license type to physicians who are licensed in another state and who provide medical services to patients of Shriners Hospitals for Children (Shriners Hospital). This license type is limited to physicians who work for Shriners Hospital, and is provided by the state at a reduced fee. The Board currently licenses, and has only ever licensed, four physicians under this license type.

Shriners Hospital is an organization that provides specialty pediatric care to children at no cost. The Shriners Hospital that serves Colorado children is located in Salt Lake City, and all the surgeries and procedures are performed there. Shriners' physicians come to Colorado only to perform follow-up care. All Shriners' physicians are fully licensed and insured in Utah.

Clearly, the state should encourage charitable organizations such as Shriners Hospital to provide services in Colorado. However, should this license type be limited to Shriners Hospital only?

Amending the scope of this license type to create a broader pro bono license would encourage other charitable organizations to provide free or reduced cost healthcare to residents in Colorado.

Arizona has a pro bono license that is similar to the Colorado limited license, except that it is not restricted to Shriners' physicians. The Arizona pro bono license requires physicians to be fully licensed in another state, and it limits practice in Arizona to 60 days per calendar year. The license facilitates the provision of care by members of charities, some of which treat underserved areas and some that hold cancer retreats for children.

Additionally, Arizona allows inactive Arizona licensees to practice under a pro bono license. To qualify for a pro bono license in Arizona, the licensee may not have had a license revoked or suspended, may not be the subject of an unresolved complaint, and must meet all the qualifications required for full licensure. The licensee must additionally agree to provide all medical care in Arizona for no fee or salary, or through a charitable organization for no cost to the patient or patient's family. In Arizona, the pro bono license fee is waived.

Twenty-four other states offer similar pro bono or volunteer licenses, including: Alabama, California, Florida, Georgia, Indiana, Kansas, Maine, Maryland, Mississippi, Missouri, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Many states require an affidavit to be signed stating that all care will be provided for free. Liability laws for pro bono or volunteer licenses vary from state to state. Some states waive liability insurance requirements altogether. Many states waive the license fee, and others offer the license for a reduced fee.

Other licensed healthcare professionals in Colorado, such as dentists[104] and nurses,[105] can obtain a retired-volunteer status license. Both regulatory boards require the applicant to attest that he or she will no longer earn an income from his or her profession. Both license types are subject to the same discipline as other licenses. Both professions are offered the retired-volunteer status license at a reduced fee.

Providing physicians, who are no longer charging fees for medical services, with the opportunity to secure a pro bono license type at a reduced fee would increase access to healthcare services for the indigent and underserved populations across Colorado.

COPIC Companies (COPIC), the company that provides liability coverage to many physicians in Colorado, recognizes the importance of encouraging healthcare providers to volunteer. COPIC has a program where it waives the premiums for liability insurance for those physicians who have retired their practice, but are still providing medical services at no cost. These providers are restricted from performing invasive surgery, and the number of hours these physicians are allowed to work is limited.

For all these reasons, a new license type should be created for physicians who do not charge for services, or who are fully licensed in another state but who work for organizations that do not charge Colorado patients for their services. The pro bono license should be provided at a reduced fee. Physicians with a pro bono license should still be required to have the same qualifications and be subject to the same regulatory oversight as any fully licensed physician. All physicians should be required to maintain liability insurance, whether or not they are charging for medical care.

Further, if this recommendation is approved by the General Assembly, the limited license type, as it is currently limited to physicians affiliated with Shriners Hospital, should be repealed.

[104] § 12-35-123, C.R.S.
[105] § 12-38-112.5, C.R.S.

Recommendation 12 – Create a new license type for those physicians returning to practice and who require a period of supervised practice to ensure competency.

The Board may deny a license to any candidate who,

> Has not actively practiced medicine or practiced as a physician assistant for the two-year period immediately preceding the filing of such application or otherwise maintained continued competency during such periods, as determined by the Board.[106]

This provision primarily applies to those physicians and physician assistants who retire for a few years and then, for whatever reason, decide to reenter practice. Since they have been out of practice for so long, the General Assembly has dictated that they demonstrate to the Board that they remain competent.

To assist physicians in demonstrating their continued competency, the Board works closely with the Center for Personalized Education for Physicians (CPEP) in Denver. The CPEP process entails a front-end evaluation to asses the physician's level of competency and to identify any areas in need of improvement. CPEP then develops an educational program specific to that physician. Finally, CPEP conducts a back-end evaluation to determine competency.

Depending on the circumstances, CPEP's education program may require a period of supervised practice for the reentering physician. During this period, the physician must be licensed somehow to enable him or her to practice, even under supervision.

To accommodate these situations, the Board enters into a stipulation with the physician whereby the physician agrees to the required limitations. In essence, this is a restricted medical license, and as such, it is considered discipline and must be reported to the National Practitioner Databank (NPDB).

This is unfortunate because the physician has done nothing wrong, seeks to reenter practice, but is still subject to disciplinary action and all of the negative consequences related thereto.

Additionally, this situation very likely dissuades many retired physicians from reentering practice. This is especially true of physicians who may have had long, distinguished careers. Why would they want to taint that record with the stain of discipline?

This is more problematic in the context of the projected physician shortages highlighted elsewhere in this sunset report.

[106] § 12-36-116(1)(d), C.R.S.

Therefore, in order to encourage physicians to reenter practice, and in order to ensure they do so in a safe and competent manner, the General Assembly should create a new license type to facilitate their transition back into practice.

Recommendation 13 – Authorize the Board to adjust the surcharge used to support the peer health assistance program to take into account any increases or decreases in program utilization, and require the Board, in establishing the surcharge, to consider the utilization of the peer assistance program by physician assistants.

Each year since 1999, physicians and physician assistants have been required to pay a $50-surcharge to help fund the peer health assistance program. Additionally, the Board is authorized to increase the surcharge based on the consumer price index (CPI) for the Denver-Boulder statistical area.[107]

In practice, this surcharge is imposed each renewal cycle, such that, between 1999 and 2009, the surcharge was $100 every two years. With the 2009 renewal cycle, the Board, for the first time, increased the surcharge based on the CPI such that the surcharge increased to $122, a 22 percent increase.

Table 23 illustrates the percentage increase in the CPI for the Denver-Boulder-Greeley statistical area for the years indicated.

Table 23
Increases in CPI[108]

Year	Increase in CPI (%)
2000	4.0
2001	4.7
2002	1.9
2003	1.1
2004	0.1
2005	2.1
2006	3.6
2007	2.2
2008	3.9

[107] § 12-36-123.5(3.5)(b), C.R.S.
[108] U.S. Department of Labor, Bureau of Labor Statistics. *Databases*. Retrieved August 5, 2009, from http://data.bls.gov/PDQ/servlet/SurveyOutputServlet

Had the Board opted to exercise its discretion in this matter and increased the surcharge each year, based on the CPI, the surcharges would have amounted to those outlined in Table 24. Note that the CPI for one year is reflected in the surcharge increase for the following year.

Table 24
Potential Surcharge Increases Based on CPI

Year	Potential Annual Surcharge	Potential Renewal Surcharge
2001	**$52.00**	**$104.00**
2002	$54.44	
2003	**$55.49**	**$110.98**
2004	$56.09	
2005	**$56.14**	**$112.28**
2006	$57.32	
2007	**$59.39**	**$118.78**
2008	$60.69	
2009	**$63.06**	**$126.12**

Years depicted in bold type face are renewal years and represent the years in which the surcharge increases would have been passed on to physicians and physician assistants.

Since the Board did not increase the surcharge on an annual basis, as it was permitted to do, the Colorado Physician Health Program (CPHP), the peer health assistance program vendor for which the surcharge provides funding, did not realize the incremental funding increases that could have come along with those surcharge increases. When then Board finally did increase the surcharge, it came close to catching up to what the surcharge would have been had the incremental increases been imposed. The difference between the authorized 2009 surcharge of $126.12 and the actual 2009 surcharge of $122, is only $4.12.

Nevertheless, in 2009, the Board authorized a 22 percent increase in the surcharge. This is a sizeable, one-time increase.

However, the statutorily-authorized increases based on CPI allow the Board to take into account the rise in the cost of services based, more or less, on inflation and the increasing costs of living. Setting aside the fact that the cost of healthcare-related services, such as those offered by the peer health assistance program, are generally recognized to have increased at a higher rate than the CPI, the statutorily-authorized increases do not take into account any increases or decreases in utilization.

According to figures provided by CPHP, overall workload has increased approximately 88 percent over the last 10 years. Table 25 demonstrates these increases by work measure.

Table 25
CPHP Workload Measures

Workload Measure	Average Annual Increase (%)	10-Year Increase (%)
New, Non-Board Referrals	9	89
Board Referrals	17	165
Active Caseloads	7	70
Reports Generated	6	64
Staff Hours	9	88

It is clear that a 22 percent increase in the surcharge is insufficient to accommodate an 88 percent increase in utilization.

CPHP also engages in fundraising activities, but these, too, are insufficient to accommodate the increase in utilization, particularly in depressed economic times when charitable giving declines.

Therefore, it is reasonable to conclude that either the quality of the services offered by CPHP will decrease, or the surcharge must be increased.

