Professional Licensing Report

Licensing, testing, and discipline in the professions

July/August 2017
Vol. 29, Numbers 1/2

Highlights in this issue

Sunset Review

Texas axes anonymous complaints, whittles entry requirements, mandates fingerprinting

Issue: Changes driven by mandated sunset review of boards

Sunset review occupied quite a bit of the Texas legislature's time in 2017—so much that after it failed to renew five boards amid disputes about their future before the session ended in July, the governor had to call legislators back for extra duty.

When the dust settled, with the session's end in August, state senators and representatives had agreed to give a two-year reprieve to the state medical board and to four behavioral science boards (psychology, marriage and family therapy, professional counseling, and social work) that sunset reviewers had unsuccessfully recommended combining.

(See Sunset Review, page 3)

Deregulation

Washington State debates: Are Internet reviews making occupational regulation obsolete?

Issue: New models of regulation

An online portal like Angie's List could take the place of professional licensing, at least in certain fields, if a novel concept in Washington State gains traction.

Prompted by the expanding roles being played by the Internet, the state House Business and Financial Services Committee held hearings during the lengthy 2017 legislative session on a proposal to eliminate occupational regulation in certain fields and replace it with online Uber- or Yelp-style ratings of people offering now-regulated services.

The brainchild of a free-market think tank, the Washington Policy Center, the proposal found its way into a bill (HB 1361) sponsored by state Rep. Matt Manweller. HB1361 would replace some current licensing with an online rating system similar to those used by Angie's list, Yelp, Uber, and Lyft. The bill proposes to use this "public feedback structure" to sideline current regulatory programs for animal massage, auctioneers, boxing announcers, fishing guides, landscape architecture, manicurists, and horse floaters (equine dentistry).

The bill would:

• Require the Department of Licensing to create a user-friendly public website called the Washington Effective Licensing Port, for the public to comment and review all individuals working in one of seven specific occupations.

• Provide that the website allow the public to view postings regarding an individual registered with the website and allow consumers to post reviews of registered individuals on a five-star rating scale.

• Eliminate occupational licensure requirements related to the seven regulated occupations and instead require people working in those fields to register with the Washington Effective Licensing Port and create a profile.

Manweller points out that the main advocates for licensing of fields like these are practicing those occupations. They often want to control entry rather than protect consumers, he says; the bills are "designed to make sure that outsiders cannot compete with insiders."

When they say they want to maintain standards, "what they really want is to cut out a lot of competition and set very high barriers" for entering the occupation "so they can keep their prices high," says Todd Myers of the Washington Policy Center, who helped draft the bill.

The public safety rationale for licensing requirements in fields like landscape architecture is weak, he adds. Over the last 10 years Myers found 16 instances of a Washington state landscape architect required to appear before the board; 15 of those were violations for operating without a license while one was for alleged malfeasance.

He argues that before the Internet age, consumers may have needed government oversight through licensing because information about professionals providing the services they received was scarce. With avenues like Yelp or Angie's List, however, "We have an opportunity to use another system in a way in which we haven't before. It's time we come into the IPhone era."

HB 1361 did not get beyond the committee hearing in 2017 but is slated to be reintroduced in the 2018 Washington legislative session.

Sunset Review

Texas sunset review ends anonymous complaints, mandates fingerprinting (from page 1)

Whether or not Texas, with a population of nearly 28 million, may be a bellwether of national trends in professional licensing is unknown. But several themes of the 2017 sunset process in Texas are becoming familiar to other states as well:

Opioids driving tighter regulations Several of the health licensing boards were ordered to monitor providers' prescribing and dispensing of prescription drugs and to develop guidelines for responsible prescribing of controlled substances. The pharmacy board must develop "red flag indicators" to address potentially harmful prescribing patterns or patient activity.

Structural changes to address "failed governance putting the state at risk" Both the dental and veterinary boards were hit with charges of "failed governance" by the Sunset Commission—leading to an order to "sweep" the dental board by replacing the leadership and reducing the number of board members. Restructuring of the veterinary board to include a veterinary assistant and members representing animal shelters and large-animal care, and to reduce board members' conflicts of interest was also ordered. The veterinary board, due to concerns about its oversight and operations, was only extended four years rather than the normal 12 years.

Axing of anonymous complaints Several boards are prohibited from accepting anonymous complaints and must maintain confidentiality of investigative reports, complaints, and other investigative information.

Upping regulation of danger areas Following media spotlighting of patient deaths in recent years, extensive requirements regulating anesthesia by dentists were set in place including inspection, additional training, and an online exam for an anesthesia permit to be conducted every five years. The licensing agency is to appoint an independent blue-ribbon panel to review de-identified data, including confidential investigative information related to dental anesthesia deaths and mishaps over the last five years.

Requiring fingerprinting for background checks The physician assistant, podiatry, and other boards must conduct fingerprint-based criminal background checks of licensure applications

Curbing mental health questions Addressing a simmering controversy, the legislature ordered the Board of Law Examiners to stop requiring applicants to attest that they do not have a mental health diagnosis. This will "ensure licensing decisions are based on present conditions and conduct and are in line with the Americans with Disabilities Act," the legislature said.

Inserting religious freedom into statutes The Board of Law Examiners and the pharmacy board are prohibited from rulemaking action that would violate religious freedom protections in the state's Civil Practice and Remedies Code.

Slimmed-down, more objective entry standards Some boards must remove "unnecessary and restrictive education requirements for applicants for licensure," set clearer expectations for supervision where it's required, and "replace onerous license verification" processes. The nursing board, for one, must demonstrate a connection between a nurse's conduct and the practice of nursing before adopting a standard.

Centralization pushed The Texas podiatry board, an independent board, was transferred to the central Department of Licensing and Regulation "to assure the agency's mission is carried out more effectively and efficiently." However, the proposed consolidation of behavioral science professions was not approved.

Prioritizing of complaints Boards such as the chiropractic board were ordered through non-statutory management actions to develop policies for prioritize complaints and complaint investigations

Reducing anti-competitive rules The psychology board, for example, must evaluate all rules for potential anti-competitive effects and repeal rules susceptible to legal challenge.

Other changes, mostly affecting individual boards, included:

Ending letters of recommendation requirement Letters of recommendations or reference, required by some boards, must no longer be part of initial application processing.

Expunging certain discipline Certain disciplinary actions by some boards must be removed from their public websites and the public licensure information system.

Bans on charging licensees for hearings Administrative costs of conducting hearings may not be charged to nurses by the nursing board.

Requiring adoption of ALJ conclusions The nursing board may not change an administrative law judge's findings of fact or conclusions of law in issuing a disciplinary order.

Efficient enforcement The chiropractic board must drop a provision requiring five affirmative votes of the nine-member board to take a disciplinary action, removing a regulatory bias favoring the licensee.

Increased Data Bank reporting Letters of formal agreement by the chiropractic board must be reported to the National Practitioner Data Bank unless the federal agency or agency counsel advise otherwise.

Expanded scope of practice The word "diagnosis" was added to the definition of the practice of chiropractic.

Discipline

Board may probe MD's prescribing records without violating patients' privacy

Issue: Confidentiality and discipline investigations

Although patients have a limited privacy expectation in the prescription information contained in the state's database, the state's interest in controlling dangerous drugs and doctors outweighs that expectation, the Supreme Court of California held July 17. The court rejected a physician's challenge to the use, in his disciplinary proceeding, of records from the state's prescription database (*Lewis v. Superior Court*).

The case involves the use of the Controlled Substance Utilization Review and Evaluation System, or CURES, California's mandatory prescription drug monitoring program which logs personal information about the recipient of controlled substance prescriptions and the identity of the prescription provider.

The board initiated an investigation against physician Alwin Lewis in 2008 after receiving a patient complaint and, as part of that investigation, a board investigator obtained a record of Lewis's CURES activity. Using those CURES records, the board charged Lewis with improper prescribing practices.

During the disciplinary process, Lewis challenged the use of the CURES reports, arguing that the board had violated his patients' privacy rights by accessing the records. An administrative law judge denied the challenge, the disciplinary case went ahead, and Lewis was given a suspended revocation and three years' probation. He appealed, and the case eventually made its way up to the state's California Supreme Court.

As a threshold matter, the Court agreed with Lewis that he had standing to assert his patients' privacy rights. "Because an individual's prescription records contain intimate details about his or her medical conditions, the government's ability to access these records may cause patients to hesitate to seek appropriate medical treatment," wrote Justice Goodwin Liu.

Citing U.S. Supreme Court precedent on standing, Justice Liu wrote that "because a physician has an interest in patients seeking appropriate treatment and using appropriate medication, the Board's actions are 'inextricably bound up with the activity the litigant wishes to pursue' in this case," and noted that "in this case, the patients are unable to assert their own rights because they were never given notice that their records were accessed."

Despite that successful assertion of standing, however, the court ruled that the board had not acted improperly in accessing the database. Patients' privacy rights in the prescription records do exist, Justice Liu wrote, but "the Board's actions in this case do not implicate a fundamental autonomy right."

". . . The disclosure of information from CURES may be one consideration affecting a patient's choice to pursue treatment, but it does not significantly impair the patient's ultimate ability to make that choice on his or her own."

Justice Liu did acknowledge that there are limits on the board's ability to access the state's drug prescription log (CURES). She wrote: "Our rejection of an individualized good cause requirement should not be understood to suggest that Board investigations may access the CURES database for any reason," and that such access was limited to aiding law enforcement and regulatory agencies control the abuse and wrongful dispersion of prescription drugs.

In addition, the board was prohibited by law from the wrongful public disclosure of patient information obtained from CURES. The information obtained was only available to be shared with other government agencies, and limits were in place on what information could be revealed about individual patients during investigations.