Since the services offered by the peer health assistance program, through CPHP, serve to protect the public by ensuring that physicians and physician assistants receive the health assistance they need to continue to practice safely, the General Assembly should authorize the Board to take into account both the CPI and the rate of utilization in determining the surcharge to be imposed.

This raises another issue, however. Since it is not currently based on utilization, the surcharge paid by physicians and physician assistants is the same. If utilization is to be a factor, it is reasonable to explore the validity of this practice.

According to figures provided by CPHP, approximately 7.6 physician assistants for every 100 fully licensed physicians utilized the services of CPHP in fiscal year 07-08. Considering there are approximately 9.7 licensed physician assistants for every 100 licensed physicians, it is clear that the rate of physician utilization is higher than that of physician assistants.

Setting aside the benefits to society as a whole, physicians, as a group, benefit more from the peer health assistance program than do physician assistants, as a group, yet both groups pay the same surcharge.

According to the Colorado Department of Labor and Employment, in 2008, the median annual income for a physician assistant was $79,284,[109] and $155,469[110] for a physician. In short, physicians earn almost double what physician assistants earn, yet both groups pay the same surcharge.

To be sure, society as a whole, benefits from the peer health assistance program's mission of keeping healthy, safe physicians and physician assistants in practice so that they can meet the healthcare needs of all. However, it seems inherently unfair for physician assistants to earn substantially less than physicians, utilize the peer health assistance program substantially less than physicians, yet they pay the same surcharge as physicians. The lower income earners are subsidizing the higher income earners.

Finally, if the General Assembly implements Recommendation 17 of this sunset report regarding physicians with illnesses or physical or mental conditions, it is reasonable to conclude that utilization of the peer assistance health program will increase at a higher rate, thus necessitating the need for even more funds.

For all of these reasons, the General Assembly should authorize the Board to increase the surcharge based on CPI and utilization, as well as utilization by license type.

Recommendation 14 – Clarify the conditions under which a physician licensed in another state may engage in the occasional practice of medicine in Colorado without obtaining a license.

In general, in order to practice medicine in Colorado, an individual must hold a Board-issued license. However, there is an exception to this rule for those physicians who are licensed in another state and who practice in Colorado on an occasional basis only.

Although neither statute nor Board rule defines "occasional," the exemption is generally recognized as applying to those physicians who, for example, volunteer at a summer camp, come to Colorado to teach for a short period, or who come to Colorado for a single rotation in a residency program.

[109] Retrieved on August 7, 2009, from http://lmigateway.coworkforce.com/lmigateway/occprofiledata.asp?session=occdetail_lms&geo=0801000000&emp=
[110] Retrieved on August 7, 2009, from http://lmigateway.coworkforce.com/lmigateway/occprofiledata.asp?session=occdetail_lms&geo=0801000000&emp=

A problem arises, however, with the way in which the exemption is worded. In short, nothing in the Act is to be construed to prohibit, or to require a license or a physician training license with respect to,

> The rendering of services in this state by a physician lawfully practicing medicine in another state or territory, whether or not such physician is in Colorado, but if any such physician does not limit such services to an occasional consultation or case or if such physician has any established or regulatory used hospital connections in this state or if such physician is party to any contract, agreement, or understanding to provide the services described in paragraph (a) of subsection (1) of this section or if such physician maintains or is provided with for his or her regular use any office or other place for the rendering of such services, such physician shall possess a license to practice medicine in this state.[111]

Perhaps it is because this exemption is phrased in the negative, but Board staff reports receiving phone calls on a relatively consistent basis inquiring as to what this provision means.

Therefore, the General Assembly should retain the exemption, but express it in a manner that is more easily understandable.

Recommendation 15 – Create a true licensure by endorsement process.

One way to obtain a medical license in Colorado is through an endorsement-like process. Specifically, the Act directs the Board to issue a license to the holder of a valid, unsuspended and unrevoked license or certificate issued by another state so long as the other state's licensing requirements are not substantially lower than Colorado's, the license is unrestricted, and the other state "grants licenses, without further examination and otherwise on a substantially equal reciprocal basis, to applicants who are licensed in Colorado."[112]

The endorsement process should be streamlined. As a matter of practice, Board staff conducts what is known as "primary source verification" on all license applicants. This requires Board staff to contact, for example, the candidate's medical school and obtain a transcript or other evidence of graduation. This can be a time consuming and laborious process.

For initial licensure, however, it is likely very necessary to ensure that a candidate has accomplished all that he or she claims. But since every licensing board in the U.S. undergoes the same basic process, it is redundant with respect to physicians licensed in another state.

[111] § 12-36-106(3)(b), C.R.S.
[112] § 12-36-107(1)(d), C.R.S.

Streamlining this process should have many benefits, including:

- Conservation of staff resources and time;
- Increasing access to medical services for patients in underserved areas by encouraging physicians to come to Colorado;
- Improving the ability to mobilize physicians during disasters;
- Facilitating the mobility of physicians and multi-state practices; and
- Reducing barriers to telemedicine.

Finally, at least five other states (Idaho, Michigan, Nevada, New Mexico and Rhode Island) have instituted a similar process. Michigan and New Mexico also require such candidates to have been in practice for at least 10 and 3 years, respectively.

Although there is no express statutory language requiring Board staff to conduct primary source verifications, there is concern that without such express language, the Board could be treating license applicants differently, thus raising due process concerns.

Therefore, the General Assembly should specifically authorize the Board to forego primary source verification for those license applicants that hold a valid, unsuspended and unrevoked license in another state.

Recommendation 16 – Require physicians and physician assistants who have been denied licensure, have had their licenses revoked, or who have surrendered their licenses in lieu of disciplinary action, to wait two years to reapply.

Sections 12-36-116 and 12-36-118, C.R.S., authorize the Board to deny or revoke the license of a physician or physician assistant for violating the Act or the rules promulgated thereunder.

Revocation proceedings, and denials when they are appealed, can be lengthy and expensive and are typically undertaken only when the alleged conduct is so egregious that the individual must be barred from practice in order to protect the public.

Similarly, many licensees, when faced with the prospect of revocation proceedings, voluntarily surrender their licenses.

However, the Act makes no provision for an individual who has had a license revoked to wait to apply for a new license. As a result, such an individual could apply for a new license the very day that a revocation order becomes effective. This not only poses a risk to the public, but also requires the Board to incur additional expenses in processing the new application and, if it is denied and appealed, additional legal expenses.

As a result, at least 27 statutes regulating various professions and occupations in Colorado provide for a waiting, or "cooling off" period. These periods range from between one and three years, with most (14 programs) requiring such individuals to wait two years before applying for a new license.

The same concerns apply to physicians and physician assistants who surrender their licenses rather than face revocation proceedings. These individuals should not be allowed to immediately apply for a new license.

Since it is an inefficient use of state resources to revoke a license only to have that same individual immediately apply for a new license, since such a loophole is a risk to the public and since many other regulatory programs impose a waiting period, a physician or physician assistant who has had a license revoked or who surrenders his or her license should be required to wait two years before applying for a new license.

Recommendation 17 – Restate the definition of unprofessional conduct such that failing to properly address the practitioner's own physical or mental condition is unprofessional conduct, and authorize the Board to enter into confidential agreements with practitioners to address their respective conditions.

Physicians and physician assistants are people. Like all people, they can become ill, suffer injuries, and have disabilities.

Some conditions can impact their ability to practice. For example, a physician with advanced Parkinson's disease can probably not perform surgery safely, but may be able to consult with patients in the office.

To determine if a physician or physician assistant has a condition that impacts his or her ability to practice, the application for initial licensure and the license renewal questionnaire ask,[113]

> Within the last five years:
>
> Have you engaged in any behavior or suffered any mental, physical or cognitive health condition that has affected or might affect your ability to practice medicine safely and competently?
>
> Have you been diagnosed with or treated for bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness or sleep disorder that disturbs your cognition, behavior or motor function?

[113] Colorado State Board of Medical Examiners, Application for Initial Licensure, April 2009, p. 4, question 8; Colorado State Board of Medial Examiners, 2009 License Renewal Application, p. 2, questions 8 and 11.

These are valid questions given that the health of a practitioner may impact the ability to practice safely and competently, and the Board's primary mission is to ensure safe, competent practitioners.

However, unprofessional conduct includes having, "such physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient."[114]

If the Board finds that a practitioner has engaged in unprofessional conduct and determines that discipline is appropriate, it must determine the form of discipline, "in determining appropriate disciplinary action, the [Board] shall first consider sanctions that are necessary to protect the public."[115]

In ordering discipline, the Board,[116]

> may also include in any disciplinary order that allows the licensee to continue to practice such conditions as the [Board] may deem appropriate to assure that the licensee is physically, mentally, morally, and otherwise qualified to practice . . . in accordance with generally accepted professional standards of practice, including any or all of the following:
>
> (A) Submission by the respondent to such examinations as the [Board] may order to determine his physical or mental condition or his professional qualifications;
> (B) The taking by him of such therapy or courses of training or education as may be needed to correct deficiencies found in the hearing or by such examinations;
> (C) The review or supervision of his practice as may be necessary to determine the quality of his practice and to correct deficiencies therein; and
> (D) The imposition of restrictions upon the nature of his practice to assure that he does not practice beyond the limits of his capabilities.