And, under existing precedent, if an agency action does not implicate such a "fundamental autonomy right," all the agency must do to justify the action is to show that an invasion of privacy "is justified by a competing state interest."

Addressing that balancing judgment, the Court held that the state's interests in regulating dangerous prescription drugs and protecting the public from dangerous physicians were sufficient competing interests to justify the board's invasion of patients' limited privacy expectations in their prescription records.

In addition, although Lewis argued that the board should be required to show that it had used the least intrusive means possible to obtain the information, by limiting its searches of the CURES database to situations in which it could show good cause, the court noted that such a consideration was only one among many to be considered when the pros and cons of CURES access.

The court also said that such a "good cause" requirement would unreasonably "compromise the Board's ability to identify and address potentially dangerous prescribing practices," since "requiring the Board to present evidence to a judicial officer establishing good cause as part of its preliminary investigations could result in protracted legal battles that effectively derail those investigations."

Having rejected Lewis's challenges, the court upheld the lower decision to allow CURES records into evidence.

Board cannot exclude licensee from acting as own expert witness

Issue: Standards of evidence for witness testimony

The state medical board erred when it denied a physician the opportunity to testify as an expert witness in her own disciplinary proceeding, a Virginia appellate court ruled March 14. But the court nonetheless upheld the board's decision because the licensee had failed to provide the court with the substance of the testimony she would have offered. (*Virginia Board of Medicine v. Zackrison*).

The board brought charges against rheumatologist Leila Zackrison in 2014, alleging that she diagnosed a patient as having Lyme disease without adequate support in the patient's medical records. During her disciplinary trial, Zackrison attempted to testify as an expert on her own behalf, but the board rejected this attempt on the grounds that Zackrison was the respondent in the case and, therefore, could not testify as an expert.

Despite her non-certification as an expert in this case, Zackrison testified as to the standard of care in related cases and otherwise testified as an expert

witness might. Following her testimony, another doctor testified as an expert on her behalf.

After the hearings, the board held that Zackrison's treatment of the patient had fallen below the standard of care, specifically finding that the testimony of Zackrison's admitted expert witness was not sufficient to overcome that of the board's own expert witnesses. Zackrison's license was placed on probation and she was required to complete additional continuing education courses. She appealed, and the case went to a state circuit court.

On appeal, Zackrison took issue with the board's decision to deny her expert witness status, arguing that the decision denied her the constitutional due process right for "an opportunity to be heard in a meaningful manner." The circuit court agreed with this reasoning and vacated the board's discipline order. The board then appealed, and the case went up to a state Court of Appeals in Richmond.

Reviewing the case law, the Court of Appeals noted that the Virginia Supreme Court has actually specifically held that a physician may serve as their own expert witness, and thus that the board erred to the extent that it denied her expert witness status solely on the basis that she was the respondent.

However, the board, as an administrative agency, has its own standards for expert witness qualification. "Given the deference accorded to the Board under [the Virginia Administrative Process Act], the ultimate decision of what standard should be applied belongs to the Board," wrote Judge Wesley Russell, Jr.

"It is free to adopt the traditional Virginia standard, the more stringent medical malpractice standard, or a lesser standard so long as the chosen standard is rational, is otherwise consistent with Virginia law, and provides determining principles . . . that can be applied consistently and that do not reduce the qualification decision to mere whim."

Addressing the substance of Zackrison's qualifications to act as an expert witness, the court noted an extensive and compelling list of her qualifications, and Judge Russell wrote that "although the Board ultimately can choose the standard to apply, we can conclude from this record that Dr. Zackrison was qualified to provide expert testimony on the practice of rheumatology under any reasonable standard the Board could adopt." The board, therefore, had erred when it denied her the opportunity to testify as an expert witness.

And, although the board argued that its ultimate decision that Zackrison's actions fell below the accepted standard of conduct meant that it could conclude that she was not a competent expert, the court rejected this reasoning. "The Board confuses a question of qualification with conduct," wrote Judge Russell.

The existence of experience to support expert witness status to testify as to the standard of care does not mean that the witness will always meet that standard in his or her own practice, he noted. And, because a decision as to whether Zackrison should be qualified as an expert had to be made before the board made its decision to discipline her, that final decision was irrelevant to the question of expert witness qualification.

Despite the board's error, the court held that the decision had not violated Zackrison's due process rights. Zackrison had still been able to present technical testimony to the board on the standard of care, and did not appear to have been prevented from offering any relevant testimony.

"As such, the Board's refusal to categorize Dr. Zackrison as an expert was not a bar on her ability to present one's own evidence . . . but rather, was merely an erroneous evidentiary ruling." Zackrison had received her opportunity to be heard, and thus the board's decision did not violate her due process rights.

Additionally, unfortunately for Zackrison, in order for improperly excluded testimony to cause the board's decision to be vacated, a court must evaluate the testimony that would have been offered. This requires that the party denied the opportunity to provide the testimony proffer its substance to the court in its filings, but Zackrison did not provide that testimonial substance.