Going back to the example of the physician with Parkinson's, the physician is obligated to disclose to the Board that he or she has a condition that impacts his or her ability to practice. The Board has the authority to order an examination of the physician to determine whether and under what conditions the physician may be able to continue to practice, and to order the license of the physician restricted to such conditions.

The problem arises, however, in the fact that in order to impose these restrictions, the Board must "discipline" the physician.

Discipline of this nature is not, in the legal sense, career-ending. As far as the Board is concerned, the physician may continue to practice.

[114] § 12-36-117(1)(o), C.R.S.
[115] § 12-36-118(5)(g)(III), C.R.S.
[116] § 12-36-118(5)(g)(III), C.R.S.

The rest of the world, however, views this situation a bit differently. As discipline, the restricted license is reportable to the federally run NPDB, which serves as a national clearinghouse for disciplinary actions taken against a wide variety of healthcare practitioners.

Discipline can negatively impact a physician's:

- Ability to participate in insurance provider networks;
- Hospital or other clinical privileges; and
- Malpractice insurance premiums.

Additionally, as discipline, the restricted license is reportable under the Michael Skolnik Medical Transparency Act (Skolnik Act) and would be reported as discipline in DORA's online computer system.

In short, then, the physician has done nothing wrong, but because he or she suffers from a disability and discloses the condition to the Board as he or she is obligated to do, he or she is disciplined.

The current system creates every disincentive for the practitioner to do the right thing, and every incentive not to. This is unacceptable from both humanitarian and public protection perspectives.

First, by disciplining a practitioner merely for having a disability or illness, the Act perpetuates the negative stigmas associated with such conditions. Physicians struggle to communicate to their patients that having a particular illness does not make them bad people, yet, at the same time, the Act creates a system whereby a physician, who is a person like any other, who contracts an illness or who is disabled, is treated as if he or she has done something wrong. The system treats ill and disabled physicians as if they are bad people.

Worse, perhaps, is the fact that not only does the Act require discipline in such situations, it defines the underlying conduct as unprofessional. In other words, having a disability is unprofessional.

In no context outside of the Act would having a disability be considered unprofessional conduct. The term "conduct" implies the person has actively done something. However, contracting an illness or having a disability is, in most cases, an inherently passive exercise. Very few people actively seek to become ill or disabled. Therefore, it is not conduct.

Further, having an illness or disability is not unprofessional, outside of the Act. Failing to properly limit one's practice may be unprofessional. Failing to seek treatment so that one can safely and competently continue to practice may be unprofessional. But merely having an illness or disability is not unprofessional.

Therefore, at the very least, the General Assembly should clarify that it is unprofessional conduct to suffer from an illness, or a physical or mental condition, *and failing to act within the limitations created by the illness or condition*.

One way to help ensure that practitioners act within the limitations created by an illness or condition, thus avoiding discipline, is to authorize the Board to enter into confidential agreements with such practitioners whereby the practitioner agrees to limit his or her practice and in failing to do so, agrees that the Board may then publicly discipline his or her license.

Under this proposal, a practitioner could go to CPHP, which has considerable expertise in evaluating the ability of physicians and physician assistants to practice safely. CPHP could report to the Board the limitations appropriate for the practitioner and those limitations would become part of the agreement.

Because many illnesses and physical and mental conditions evolve over time, periodic re-evaluations or monitoring may also be appropriate.

The key is that the physician or physician assistant is allowed to continue to practice with dignity and is not disciplined. Additionally, the Board is satisfying its mandate to protect the public.

The disincentives discussed earlier, therefore, are at least considerably mitigated, if not removed outright.

Importantly, it does not appear as though these types of agreements would be reportable to NPDB because so long as the physician addresses the condition, there would be no violation of the Act. Therefore, discipline is avoided.

Additionally, this process should not be available to those practitioners with substance abuse problems. Practicing with such a condition already constitutes a separate statutory violation, and this Recommendation 17 is not intended to in any way limit the Board's authority to discipline such practitioners.

For such physicians, nothing will change with the adoption of this Recommendation 17. The safe harbor provisions available through CPHP will still be available to those practitioners seeking to avail themselves of it.[117] Just as is the case now, if the Board learns of the conduct, it would still be able to take disciplinary action.

For all these reasons, the General Assembly should clarify that it is unprofessional conduct to fail to practice within the limitations created by an illness or mental or physical condition, and authorize the Board to enter into confidential agreements with such physicians in order to confirm that the physician is addressing the condition.

[117] Under CPHP's safe harbor, a practitioner can voluntarily seek assistance from CPHP, and continue to practice, so long as CPHP determines that the condition does not impact the practitioner's ability to practice safely. Such a practitioner may legitimately answer "no" to the screening questions outlined earlier in this discussion. However, if the Board learns of the condition, by any means, disciplinary action can be taken.

Recommendation 18 – Protect physician and physician assistant communications with the Board.

In general, the Board's investigations of the complaints it receives are confidential and not subject to public scrutiny.

Typically, a consumer files a complaint with the Board and Board staff sends the physician or the physician assistant complained of, a copy of the complaint. The practitioner has 30 days in which to respond.

The practitioner's response typically involves a copy of the complainant's medical file, and any other pertinent records, as well as the practitioner's assessment of the events surrounding the complained of activity. This response, too, is confidential.

Once the practitioner's response is received by Board staff, the case is assigned to one of the Board's inquiry panels (Panel A or B). The inquiry panel then reviews, in closed session, the complaint and the practitioner's response. If the inquiry panel determines that it has enough information, it may either dismiss the case, if there was no violation, or pursue disciplinary action, if there was a violation. In either situation, the complainant is informed of the inquiry panel's decision, but not the reasoning behind that decision.

If the inquiry panel finds that a violation has occurred, it may refer the case to:

- The Division's Office of Expedited Settlement in order to reach a stipulated agreement with the practitioner;
- The Attorney General's Office (AGO) for the filing of charges in the Office of Administrative Courts; or
- In the case of a letter of admonition, issue the letter.

More frequently, however, the inquiry panel finds that it needs more information, so it may:

- Request additional information from the practitioner;
- Refer the case to an expert to determine if the practitioner's conduct fell below the generally accepted standards of practice;
- Refer the case to the Division's Office of Investigations (OI) for further investigation;
- Refer the case to CPHP to obtain an evaluation of the practitioner's fitness to practice; or
- All of the above.

At the conclusion of all of this, the inquiry panel then reviews, in closed session, the complaint, the practitioner's response, and any other materials submitted. If the inquiry panel determines that it has enough information, it may either dismiss the case, if there was no violation, or pursue disciplinary action, if there was a violation. In either situation, the complainant is informed of the inquiry panel's decision, but not the reasoning behind that decision.

If the inquiry panel finds that a violation has occurred, it may refer the case to:

- The Division's Office of Expedited Settlement in order to reach a stipulated agreement with the physician;
- The AGO for the filing of charges in the Office of Administrative Courts; or
- In the case of a letter of admonition, issue the letter.

All of this, confidentiality and review in closed session, is clearly authorized by the Act, which provides,

> Investigations, examinations, hearings, meetings, or any other proceedings of the Board conducted pursuant to the provisions of [the Act] shall be exempt from any law requiring that proceedings of the Board be conducted publicly or that the minutes or records of the Board with respect to action of the Board taken pursuant to the provisions of this section be open to public inspection.[118]

Some, particularly patient advocates, maintain that this process is overly secretive and lacks transparency. Complainants, they argue, should have access, at the very least, to the practitioner's initial response to, among other things:

- Clarify the issue actually complained of;
- Provide additional information that the complainant may have originally thought irrelevant or to which the complainant did not originally have access; or
- Provide the names of additional witnesses to counter the practitioner's response.

While these concerns certainly have merit, a mechanism already exists to address them – OI. The staff of OI is trained in information gathering and is capable of performing this task without violating the confidentiality of the statutorily-mandated process.

Perhaps the Board should take greater advantage of this resource. Based on information provided by OI and Board staff, between fiscal years 03-04 and 07-08, the Board referred just 260 cases (approximately 6.4 percent of complaints) it received to OI.

[118] § 12-36-118(10), C.R.S.

This is not to say that the Board should refer every case. The Board, like all state agencies, must work within certain resource limitations, and if it finds that a case does not require further investigation, it should neither be required to refer a case nor feel compelled to. However, perhaps OI is a resource the Board under utilizes and should take increased advantage of.

This solution, however, presumes the validity of the current process. There are several policy reasons why the confidentiality of Board investigations is important and should be retained.

First, anyone can file a complaint for any reason. Although most complainants truly believe that the practitioner they complain of has done something wrong, not all do. Some complainants file complaints for the sole purpose of harassing a practitioner. When the process is not confidential, complainants can file complaints simply to besmirch the name and reputation of the practitioner. Therefore, the confidentiality of the process serves to protect the reputations of those practitioners against whom frivolous or harassing complaints are filed.

Second, and more importantly, the purpose of the administrative process demands confidentiality. When a consumer files a complaint against a practitioner, the consumer is essentially alerting the state that one of the individuals to whom it has issued a license may have violated the law. Contrary to wide misperception, the consumer has not initiated any kind of claim or lawsuit against the practitioner; such endeavors are the domain of the state's civil courts.

As such, the interests of the state, through the Board in this case, are pursued through the investigatory and disciplinary process. The state's interest is not one of recompense or being made whole. Rather, the state's interest lies in ensuring that the practitioners to whom it has issued licenses are competent and safe to practice.

The best, and perhaps the only, way to ensure this is to encourage the practitioners involved to be forthright and candid with the Board. After all, the Board is comprised of practitioners. Who better than one's peers can a practitioner expect to consider the evidence and render judgment? This is the purpose of professional regulatory boards and professional membership on them.

If, for example, the process was not confidential, and complainants and their lawyers had access to all of the same information as the Board, it is reasonable to conclude that a practitioner would hold back for fear of not only disciplinary action, but also civil action.

This may best be illustrated by way of example. In formulating a confidential response to a complaint, a physician is more likely to explain the symptoms presented and go through his or her thought process, including possible alternatives and possible tests that could have been run, in reaching a diagnosis. Perhaps the diagnosis was incorrect – thus the complaint – but was the thought process? Did the physician act in a competent manner in making the diagnosis and simply get it wrong? This is the state's paramount interest, for if the physician did everything correctly, but got the diagnosis wrong, the physician may not be incompetent and, therefore, should not be subject to discipline because there is low risk of the physician harming other patients. On the other hand, if the physician did everything incorrectly, then perhaps the physician has some competency issues and should be disciplined to avoid harm to future patients.

On the other hand, in formulating a non-confidential response, a response that the physician has every reason to believe will be obtained by the complainant's attorneys, it is reasonable to conclude that the physician will be less forthcoming. Rather than explaining all of the patient's presenting symptoms, the physician may present only those that support the physician's diagnosis.

Granted, this is a possibility even in a confidential system, but it is less likely. As a result, fewer state resources need to be expended to determine the truth, and thus the competency of the physician.

This is not a purely hypothetical situation. In July 2009, the Colorado Supreme Court rendered an opinion in *DeSantis v. Simon*.[119] In *DeSantis*, plaintiff's counsel sought to subpoena the physician's response to the complaint before the Board. Rather than subpoena the Board, which the Act clearly authorizes the Board to refuse, plaintiff's counsel subpoenaed the physician. The trial judge upheld the subpoena and admitted the physician's response into evidence without first conducting an in camera inspection to determine its admissibility.

The Colorado Supreme Court ultimately remanded the case back to the trial court with an order for the trial judge to review the physician's response in camera. In doing so, however, the Court essentially approved of the plaintiff's strategy by finding, "the . . . Act does not directly govern civil discovery requests for the doctor's records."[120]

[119] *DeSantis v. Simon*, 209 P.3d 1069 (Colo. 2009).
[120] *DeSantis* at 1072.

The Board filed an *amicus* brief in *DeSantis*, which outlined policy reasons, as opposed to the legal reasons within the jurisdiction of the Court, to support the confidentiality of the documents exchanged between the Board and the physician. In particular, the Supreme Court mentioned:[121]

- Under section 12-36-117(1)(gg), C.R.S., physicians are required to respond to complaints in a timely, honest and materially responsive manner;
- The discoverability of the physician self-assessments that occur in responses to the Board would stifle the frank self-analysis that the Board employs to obtain prompt curative conduct by physicians; and
- The free flow of information between the Board and physicians protects the public from the unqualified or improper practice of medicine.

Finally, the Court found,

> [T]he types of records associated with [Board] investigations (e.g., medical records, internal agency communications and self-assessments) are precisely the types of records traditionally afforded non-disclosure protections. Such communications originate with the expectation they will not be disclosed to third parties.[122]

However, there is no clear privilege for such communications and, "generally, privileges are creatures of statute and therefore must be strictly construed."[123]

Although there is no statutorily created privilege for communications between the Board and a respondent, such privilege, ironically, exists between a physician and a professional peer review committee:

> The records of a professional review committee . . . shall not be subject to subpoena or discovery and shall not be admissible in any civil suit brought against a physician who is the subject of such records.[124]

The Act goes on to define "records," in the context of professional review committees, as meaning,

> any and all written or verbal communications by any person, any member of an investigative body, or any professional review committee or governing board, or the staff thereof, arising from any activities of a professional review committee authorized by this article, including the complaint, response, correspondence, decisions, exhibits, and other similar items or documents typically constituting the records of administrative proceedings.[125]

[121] *DeSantis* at 1075.
[122] *DeSantis* at 1075.
[123] *DeSantis* at 1073, citing *People v. Turner*, 109 P.3d 639, 644 (Colo. 2005).
[124] § 12-36.5-104(10)(a), C.R.S.
[125] § 12-36.5-102(4), C.R.S.

In the words of the *DeSantis* court, these are precisely the types of documents submitted during Board investigations.

This is ironic because professional review committees are extensions of the Board.[126] In the final analysis, then, records are protected from discovery when submitted to a professional review committee (a creature of statute, but nevertheless, a non-state entity), but those very same records are not similarly protected when submitted to the Board (a state entity).

For all of these reasons, it is reasonable to conclude that the current confidential process is valid and should be protected. Devising a way to protect it, however, is complicated.

One option would be to declare all information exchanged between the Board and a respondent to be privileged. This is overly broad, however, and would permit respondents to essentially hide potentially pertinent information from plaintiffs by simply submitting it to the Board.

Another option would be to declare the Board to be a professional review committee so that the current statutory protections would apply to the Board. While both organizations act similarly, the Board is far more than a professional review committee.

However, the protections afforded to professional review committees address perfectly the concerns raised in this sunset report. Additionally, they represent a current system of privileges, so nothing new would be created in extending those same protections to communications with the Board.

This would continue to encourage physicians to respond to complaints in an honest and forthright manner. Similarly, it would afford greater comfort to the experts utilized by the Board during the course of its investigations because the reports of experts, too, would be protected, thereby maintaining the integrity of the process.

For all of these reasons, the General Assembly should extend to the Board the same protections it has already deemed appropriate for professional review committees.

Recommendation 19 – Require licensees to report within 30 days any adverse action taken against the licensee.

In section 12-36-117(1)(y), C.R.S., licensees are required to report to the Board any adverse action taken by another licensing agency in another jurisdiction, by a peer review body, a healthcare institution, professional association, government agency, law enforcement agency, or any court for acts or conduct that would constitute grounds for discipline. However, the Act is silent as to the timing of this report to the Board.

[126] § 12-36.5-103(3)(a), C.R.S.

Requiring licensees to report to the Board within 30 days any adverse action against the licensee, including criminal charges or convictions, would alleviate this issue. The Board would be able to consider the facts behind the adverse action and determine if the licensee violated the Act. A 30-day reporting requirement would help protect public health and safety by allowing the Board to act sooner to suspend or revoke a license when a licensee is unsafe to practice.

Licensees should be required to report to the Board within 30 days any adverse actions against a licensee, including criminal charges or convictions.

Recommendation 20 – Expand the Board's authority to impose fines by eliminating the requirement that fines can only be imposed in lieu of suspension.

Section 12-36-118(5)(g)(III), C.R.S., outlines the various disciplinary tools available to the Board. Included in this list of tools is the authority to impose a fine of up to $10,000, "in lieu of a suspension." This same statutory section goes on to provide, "In determining appropriate disciplinary action, the [Board] shall first consider sanctions that are necessary to protect the public."

The "in lieu of a suspension" language is problematic for a number of reasons. First and foremost, it appears to run contrary to the Board's guiding mission of protecting the public. This language essentially provides that, if a physician or physician assistant has engaged in conduct that is so egregious that suspension is warranted in order to protect the public, rather than imposing a suspension and removing that physician or physician assistant from practice, the Board may instead impose a fine.

Granted, a $10,000-fine is substantial, but it does little to ensure public protection. Additionally, it creates the perception that a physician can buy his or her way out of a suspension.

Further, the "in lieu of a suspension" language unnecessarily hinders the Board's ability to impose discipline because even if a fine is appropriate in a particular situation, the Board must first find that a suspension is warranted, and then determine to impose the fine instead.

Fining authority is relatively common, if controversial, in professional and occupational regulation. Although boards and regulatory authorities are typically entrusted to act within the bounds of reason, their statutory authority to impose a fine is usually limited by a maximum dollar amount for any violation of the act and rules at issue. In practice, fines are most commonly imposed for more mundane administrative violations, as opposed to serious, practice- or competence-related issues, as would be reasonable to expect when suspension is a possible sanction.

In this case, the Board may impose a fine when, for example, a physician amputates the incorrect toe, but not when the physician fails to inform the Board of a new mailing address.

In order to ensure public protection, the "in lieu of a suspension" provision should be repealed, but the fining authority should be preserved. As the fining authority is for mundane administrative purposes, $10,000 is an excessive amount. A maximum fine of $5,000 would be more reasonable.

Therefore, the General Assembly should repeal the "in lieu of a suspension" language and lower the maximum amount to $5,000.

Recommendation 21 – Restate the grounds for discipline regarding alcohol and drug abuse.

Included in the Act's definition of unprofessional conduct is, "habitual intemperance or excessive use of any habit-forming drug or any controlled substance as defined in section 12-22-303(7)."[127]

Although the Colorado Court of Appeals has ruled that the term "intemperance" is not unconstitutionally vague,[128] it remains a vague term for the average lay person.