"We do not know whether her testimony simply would have recited the literature, which had been admitted into evidence already, or done something more. We do not know how her citations to the literature would have differed from the references she was allowed to make or from [her admitted expert's] repeated references to the literature in support of his opinion that Dr. Zackrison's care and treatment . . was appropriate," wrote Judge Russell.

Without the specifics of her potential testimony, the court was unable to rule on whether the board's error prejudiced Zackrison's defense, and it upheld the decision of the board to discipline her.

Pre-printed forms not enough to document pain medication Rx

Issue: Discipline over failure to prepare individualized treatment plans

A Texas appellate court, in an August 21 decision, upheld a discipline ruling against a physician who had, among other things, documented his patient goals during visits for pain medication by using a pre-printed form to be filled out by those patients, often with only a "Y" or "N" to indicate whether a goal was being met. (*Swate v. Texas Medical Board*).

The Texas Medical Board revoked physician Tommy Swate's license in 2011, alleging that he improperly prescribed pain medications for a number of patients. Swate appealed, and the case eventually rose to the Court of Appeals.

On appeal, Swate argued that the board had incorrectly concluded that he had inadequately documented his treatment of patients. Among the board's complaints was that, instead of creating and documenting individualized treatment plans for his patients, Swate instead used two pre-printed forms which were filled out by his patients during visits.

The forms contained a list of 16 elements of a treatment plan, including a pain-level section in which the patient rated pain from 1 to 10, and a series of suggested treatment goals, such as "reduce pain," for each of which the patient was to circle "Y" or "N."

The board and its expert witness maintained that this system was inadequate, as it lacked Swate's own stated goals for the patients, as well as a periodic review, by the physician, of progress towards those goals.

Moreover, information on several of these filled-out forms contradicted information in other parts of the patients' records, including compliance with dosing schedules of pain medications, and several of the forms and other patient records were simply incomplete in many areas.

The court upheld the board's holding on the issue of adequate treatment documentation, finding that the evidence in the record provided a reasonable

basis for the board to conclude that Swate "failed to appropriately document treatment goals, objectives, or progress" for his patients.

"Treatment plans were not documented for every visit," wrote Justice Cindy Bouchard for the court, "and where they were documented, they were regularly incomplete, inconsistent, or lacking information required by Board rules."

The court also upheld the board's finding that Swate, while appearing to monitor his patients' non-compliance with dosing schedules and other aberrant opioid behavior, nonetheless failed to take any action on those findings. And it rejected several arguments by Swate regarding the board's treatment of expert witnesses.

Board cannot grant summary determination when facts are in dispute

Issue: Administrative procedure

An Oregon court overturned a disciplinary decision by the state massage therapy board August 9, holding that the board improperly issued a summary determination on a charge that a licensee had improperly influenced a client, when the underlying facts of that charge were reasonably in dispute. (*Nacey v. Board of Massage Therapists*).

The case began when licensed massage therapist James Nacey sold a package of 10 massages to a customer. However, after the first massage, the customer requested a refund, which Nacey declined to give. The facts of the case were contested; Nacey testified that the massage package was understood to be non-refundable. The customer filed a complaint with the board, which convened a disciplinary process.

During the hearing, the board moved for summary determination on all of the charges against Nacey and was successful on three. One of the charges granted a summary determination, despite the fact that Nacey contested the underlying facts, alleged that Nacey violated a provision prohibiting therapists from “exercising undue influence on a client . . . in such a manner as to exploit the client for financial gain,” on the grounds that Nacey improperly kept the balance of the payment for future massages after the customer requested a refund.

The administrative law judge then held a factual hearing on the fourth charge and determined that Nacey was guilty of this too, fining him $4,000 plus costs.

The Court of Appeals of Oregon, hearing the appeal, agreed with Nacey’s argument that the board had improperly used summary determination on a charge for which the underlying facts were contested.

Reviewing the facts of the case in the light most favorable to Nacey (a standard required for review of summary determinations), the court determined that the board could not reasonably find that Nacey had used undue influence over the customer. In Nacey’s telling, the customer approached him for a package of massages, which Nacey informed him were non-refundable.

This, the court held, was an “arms-length” transaction and Nacey could not have been said to have exploited a prior relationship with the customer. “Nothing in the terms of the rule reasonably can be construed to suggest that, in the absence of any exploitative conduct, a massage therapist must provide a refund to a customer who made an arms-length bargain for a nonrefundable package of massages,” wrote Judge Erin Lagesen. She noted that there were facts to support the charge, but, because those facts were in contention, the board could not have imposed a summary determination. The judge then vacated the civil penalty and fines and remanded the case to the board.

Fourteen weeks sufficient time to secure attorney and review evidence

Issue: Continuance requests for discipline hearings

The Court of Appeals of Virginia, in a March 21 decision, rejected an argument by a physician whose license had been revoked, after a bizarre complaint involving unnecessary "invasive procedures" with military cadets and alleged lack of time to prepare a defense.

The physician, John Hagmann, charged that the state's medical board had provided him insufficient time to prepare a defense and had unreasonably denied a continuance request which would have allowed his chosen attorney to be present. The court held that the fourteen weeks from the initial notice of charges to the final hearing date was sufficient time to accommodate scheduling issues and review the evidence in the case (*Virginia Board of Medicine v. Hagmann*).

In March 2015, the board summarily suspended physician John Hagmann's license after the federal military school at which he taught reported that Hagmann and his students were performing on each other, "invasive medical procedures that were unapproved and not undertaken in good faith for medicinal or therapeutic purposes" and Hagmann was "encouraging students to use alcohol and various drugs in unapproved and dangerous ways."

"The record," wrote Judge Maria Graff Decker, "viewed under the proper standard, shows that Hagmann had a period of fourteen weeks during which he and his attorney, if he had promptly retained one, could have reviewed the manageable amount of evidence, sought additional discovery, and made tentative arrangements for any necessary witnesses."

Prior to his disciplinary hearing, Hagmann, acting as his own attorney, requested and received a continuance of that hearing set for April 22. In May, Hagmann's new attorney requested a second continuance because of a scheduling conflict, this time asking to push the date from June to October. The board panel hearing the case denied that request, and Hagmann's attorney then moved to disqualify the panel.

When that effort proved unsuccessful, the attorney notified the panel that neither he nor Hagmann would attend the June hearing, a promise that—despite records and exhibits submitted for that hearing—both men kept, with the result that the board revoked Hagmann's license.

Hagmann appealed, and a circuit court vacated the board's decision, on the grounds that the board's refusal of the second continuance request denied Hagmann the time to prepare an adequate defense. However, the court rejected Hagmann's arguments that the continuance denial violated his right to be present at the hearing, and that the board panel chair should have recused himself. The board appealed, and the case went up to a state Court of Appeals in Richmond.

Addressing Hagmann's contention that the denial of continuance also unfairly denied him the services of his specific attorney, the court held that, since Hagmann had already received a continuance and had been given three months from the initial notice of suspension to prepare for his hearing, given the lack of explanation from Hagmann or his attorney as to the nature of the scheduling conflict or why a replacement could not be arranged, the board had not acted unreasonably when it failed to accommodate Hagmann's request.

Additionally, the court cited several other factors offered by the board that supported its decision to deny the continuance. Several of the witnesses were members of the military and were scheduled to be on mandatory field exercises during October. On other prospective hearing dates, insufficient numbers of board members would be available to hear the case, and the October docket was already full enough that an additional case could not be guaranteed to be heard that month.

Addressing Hagmann's argument that the board denied him adequate time to prepare for his hearing, the court noted that Hagmann was notified about the suspension in March, which gave him approximately 14 weeks from that date until the first continued hearing in June, and that the vast majority of the evidence in the case was available for his inspection at that time.

Having rejected these arguments, the court reversed the decision by the circuit court and reinstated the revocation of Hagmann's license.

Agent selling property had affirmative duty to verify boundaries

Issue: Due diligence obligations of licensees

A real estate agent who sold a property that both she and the purchaser apparently mistakenly believed was larger than it actually was, had, under the circumstances of that case, been provided with sufficient evidence that she could and should have been able to uncover the mistake before the purchase and alert the buyer, New Zealand's Real Estate Agent Disciplinary Tribunal ruled May 11 (*Wang v. Real Estate Agents Authority*).

The Tribunal also held that the actions of the agent's assistant, who had failed to notice a warning about the property from another agent, were imputable to his employer.

The complaint centered on the purchase of an Auckland property. Real estate agent Jane Wang's advertisement for the property included an image of a wooden fence, with horses just on the other side, and stressed its rural nature. Although the fence was not actually within the bounds of the advertised property, the eventual buyer, based on the photo and the appearance of the property, believed that it was, and built an $8,000 wooden deck on land that turned out not to be hers.

"There is no question that, as a general principle, licensees do not have a duty to identify and point out the boundaries of a property," the Tribunal wrote. "However, there is also no question that there are exceptions to the general principle, in which the licensee will be obliged to be proactive and ascertain boundaries."

Although the amount of information regarding the discrepancy had been debated by the parties, there were, the court concluded, sufficient factors to alert Wang to a potential problem such that she should have made enquiries as to the location of the boundary.

Later, the New Zealand Transport Authority, the actual owner of the land on which the fence was located, demolished the fence and built a bike trail, which was to be lighted at night. The newly-built deck was partly demolished as well, as the owner had mistakenly located it on Authority land.

Following the complaint, the Complaints Assessment Committee hearing Wang's case made a finding that she had violated provisions of the Real Estate Agents Act, which requires an agent to act competently and not mislead purchasers. The committee reasoned that Wang should have noticed the discrepancy between the location of the wooden fence and the actual property boundary and, after being alerted to the possible problem by another agent, should have made enquiries to that effect.