A more easily understandable standard, and, indeed, more typical of practice acts, would be habitual or excessive use or abuse of alcohol or controlled substances.

Therefore, in order to make the Act more understandable to those who are expected to comply with it, the General Assembly should revise the definition of unprofessional conduct to include the habitual or excessive use or abuse of alcohol or controlled substances.

Recommendation 22 – Increase the minimum level of professional liability insurance to $1 million per incident and $3 million annual aggregate per year.

Professional liability insurance is vital to protecting Colorado consumers. In many instances, it is the only avenue by which an injured consumer can seek redress in an attempt to be made whole.

Establishing the appropriate minimums for coverage, then, is equally important. Minimums that are too low will fail to accomplish the desired goal. Minimums that are too high may result in excessive premiums, forcing physicians to leave practice, leave Colorado or run the risk of practicing without insurance.

[127] § 12-36-117(1)(i), C.R.S.
[128] *Colo. State Bd. of Med. Exam'rs v Hoffner*, 832 P.2d 1062, 1065 (Colo. App. 1992).

Section 13-64-301(1), C.R.S., requires each physician to maintain professional liability insurance of at least $500,000 per incident and $1.5 million annual aggregate per year.

However, according to one source, in 1991, the average malpractice payment was $284,896, but that number climbed to $461,524 in 2005.[129] According to another source, the median in 2001 for medical malpractice claims paid by non-surgeon physicians was $511,000 and $575,000 for surgeons.[130]

Regardless of which set of numbers one chooses to rely upon, both confirm the fact that Colorado's minimums for physicians in medical practices are woefully inadequate. Similarly, the minimums for individual physicians are either just above the national average as of a few years ago, or have already been surpassed by them.

According to representatives of COPIC, Colorado's largest supplier of professional liability insurance for physicians, the vast majority of physicians already maintain coverage of at least $1 million per incidence and $3 million annual aggregate per year. In fact, COPIC writes only 24 policies at the statutory minimum, and, depending on a variety of factors (i.e., specialty and claims history) a modest premium increase of between 13 and 19 percent is expected for these individuals. As a result, the proposed mandate should have minimal impact on practitioners.

Additionally, since 1987, medical costs in general have increased by 113 percent, but the amount spent on professional liability premiums has increased just 52 percent.[131]

For these reasons, the General Assembly should require physicians to carry at least $1 million per incident and $3 million annual aggregate per year in professional liability insurance.

Recommendation 23 – Restate the definition of the practice of medicine such that compensation for services is irrelevant.

Section 12-36-106(1)(b), C.R.S., includes in the definition of the practice of medicine:

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

[129] Consumer Injury Lawyers. *Medical Malpractice Verdicts*. Retrieved August 3, 2009, from www.consumerinjurylawyers.com/catastrophic-medical-malpractice/jury-verdicts.html
[130] Thomas H. Cohen, "Medical Malpractice Verdicts and Trials in Large Countries, 2001," MedicalMalpractice.com (April 2004). Retrieved August 3, 2009, from www.medicalmalpractice.com/medical-malpractice-verdicts.cfm
[131] Resource4MedicalMalpractice. *Medical Malpractice Facts.* Retrieved from www.resource4medicalmalpractice.com/topics/medicalmalpracticefacts.html

Should a physician who provides care to the indigent at no cost be held to a lower standard than one who provides care for a fee? The consequences of defining the practice of medicine only for compensation could be devastating. Regulation of the practice of medicine has been widely recognized, in all jurisdictions, to be of high importance to the health, safety and welfare of the public. The harm that can be done to a patient who is treated by an incompetent or unqualified person is substantial, including death. By defining the practice of medicine as requiring for compensation means that care for the indigent could be held to a lower standard than that provided to those who are able to pay. In some cases, the Board may be unable to discipline a physician who has lost his or her license but is still treating patients, albeit at no cost.

If a person is providing medical care for no compensation, the care should still be considered the practice of medicine. This is not to imply that any person performing a Good Samaritan act in the case of an emergency would require a license to practice medicine. The Act already contemplates this in section 12-36-106(3)(a), C.R.S., where it states, "Nothing in this section shall be construed to prohibit, or to require a license or a physician training license under this article with respect to… The gratuitous rendering of services in cases of emergency…."

Therefore, the General Assembly should repeal, "…with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever," from section 12-36-106(1)(b), C.R.S.

Recommendation 24 – Require physicians and physician assistants to make arrangements for the safekeeping of the medical records in their custody in the event they are not able to do so themselves.

The patient medical files maintained by physicians and physician assistants contain vast amounts of highly sensitive information. In addition to containing the intimate health history of the particular patient, a medical file often contains all of the information necessary to steal the patient's identity. Thus, the costs associated with lost or irretrievable medical files are high, and potentially deadly.

Unfortunately, the improper disposal of medical files is a growing concern among both the physician and patient communities. It is no longer unusual to hear of someone finding a dumpster full of medical files, or of physicians closing their offices and leaving their medical files behind. Non-medical property owners suddenly find themselves in possession of this sensitive information with no idea of what to do with it.

As recently as the summer of 2009, at least two physicians – one in Colorado Springs and one in Englewood -- closed their offices, leaving their patients without access to their medical records for an extended period of time.[132] For patients with critical conditions that require constant monitoring, this created a potentially deadly situation.

[132] David Nancarrow, "Doctor Closes Shop: Some Patients Missing Medical Records," 11News. Retrieved on July 10, 2009, from www.kktv.com/home/headlines/50182232.html. Dave Young, "Englewood doctor who abruptly closed office explains why." Retrieved on August 20, 2009, from www.kdvr.com/news/kdvr-englewood-doctor-081909,0,7277867.story

Medical files can also become inaccessible through no fault of the physician or physician assistant. Unfortunately, physicians and physician assistants can die, leaving their families with patient medical files. Like the non-medical property owners referenced earlier, these family members often do not know what to do with the files.

Similarly, physicians and physician assistants retire. If they cannot find someone to purchase, or otherwise take over their practices, they may have to store patient medical files in their basements or garages.

Thus, the issue of medical file security is genuine and of great concern to physicians, physician assistants and patients. Unfortunately, there are no easy solutions.

Proposed solutions include:

- Authorizing the Board or some other agency of state government to receive these medical files and ensure their safekeeping. Obviously, this would be very expensive and difficult to implement. Additionally, patients may still have a difficult time accessing their medical records if those records are merely warehoused in some state-run facility.

- Requiring hospitals to receive these medical files and ensure their safekeeping. Historically, this was the practice. However, physically storing medical files can be expensive, and as the nation's healthcare system has come under increasing financial pressure, very few hospitals are willing to assume these added costs today.

- Permitting physicians and physician assistants to destroy medical records after a period of time. While this would help the retired practitioner, or the deceased practitioner's family, it would do little to address the abandonment or improper disposal of medical records.

- Requiring practitioners to make their own arrangements for the safekeeping of medical records in the event they are not able to do so themselves. This would allow practitioners the flexibility to find a solution that works best for them as individuals and would cost the state and hospitals nothing. Practitioners could form buddy systems in which two or more practitioners agree to safeguard each others' medical records. Alternatively, commercial enterprises may exist or come into existence whereby a practitioner could contract with an entity to safeguard the medical records.

This last proposal seems to have the greatest merit. It is flexible and carries no or little cost, yet seeks to achieve the end goal of ensuring the security and accessibility of patient records.

It would also give the Board clear authority to discipline a practitioner who abandons medical records, whereas currently, the Board possesses no such clear authority.

To ensure compliance with this new requirement, physicians and physician assistants should be required to attest to the Board, upon initial licensure and at renewal times, that they have made such arrangements.

Finally, making these kinds of arrangements to safeguard files will mean little if patients do not know how to access the files. Therefore, practitioners should be required to inform patients, in writing, how to access their files in such an eventuality.

For all these reasons, the General Assembly should require physicians and physician assistants to make arrangements for the safekeeping of their medical records, give the Board clear authority to discipline any practitioner who fails to do so, require practitioners to attest that they have made such arrangements, and require practitioners to inform patients, in writing, of the arrangements.

Recommendation 25 – Amend the physician assistant to physician ratio to allow physicians to supervise up to three physician assistants.

In Colorado, a physician may delegate the authority to practice medicine, including the prescription of medication, to a physician assistant. Physician assistants do not have their own scope of practice; they are authorized to practice medicine only under the personal and direct responsibility and supervision of a licensed physician. A physician may not supervise more than two physician assistants without Board approval. The Board does grant waivers to physicians who request approval to supervise more than two physician assistants.

Allowing a physician to supervise more physician assistants without Board approval could help improve access to healthcare by increasing the ratio of midlevel providers to physicians in Colorado. The 208 Commission recommended that Colorado explore ways to minimize barriers to midlevel providers, especially in the rural areas where there is a shortage of physicians. Increasing the ratio of physician assistants could be one way to achieve this goal.

Increasing the number of physician assistants would not negatively impact public health or safety. Over the past five fiscal years, the Board received a relatively small number of complaints against physician assistants. The Board did not take many disciplinary actions against physician assistant licenses. In comparison to physicians, physician assistants receive a smaller percentage of complaints than physicians.

Other states have recognized the value of increasing the physician assistant ratio. While a quarter of the U.S. states limit the physician assistant ratio to two, half of the states allow physicians to supervise more than two physician assistants. Connecticut allows six physician assistants per physician, and five states have no restrictions on the number of physician assistants per physician.