The Committee fined Wang $2,000 and ordered her to pay $4,000 to the client and to complete an educational unit on misleading and deceptive conduct. Wang appealed, and the case went up to the Tribunal.

On appeal, Wang's counsel argued that Wang, as a real estate agent, was not required to explore where the boundaries of a given property were and convey that information to a purchaser. Although counsel for the Real Estate Agents Authority conceded that Wang was unaware of the boundary discrepancy, it contended that Wang *should* have been aware. The Tribunal agreed with the Authority.

One potential warning on which Wang and the Authority disagreed was an email sent from another real estate agent to Wang describing misleading aspects of her advertisement for the property, which the Tribunal held should have alerted Wang to the problem.

Wang's assistant, who read her email for her, had not noticed the warning and thus had not passed it along to Wang. Accepting that as true, and citing legal precedent, the Tribunal held that, in reading the emails, the assistant was carrying out real estate work for Wang, and her professional responsibility extended to work done on her behalf.

By not making enquiries, Wang had "failed to exercise skill, care, competence, and diligence," and was thus in breach of the Act. The Tribunal further upheld the other decisions made by the Committee concerning the culpability of Wang.

However, the Tribunal did overturn the Committee on the matter of compensation to the purchaser. In ordering Wang to pay $4,000 to the purchaser, the Committee had relied on a section of the Real Estate Agents Act that authorizes the Committee to order a licensee to "take steps to provide, at his or her own expense, relief . . . from the consequences of the error or omission' made by the licensee."

Rather than the "relief" contemplated by the act, the order to pay the purchaser appeared to be "an order for compensation for the cost of building the deck," an action outside the jurisdiction of the Committee, the Tribunal said.

In spilled pills case, board improperly changed discipline charge from unethical conduct to "act tending to bring discredit" on appeal

Issue: Administrative procedure and due process

A Delaware court, in an August 7 decision, overturned a disciplinary finding by the Delaware medical board in which the board had changed the theory of the licensee's liability during an appeal hearing (*Spraga v. Board of Medical Licensure & Discipline*).

Such a change, the court held, violated the state's Administrative Procedure Act and the licensee's right to due process. The judge remanded the case to the board.

When nurses working at the Delaware Correctional Center, responsible for the medical care of prisoners, spilled 12 hepatitis C pills on the ground in 2015, they placed the pills–valued at $1,000 each–in a sharps container as waste.

However, when the nurses contacted the Center's pharmaceutical provider to obtain replacement pills, they were instructed by a pharmacist representative of the provider, as well as the medical director of the company that employed the nurses, physician Laurie Spraga, to instead retrieve the pills from the sharps container, which they did by turning the container upside down and shaking out the pills, as well as other assorted medical sharps waste.

Another representative of the pharmaceutical provider, pharmacist Jamie McGee, also inspected the pills and declared them safe, and Spraga left to the two pharmacists the decision as to whether to reuse the pills. McGee and the nurses then placed the pills back into the container, from which they were later administered to a patient.

After one of the nurses involved filed a complaint over the incident, the Delaware Division of Professional Regulation filed a formal complaint against Spraga, alleging that she had acted unprofessionally by ordering reuse of the pills.

However, contrary to the theory of the facts alleged by board prosecutors, a hearing examiner determined that the pharmacists involved had made the decision to reuse the pills, and that Spraga had only relied on their advice that reuse of the pills would be medically safe.

In her defense, Spraga called two expert witnesses who testified that the reuse of the pills would have been safe, the examiner noted that the patient who took the pills had not been harmed, and the state did not reply with any evidence or testimony to the contrary.

Despite this evidence, the hearing examiner also determined that Spraga had a duty to overrule the pharmacists on this decision, though the hearing examiner failed to cite to the basis for this duty, as the state's attorneys had prosecuted the case that the pharmacists had not known about the sharps incident and had not argued any other theory of Spraga's liability.

Spraga appealed the hearing examiner's decision to the board, which also decided to sanction Spraga, but changed the section of code with which Spraga had been charged to compensate for the fact that the hearing examiner had failed to articulate a standard of care which she had violated.

> The state's original theory of liability relied on the notion that Spraga had acted alone, Judge Butler wrote in remanding the case to the board. "The Examiner's . . . finding that Respondent relied on the advice of the pharmacists made the State's case against Respondent virtually untenable, save for the graphically ugly facts."
>
> "Liability must be shown by a process that gives the party fair notice and an opportunity be heard, not a *post hoc*, post hearing, duty to overrule the pharmacist that was never presented or argued, or an 'oh, by the way' regulatory violation apparently conceived by the Board after the hearing, after the briefing, after the arguments, while the Board deliberated privately."

Now, instead of being found to have engaged in "dishonorable or unethical conduct likely to deceive, defraud, or harm the public," as originally charged, Spraga was found to have committed an "act tending bring to discredit upon the profession," a catch-all disciplinary provision in the state's medical code. Spraga appealed this decision, and the case went up to the state Superior Court in New Castle.

Reviewing the record, Judge Charles Butler reversed the board's decision to discipline Spraga. Given the lack of evidence that the reuse of the pills had harmed the patient or even had the potential to harm a patient, Butler held that a finding that Spraga had taken an action "likely to . . . harm the public" lacked merit.

Butler also held that the introduction—at the appeals hearing before the board—of the amended charge under which the board eventually disciplined Spraga (that she had committed an "act tending to bring discredit upon the profession"), was a violation of the state's Administrative Procedure Act and Spraga's right to due process.

Noting that the state had not provided any example of an administrative agency amending a charge while in the process of a proceeding, Butler said, "This is not a surprise, since such a fundamental change in the State's theory of liability is inconsistent with fair notice and an opportunity to be heard, the touchstones of due process."

"Promise" not to perform surgery not sufficient to lift license restrictions

Issue: Conditions of probation following revocation

A California appellate court held August 1 that a doctor placed on probation for causing the deaths of three surgical patients could not be removed from probationary status simply because of assertions on his part that he would no longer engage in surgery, even if the assertions were credible (*Witzling v. Medical Board of California*).

The state attorney general filed an accusation against surgeon Sandy Witzling in 2009, alleging that he had engaged in gross negligence in his care of five patients, three of whom died. Witzling and the board agreed to a settlement in which his license was revoked, but with the revocation stayed for a seven-year period of probation, during which he was barred from surgical practice.

Witzling then closed his practice and began working as a medical records reviewer. However, when a large client of his employer discovered that his license was restricted, the employer fired him rather than lose the client.

In 2013, Witzling filed a request to have his probation terminated, so that he could regain his employment as a records reviewer. Hearing testimony seemed to create a sympathetic atmosphere for Witzling; he expressed support for the probation process, indicated remorse for the actions causing the deaths of his patients, and detailed the extensive steps he had taken to improve his practice.

Witzling stated that he did not intend to return to surgical practice, but explained that his attempt to find other work had been hampered by the restrictions on his license.

At the end of the hearing, the administrative law judge recommended granting Witzling's petition, finding that the evidence indicating that Witzling would not practice surgery were he to be reinstated..

However, the board rejected the recommendation, stating that it had no ability to issue Witzling an unrestricted license and limit his practice, and that Witzling could not provide sufficient evidence that he was competent to practice with an unrestricted license. Witzling appealed, and the case went up to a state Court of Appeal.

Although Witzling argued that the board's decision was not supported by the evidence because "it is based entirely on the absurd theory that with an unrestricted license, he would pose a danger and might wander around, having a go at surgery," the court nonetheless agreed with the board and rejected his appeal.

The board had indicated that it believed his assertion that he had no intention of practicing surgery, but it had also stated that Witzling would nonetheless be able to do so with an unrestricted license.

Witzling's appeal was unsuccessful. The court acknowledged his "difficult position," in that, without an unrestricted license, he would likely be forced to stop practicing entirely. It agreed with the board both that it did not have the authority to issue a limited license to Witzling and that its consumer protection mandate forbade it from issuing an unrestricted license to a physician it did not consider competent to practice.

In the words of the board, "it would be relying on [the assertion] of a doctor, whose conduct caused at least three patient deaths, to protect the public by voluntarily refraining from the practice of medicine. Such a delegation of responsibility defeats the essential purpose of a regulatory agency."

Submission of plan to client by out-of-stater deemed unlicensed practice

Issue: Standards for judging unlicensed practice across state lines

The Supreme Court of Oregon, in a June 2 decision, upheld a sanction for unlicensed practice imposed by the state's architectural board on two men who submitted master plans for projects in Oregon despite not having an architect's license in the state (*Twist Architecture & Design, Inc. v. Oregon Board of Architect Examiners*).

Neither Kirk Callison or David Hansen, principals of Twist Architecture & Design, the firm at issue in the case, were licensed to practice in Oregon when, in 2008, Twist agreed to design a master plan for three shopping centers in the state and later submitted those plans—stamped with the firm's logo—to the client.

Additionally, Twist maintained a website that, among its biographical information, listed Callison and Hansen as "Licensed in the State of Oregon (pending)" and listed one of the proposed shopping centers as experience. At the time of the site's creation, Callison, a Washington State licensee, had intended to apply for licensure in Oregon but had not done so. Hansen was not licensed to practice in any jurisdiction.

The board, learning of the plans, filed a complaint against Twist and its two principals in May of 2011, seeking penalties for unlicensed practice. After a hearing, the board found that the purported architects had, in fact, engaged in unlicensed practice and improper advertising. The board held that the creation of master architectural plans constituted the practice of the profession and that Twist's website improperly claimed the two were architects.