Increasing the physician assistant ratio to three would help increase access to healthcare and should not negatively impact the interests of the public. Section 12-36-106(5)(b)(1), C.R.S., should be amended to allow physicians to supervise three physician assistants.

Recommendation 26 – Create a separate statutory section for the licensing requirements of each type of license issued by the Board.

The licensing requirements for all types of physicians are contained in section 12-6-107, C.R.S., and physician assistants are contained in section 12-36-106, C.R.S., which also defines the practice of medicine.

Any person seeking licensure as, for example, a physician assistant, may seek out the statutory requirements, but would have a difficult time finding them as they are buried in the section that defines the practice of medicine.

Creating a new statutory section for each license type would improve the Act by making it more logical and easier to for the public to use.

Recommendation 27 – Limit to 10 years the time period for which physicians must report their licensing histories under the Skolnik Act.

Among the items a physician must disclose under the Skolnik Act is,

> . . . information pertaining to any license to practice medicine held by the applicant at any time, including the license number, type, status, original issue date, last renewal date, and expiration date; . . .[133]

Importantly, the duty to report disciplinary actions taken by any licensing board is articulated in a separate statutory provision.

At issue here is the requirement to report license numbers, as well as issuance, renewal and expiration dates. Although this sounds like a reasonable requirement, for a physician who has, for example, been in practice for 30 or 40 years and has held licenses in multiple states, this can prove to be highly problematic.

Unless the physician retained all of those records, it is highly unlikely that he or she could retrieve the required information with respect to a 30-year old license.

[133] § 12-36-111.5(3)(a), C.R.S.

Therefore, the General Assembly should limit the reporting period to the preceding 10 years. Again, this does nothing to alter the fact that the physician must still disclose any disciplinary actions, regardless of date.

Administrative Recommendation 1 – When sending license renewal notices, remind physicians to update their Skolnik Act-mandated physician profiles.

Under the Skolnik Act, physicians are required to create and then maintain their respective profiles. After creation, this essentially requires the physician to ensure that all of the necessary disclosures are current and up to date. The penalty for failing do so is a fine of $5,000.[134]

Given the scope of the required disclosures, it is not unreasonable to expect physicians to forget to make some of them. Although it may be difficult to forget to report a malpractice judgment or settlement, it may be easier to forget to report changes in business ownership interests or allowing staff privileges at a particular hospital to lapse. All of these are required disclosures under the Skolnik Act.

True, the Skolnik Act creates an affirmative obligation on the part of the physician to maintain the profile, but the Act, in general, also creates an affirmative obligation on the part of the physician to renew his or her license every two years. The Board sends renewal notices, or reminders, to physicians each renewal cycle, but it does not currently have a similar system in place to remind physicians to update their profiles.

Since the Board already sends license renewal notices, those notices should include a reminder to keep profiles current.

Administrative Recommendation 2 – Seek to amend the sunset review bill to include any technical changes necessary.

During the course of the sunset review, the Board, its staff and researchers found several places in the statutes administered by the Board that need to be updated and clarified to reflect current practices, conventions, and technology. Issues such as the statutes being made gender neutral; changing references to “physicians” or “physician assistants” to “licensees;” among several other technical issues, all should be addressed.

Recommendations of this nature do not rise to the level of protecting the health, safety, and welfare of the public, but an unambiguous law makes for more efficient implementation. All of the statutes pertaining to physicians and physician assistants are commonly only examined by the General Assembly during a sunset review. Therefore, the Board and staff should review these statutes and prepare an omnibus amendment, which will rectify all identified technical problems, to the sunset review bill.

[134] § 12-36-111.5(7), C.R.S.

Appendix A – Medical Skills and Acts Allowed by Emergency Medical Technicians

The following table is based on Board Rule 500, Appendices A through D.

APPENDICES [Eff. 04/30/2009]

These Appendices define the maximum skills, acts or medications that may be delegated to an EMT-Basic, EMT-Basic with IV Authorization, EMT-Intermediate, EMT-Paramedic under appropriate supervision by a medical director.

Y = YES May be performed or administered by emergency medical technicians with physician supervision as described in these rules.

Y* = Medications with an asterisk (*) shall be administered only under direct verbal order by a physician.

There are a few special circumstances when the EMT-Intermediate is unable, despite adequate attempts, to make contact with a physician to obtain a direct verbal order. In those cases the EMT-Intermediate is allowed to administer the following medications under standing order:

1) Cardiac arrest medications (amioderone, atropine, epinephrine, lidocaine, vasopressin) may be administered under standing order in the case of cardiac arrest.

2) Behavioral management medications (haloperidol, diazepam, and midazolam) may be administered under standing order when the safety of the patient or the EMT is at risk.

3) In such special circumstances when, a direct verbal order has not been obtained, the medical director should be notified.

N = NO May not be performed or administered by emergency medical technicians except with a BME-approved waiver as described in Section 7.4 of these rules.

B = Medical acts, skills or medications that may be performed or administered by an EMT-Basic with appropriate medical director supervision and training recognized by the department.

B-IV = Medical acts, skills or medications that may be performed or administered by an EMT-Basic with IV Authorization with appropriate medical director supervision and training recognized by the department.

I = Medical acts, skills or medications that may be performed or administered by an EMT-Intermediate with appropriate medical director supervision and training recognized by the department.

P = Medical acts, skills or medications that may be performed or administered by an EMT-Paramedic with appropriate medical director supervision and training recognized by the department.

APPENDIX A

PREHOSPITAL MEDICAL SKILLS AND ACTS ALLOWED

Additions to these medical skills and acts allowed cannot be delegated unless a waiver has been granted as described in Sections 7.4 – 7.8 of these rules.

AIRWAY/VENTILATION/OXYGEN ADMINISTRATION.				
Skill	**B**	**B-IV**	**I**	**P**
Airway – Esophageal-Single Lumen	N	N	N	N
Airway – Laryngeal Mask	Y	Y	Y	Y
Airway – Esophageal/Tracheal – Multi Lumen	Y	Y	Y	Y
Airway – Nasal	Y	Y	Y	Y
Airway – Oral	Y	Y	Y	Y
Bag – Valve – Mask (BVM)	Y	Y	Y	Y
Carbon Monoxide Monitoring	Y	Y	Y	Y
Chest Decompression – Needle	N	N	Y	Y
Chest Tube Insertion	N	N	N	N
CPAP/BiPAP/PEEP	N	N	Y	Y
Cricoid Pressure - Sellick's Maneuver	Y	Y	Y	Y
Cricothyroidotomy – Needle	N	N	N	Y
Cricothyroidotomy – Surgical	N	N	N	N
Demand Valve – Oxygen Powered	Y	Y	Y	Y
End Tidal CO_2 Monitoring/Capnometry/ Capnography	Y	Y	Y	Y
Flow Restrictive Oxygen Powered Ventilatory Device	Y	Y	Y	Y
Gastric Decompression – NG/OG Tube Insertion	N	N	N	Y
Inspiratory Impedence Threshold Device	Y	Y	Y	Y
Intubation – Digital	N	N	N	Y
Intubation – Bougie Style Introducer	N	N	Y	Y
Intubation – Lighted Stylet	N	N	Y	Y
Intubation – Medication Assisted (non-paralytic)	N	N	N	N
Intubation – Medication Assisted (paralytics) (RSI)	N	N	N	N
Intubation – Maintenance with paralytics	N	N	N	N
Intubation – Nasotracheal	N	N	N	Y
Intubation – Orotracheal	N	N	Y	Y
Intubation – Retrograde	N	N	N	N
Extubation	N	N	Y	Y
Obstruction – Direct Laryngoscopy	N	N	Y	Y
Oxygen Therapy - Humidifiers	Y	Y	Y	Y
Oxygen Therapy – Nasal Cannula	Y	Y	Y	Y
Oxygen Therapy – Non-rebreather Mask	Y	Y	Y	Y
Oxygen Therapy – Simple Face Mask	Y	Y	Y	Y
Oxygen Therapy – Venturi Mask	N	N	Y	Y

Pulse Oximetry	Y	Y	Y	Y
Suctioning – Tracheobronchial	N	N	Y	Y
Suctioning – Upper Airway	Y	Y	Y	Y
Tracheostomy Maintenance - Airway management only	Y	Y	Y	Y
Tracheostomy Maintenance – Includes replacement	N	N	Y	Y
Ventilators – Automated Transport (ATV)	N	N	N	Y
CARDIOVASCULAR/CIRCULATORY SUPPORT				
Skill	**B**	**B-IV**	**I**	**P**
Cardiac Monitoring – Application of electrodes and data transmission	Y	Y	Y	Y
Cardiac Monitoring – Rhythm and diagnostic EKG interpretation	N	N	Y	Y
Cardiopulmonary Resuscitation (CPR)	Y	Y	Y	Y
Cardioversion – Electrical	N	N	N	Y
Carotid Massage	N	N	N	Y
Defibrillation – Automated/Semi-Automated (AED)	Y	Y	Y	Y
Defibrillation – Manual	N	N	Y	Y
External Pelvic Compression	Y	Y	Y	Y
Hemorrhage Control – Direct Pressure	Y	Y	Y	Y
Hemorrhage Control – Pressure Point	Y	Y	Y	Y
Hemorrhage Control – Tourniquet	Y	Y	Y	Y
MAST/Pneumatic Anti-Shock Garment	Y	Y	Y	Y
Mechanical CPR Device	Y	Y	Y	Y
Transcutaneous Pacing	N	N	Y	Y
Transvenous Pacing – Maintenance	N	N	N	N
Implantable Cardioverter/Defibrillator Magnet Use	N	N	N	N
Therapeutic Induced Hypothermia (TIH) [1]	N	N	Y*	Y
Arterial Blood Pressure Indwelling Catheter – Maintenance	N	N	N	N
Invasive Intracardiac Catheters – Maintenance	N	N	N	N
Central Venous Catheter Insertion	N	N	N	N
Central Venous Catheter Maintenance/Patency/Use	N	N	Y	Y
Percutaneous Pericardiocentesis	N	N	N	N
IMMOBILIZATION.				
Skill	**B**	**B-IV**	**I**	**P**
Spinal Immobilization – Cervical Collar	Y	Y	Y	Y
Spinal Immobilization – Long Board	Y	Y	Y	Y
Spinal Immobilization – Manual Stabilization	Y	Y	Y	Y
Spinal Immobilization – Seated Patient, etc.	Y	Y	Y	Y
Splinting – Manual	Y	Y	Y	Y
Splinting – Rigid	Y	Y	Y	Y
Splinting – Soft	Y	Y	Y	Y
Splinting – Traction	Y	Y	Y	Y
Splinting – Vacuum	Y	Y	Y	Y
INTRAVENOUS CANNULATION/FLUID ADMINISTRATION/FLUID MAINTENANCE.				

Blood/Blood By-Products Initiation (out of facility initiation)	N	N	N	N
Colloids - (Albumin, Dextran) – Initiation	N	N	N	N
Crystalloids (D_5 W, LR, NS) – Initiation/Maintenance	N	Y	Y	Y
Intraosseous – Initiation	N	N	Y	Y
Medicated IV Fluids Maintenance – As Authorized in Appendix B	N	N	Y	Y
Peripheral – Excluding External Jugular - Initiation	N	Y	Y	Y
Peripheral – Including External Jugular – Initiation	N	N	Y	Y
Use of Peripheral Indwelling Catheter for IV medications (Does not include PICC)	N	Y	Y	Y
MEDICATION ADMINISTRATION - ROUTES.				
Skill	**B**	**B-IV**	**I**	**P**
Aerosolized/Nebulized/Atomized	Y	Y	Y	Y
Buccal	Y	Y	Y	Y
Endotracheal Tube (ET)	N	N	Y	Y
Extra-abdominal umbilical vein	N	N	Y	Y
Intradermal	N	N	Y	Y
Intramuscular (IM)	Y	Y	Y	Y
Intranasal (IN)	N	Y	Y	Y
Intraosseous	N	N	Y	Y
Intravenous (IV) Piggyback	N	N	Y	Y
Intravenous (IV) Push	N	Y	Y	Y
Nasogastric	N	N	N	Y
Ophthalmic	N	N	Y	Y
Oral	Y	Y	Y	Y
Rectal	N	N	Y	Y
Subcutaneous	Y	Y	Y	Y
Sublingual	Y	Y	Y	Y
Topical	N	N	Y	Y
Use of Mechanical Infusion Pumps	N	N	Y	Y
MISCELLANEOUS.				
Skill	**B**	**B-IV**	**I**	**P**
Aortic Balloon Pump Monitoring	N	N	N	N
Assisted Delivery	Y	Y	Y	Y
Blood Glucose Monitoring	Y	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y
Esophageal Temperature Probe for TIH	N	N	Y*	Y
Eye Irrigation Noninvasive	Y	Y	Y	Y
Eye Irrigation Morgan Lens	N	N	Y	Y
Maintenance of Intracranial Monitoring Lines	N	N	N	N
Physical examination	Y	Y	Y	Y
Restraints - Verbal	Y	Y	Y	Y
Restraints - Physical	Y	Y	Y	Y
Restraints - Chemical	N	N	Y	Y

Urinary Catheterization – Maintenance	Y	Y	Y	Y

1 Therapeutic Induced Hypothermia (TIH) -

1. Approved methods of cooling include:
   a. Surface cooling methods including ice packs, evaporative cooling and surface cooling blankets or surface heat-exchange devices.
   b. Internal cooling with the intravenous administration of cold crystalloids (4°C / 39°F)
2. Esophageal temperature probe allowed for monitoring core temperatures in patients undergoing TIH.
3. The medical director should work with the hospital systems to which their agencies transport in setting up a "systems" approach to the institution of TIH. Medical directors should not institute TIH without having receiving facilities that also have TIH programs to which to transport these patients.

APPENDIX B

PREHOSPITAL FORMULARY OF MEDICATIONS ALLOWED TO BE ADMINISTERED

Additions to this medication formulary cannot be delegated unless a waiver has been granted as described in Sections 7.4 – 7.8 of these rules.

GENERAL				
Medications	**B**	**B-IV**	**I**	**P**
Over-the-counter-medications	Y	Y	Y	Y
Oxygen	Y	Y	Y	Y
ANTIDOTES.				
Medications	**B**	**B-IV**	**I**	**P**
Atropine	N	N	Y*	Y
Calcium salt - Calcium chloride	N	N	N	Y
Calcium salt - Calcium gluconate	N	N	N	Y
Cyanide antidote	N	N	Y	Y
Glucagon	N	N	Y*	Y
Naloxone	N	Y	Y	Y
Nerve agent antidote	Y	Y	Y	Y
Pralidoxime	N	N	N	Y
Sodium bicarbonate	N	N	N	Y
BEHAVIORAL MANAGEMENT.				
Medications	**B**	**B-IV**	**I**	**P**
Anti-Psychoic - Droperidol	N	N	N	N
Anti-Psychotic - Haloperidol	N	N	Y*	Y
Anti-Psychotic - Olanzapine	N	N	N	Y
Anti-Psychotic - Zisprasidone	N	N	N	Y
Benzodiazepine - Diazepam	N	N	Y*	Y
Benzodiazepine - Lorazepam	N	N	N	Y
Benzodiazepine - Midazolam	N	N	Y*	Y
Diphenhydramine	N	N	Y*	Y
CARDIOVASCULAR.				
Medications	**B**	**B-IV**	**I**	**P**
Adenosine	N	N	Y*	Y

Amiodarone - bolus infusion only	N	N	Y*	Y
Aspirin	Y	Y	Y	Y
Atropine	N	N	Y*	Y
Calcium salt - Calcium chloride	N	N	N	Y
Calcium salt - Calcium gluconate	N	N	N	Y
Diltiazem - bolus infusion only	N	N	N	Y
Dopamine	N	N	N	Y
Epinephrine	N	N	Y*	Y
Lidocaine - bolus and continuous infusion	N	N	Y*	Y
Magnesium sulfate - bolus infusion only	N	N	N	Y
Morphine sulfate	N	N	Y*	Y
Nitroglycerin – sublingual (patient assisted)	Y*	Y*	Y	Y
Nitroglycerin – sublingual (tablet or spray)	N	N	Y	Y
Nitroglycerin – topical paste	N	N	Y*	Y
Sodium bicarbonate	N	N	Y*	Y
Vasopressin	N	N	Y*	Y
Verapamil - bolus infusion only	N	N	N	Y
DIURETICS.				
Medications	**B**	**B-IV**	**I**	**P**
Butanemide	N	N	N	Y
Furosemide	N	N	Y*	Y
Mannitol (trauma use only)	N	N	N	Y
ENDOCRINE AND METABOLISM.				
Medications	**B**	**B-IV**	**I**	**P**
IV Dextrose	N	Y	Y	Y
Glucagon	N	N	Y	Y
Oral glucose	Y	Y	Y	Y
Thiamine	N	N	N	Y
GASTROINTESTINAL MEDICATIONS.				
Medications	**B**	**B-IV**	**I**	**P**
Anti-nausea - Droperidol	N	N	N	N
Anti-nausea - Metoclopramide	N	N	Y*	Y
Anti-nausea - Ondansetron	N	N	Y*	Y
Anti-nausea - Prochlorperazine	N	N	N	Y
Anti-nausea - Promethazine	N	N	Y*	Y
Decontaminant - Activated charcoal	Y	Y	Y	Y
Decontaminant – Sorbitol	Y	Y	Y	Y
PAIN MANAGEMENT.				
Medications	**B**	**B-IV**	**I**	**P**
Anesthetic – Lidocaine (for intraosseous needle insertion)	N	N	Y	Y
Benzodiazepine - Diazepam	N	N	Y*	Y
Benzodiazepine - Lorazepam	N	N	Y*	Y

Benzodiazepine - Midazolam	N	N	N	Y
General - Nitrous oxide	N	N	Y*	Y
Narcotic Analgesic - Fentanyl	N	N	Y*	Y
Narcotic Analgesic - Hydromorphone	N	N	N	Y
Narcotic Analgesic - Morphine sulfate	N	N	Y*	Y
Ophthalmic anesthetic – Opthaine	N	N	Y	Y
Ophthalmic anesthetic –Tetracaine	N	N	Y	Y
Topical Anesthetic - Benzocaine spray	N	N	N	Y
Topical Anesthetic - Lidocaine jelly	N	N	N	Y
RESPIRATORY AND ALLERGIC REACTION MEDICATIONS.				
Medications	**B**	**B-IV**	**I**	**P**
Antihistamine - Diphenhydramine	N	N	Y*	Y
Bronchodilator – Anticholinergic – Atropine (aerosol/nebulized)	N	N	Y*	Y
Bronchodilator – Anticholinergic - Ipratropium	N	N	Y*	Y
Bronchodilator - Beta agonist – Albuterol	Y*	Y*	Y*	Y
Bronchodilator - Beta agonist - L-Albuterol	N	N	Y*	Y
Bronchodilator - Beta agonist - Metaproterenol	N	N	Y*	Y
Corticosteroid - Dexamethasone	N	N	N	Y
Corticosteroid - Methylprednisolone	N	N	Y*	Y
Corticosteroid – Prednisone	N	N	N	Y
Epinephrine	N	N	Y*	Y
Epinephrine Auto-Injector	Y	Y	Y	Y
Magnesium Sulfate—bolus infusion only	N	N	N	Y
Racemic Epinephrine	N	N	Y*	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	Y*	Y*	Y*	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	N	N	Y*	Y
Terbutaline	N	N	N	Y
SEIZURE MANAGEMENT.				
Medications	**B**	**B-IV**	**I**	**P**
Benzodiazepine - Diazepam	N	N	Y*	Y
Benzodiazepine - Lorazepam	N	N	Y*	Y
Benzodiazepine - Midazolam	N	N	Y*	Y
OB -associated – Magnesium sulfate – bolus infusion only	N	N	N	Y
VACCINES				
Medications	**B**	**B-IV**	**I**	**P**
Post-exposure, employment, or pre-employment related - Hepatitis B	N	N	N	Y
Post-exposure, employment, or pre-employment related - Tetanus	N	N	N	Y
Post-exposure, employment, or pre-employment related - Influenza	N	N	N	Y
Post-exposure, employment, or pre-employment related - PPD placement	N	N	N	Y
Public Health Related - Vaccine administration in conjunction with County Public Health Departments and local EMS medical direction, after demonstration of proper training, will be authorized for public health vaccination efforts and pandemic planning exercises.	N	N	Y	Y

MISCELLANEOUS.				
Medications	**B**	**B-IV**	**I**	**P**
Analgesic Sedative – Etomidate	N	N	N	N
Benzodiazepine - Midazolam for TIH	N	N	Y*	Y
Lidocaine - bolus for intubation of head-injured patients	N	N	Y*	Y
Narcotic Analgesic - Fentanyl for TIH	N	N	Y*	Y
Hemostatic agents - topical	Y	Y	Y	Y

Technology- and Pharmacology- Dependent Patients

The transport of patients with continuous intravenously administered medications and nutritional support, previously prescribed by licensed healthcare workers and typically managed day-to-day at their residence by either the patient or caretakers, shall be allowed. This will simplify transport options for patients that currently may require specialized critical care transport teams under existing Rule. The EMS provider is not authorized to manage, alter, or interfere with these patient medication/nutrition systems except after direct contact with medical control, and where cessation and/or continuation of medication pose a threat to the safety and well-being of the patient.

Procedural Sedation

Procedural sedation, as defined by the combination of intravenous agents such as benzodiazepines and/or narcotics for the planned purpose of facilitating the performance of a procedure is not an authorized EMS practice in Colorado.

INTERFACILITY TRANSPORT

The EMS Medical Director, in collaboration with the transferring facility's medical director, should have protocols in place to ensure the appropriate level of care is available during interfacility transport and the transporting EMT may decline to transport any patient he/she believes requires a level of care beyond his/her capabilities.

Inter-facility transport typically involves three types of patients:

1. Those patients whose safe transport can be accomplished by ambulance, under the care of an EMT-Basic, EMT-Intermediate, or EMT-Paramedic, within the "acts allowed" prescribed by Rule 500.
2. Those patients whose safe transport can be accomplished by ambulance, under the care of an EMT-Paramedic, but may require skills to be performed or medications to be administered that are outside the "acts allowed" prescribed by Rule 500, but have been approved through waiver granted by the BME.
3. Those patients whose safe transport requires the skills and expertise of a critical care transport team under the care of an experienced critical care practitioner.

The hemodynamically unstable patient (typically from an Intensive Care setting) who requires special monitoring (i.e. CVP, ICP), multiple cardioactive/vasoactive medications, or specialized critical care equipment (i.e. intra-aortic balloon pump) should remain under the care of an experienced critical care practitioner and every attempt should be made to transport that patient while maintaining the appropriate level of care. The capabilities of the institution, the capabilities of the transporting agency and most importantly, the well-being of the patient, should be considered when making transport decisions.

Unless otherwise noted, these indicate hospital/facility initiated interventions and/or medications.

APPENDIX C

INTERFACILITY TRANSPORT – ONLY MEDICAL SKILLS AND ACTS ALLOWED

Additions to these medical skills and acts allowed cannot be delegated unless a waiver has been granted as described in Sections 7.4 – 7.8 of these rules.

The following medical skills and acts are approved for interfacility transport of patients, with the requirements that the medical skill or intervention must have been initiated in a medical facility under the direct order and supervision of licensed medical providers, and are NOT authorized for field initiation. EMS continuation and monitoring of these interventions is to be allowed with any alterations in the therapy requiring direct online medical control. The EMS

provider should continue the same medical standards of care with regards to patient monitoring that was initiated in the medical care setting.

It is understood that these skills or interventions may not be addressed in the National Standard EMT-Basic, EMT-Intermediate or EMT-Paramedic Curricula and may not be addressed in any future national education standards that may replace the current National Standard Curriculum. As such, it is the joint responsibility of the medical director and individuals performing these skills, to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the interfacility transport environment.

CARDIOVASCULAR/CIRCULATORY SUPPORT.				
Skill	**B**	**B-IV**	**I**	**P**
Aortic Balloon Pump Monitoring	N	N	N	N
Chest Tube Monitoring	N	N	N	Y
Central Venous Pressure Monitor Interpretation	N	N	N	N

APPENDIX D

INTERFACILITY TRANSPORT – ONLY FORMULARY OF MEDICATIONS ALLOWED TO BE ADMINISTERED

Additions to this medical formulary cannot be delegated unless a waiver has been granted as described in Sections 7.4 – 7.8 of these rules.

The following formulary of medications are approved for interfacility transport of patients, with the requirements that the intervention must have been initiated in a medical facility under the direct order and supervision of licensed medical providers, and are NOT authorized for field initiation. EMS continuation and monitoring of these interventions is to be allowed with any alterations in the therapy requiring direct online medical control. The EMS providers should continue the same medical standards of care with regards to patient monitoring that was initiated in the medical care setting.

It is understood that these skills or interventions may not be addressed in the National Standard EMT-Basic, EMT-Intermediate or EMT-Paramedic Curricula and may not be address in any future national education standards that may replace the current National Standard Curriculum. As such, it is the joint responsibility of the medical director and individuals administering these medications, to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the interfacility transport environment.

CARDIOVASCULAR.				
Medications	**B**	**B-IV**	**I**	**P**
Anti-arrhythmic – Amiodarone - continuous infusion	N	N	Y	Y
Anti-arrhythmic - Lidocaine - continuous infusion	N	N	Y	Y
Anticoagulant - Glycoprotein inhibitors	N	N	N	Y
Anticoagulant - Heparin (unfractionated)	N	N	N	Y
Anticoagulant - Low Molecular Weight Heparin (LMWH)	N	N	N	Y
Diltiazem	N	N	N	Y
Dobutamine	N	N	N	Y
Nitroglycerin, intravenous	N	N	N	Y
HIGH RISK OBSTETRICAL PATIENTS.				
Medications	**B**	**B-IV**	**I**	**P**
Magnesium sulfate	N	N	N	Y
Oxytocin - infusion	N	N	N	Y
INTRAVENOUS SOLUTIONS.				
Medications	**B**	**B-IV**	**I**	**P**
Monitoring and maintenance of hospital/medical facility initiated crystalloids	N	Y	Y	Y

Monitoring and maintenance of hospital/medical facility initiated colloids (non-blood component) infusions	N	N	Y	Y
Monitoring and maintenance of hospital/medical facility initiated blood component infusion	N	N	N	Y
Initiate hospital/medical facility supplied blood component infusions	N	N	N	Y
Total parenteral nutrition (TPN) and/or vitamins	N	N	Y	Y
MISCELLANEOUS				
Medications	**B**	**B-IV**	**I**	**P**
Antibiotic infusions	N	N	Y	Y
Antidote infusion – Sodium bicarbonate infusion	N	N	N	Y
Electrolyte infusion – Magnesium sulfate	N	N	N	Y
Electrolyte infusion – Potassium chloride	N	N	N	Y
Insulin	N	N	N	Y
Mannitol	N	N	N	Y
Methylprednisolone – infusion	N	N	N	Y

Revised 2/9/06, effective 3/31/06; Revised 5/17/07, effective 7/30/07; Revised 09/26/07, effective 11/15/07. Revised 2/19/09, effective 04/30/09;