Callison and Hansen appealed, arguing that the plans they submitted were never intended to be used for the actual preparation of construction and, thus, could not be considered the practice of architecture. An appellate court agreed with this argument and threw out most of the board's sanctions. The board appealed this decision and the case went up to Oregon's Supreme Court.

In their appellate arguments, Callison and Hansen argued that the Oregon statute on the unlicensed practice of architecture only prohibits "planning" and "designing" if those plans or designs were done in contemplation of construction. The plans they created for the Oregon project, they claimed, were not sufficiently detailed that they could have been used for actual construction.

The justices of the court did not agree. While the Oregon statute defining the practice does include the creation of plans intended for construction, the legislature did not limit the practice to only the creation of those final plans, wrote Justice Martha Walters, noting that the definition also included types of preliminary planning.

"If respondents were correct that the practice of architecture requires the preparation of drawings that could be used in actual construction, it seems that the legislature would have limited the activities it described to the preparation of such drawings, rather than including activities preliminary to their preparation."

Further, the justice continued, among the legislature's motives for prohibiting the unlicensed practice of architecture was the elimination of "unnecessary loss and waste" and "it is reasonable to conclude that the legislature contemplated that economic loss and waste could occur if individuals untrained in master planning undertook to perform those tasks for developers for remuneration but without the requisite skills, and therefore required that those who engage in such planning must be licensed as architects."

The creation of master plans constituted the practice of architecture and the preparation of such plans by Callison and Hansen was unlicensed practice.

The Court also upheld the board's judgment that Callison and Hansen improperly represented themselves as practicing architects on their website. Although the site's text contained the qualifier that licensure of the pair was only "pending," Justice Walters wrote that "a representation can violate the statute even if it does not address licensure status at all; it need only indicate, or tend to indicate, that the person is practicing architecture in Oregon."

". . . When the principals have not submitted an application for registration in Oregon, they are not qualified to practice in Oregon and, therefore, when they make claims of pending licensure in conjunction with advertising architectural projects that they have undertaken in Oregon, they violate [Oregon law]."

Entry Standards

Would-be contractor can't meet experience requirement by hiring contractor

Issue: Standards for meeting experience requirements

The Commonwealth Court of Pennsylvania, in a July 7 ruling, upheld a decision by the city of Philadelphia to deny an electrical contractor license to a man who had completed training and certification, but instead of finding apprentice-like employment with a licensed electrical contractor, had hired contractors and worked alongside them as they taught him the trade. (*In re City of Philadelphia*).

In April 2015, the Philadelphia Department of License and Inspection rejected Nikolaos Tsiakanikas's application for an electrical contractor's license. Tsiakanikas appealed, while filing another application in July 2015. Before the city's Board of License and Inspection Review, the city stated that it was going to reject Tsiakanikas's application on the grounds that he did not have sufficient experience in the field.

Although Tsiakanikas supplied evidence of nine years' experience working alongside electrical contractors, the Department rejected the documentation of that experience, saying that Tsiakanikas had not provided documentation that he was employed by electrical contractors during the relevant time.

Tsiakanikas explained that, as a general contractor, he had hired several electrical contractors to work with him and show him the trade, allowing him to work alongside them as they practiced. Unfortunately, this meant that Tsakanakis himself had not had much formal employment as an apprentice in the field.

A board inspector testified that W-2 employment forms were required for all applicants, although he could not point to a specific regulation where the requirement was codified.

The review board found for Tsiakanikas, stating that the evidence of experience he supplied was reliable, holding that he had satisfied the requirements for the issuance of an electrical contractor's license, and noting that the Department had not cited any regulation that would require Tsiakanikas's experience to be documented by W-2 forms.

The city appealed, and a trial court overturned the Board's decision on the ground that the licensing requirements require an applicant to have been employed to perform electrical contracting work, not hire an electrical contractor

and work with that person, as Tsiakanikas had done. Tsiakanikas appealed, and the case went up to the Commonwealth Court of Pennsylvania.

The Court upheld the lower court's decision, holding that the board was in error when it granted Tsiakanikas's appeal. The section of code dealing with electrical contractor experience requirements states that "The applicant shall have a minimum of four years of practical experience gained while employed in electrical work."

The meaning of "employed" in this sentence was the key to the case. Although Tsiakanikas had argued that "employed" should be interpreted in a broad, general sense that included his relationships with the general contractors from which he learned, the court disagreed, concluding that the code required a traditional employer-employee relationship while the relevant contracting experience was being obtained.

"While no proof of the payment of wages was required to establish such a relationship, there was no evidence that either [of the electrical contractors Tsiakanikas worked with] had the right to select Application as an employee or to discharge him from employment."

The trial court's order rejecting Tsiakanikas's application was upheld.

Professional Licensing Report is published bimonthly by **ProForum**, a non-profit organization conducting research and communications on public policy, 9425 35th Ave NE, Suite E, Seattle WA 98115. Telephone: 206-526-5336. Fax: 206-526-5340. E-mail: plrnet@earthlink.net Website: professionallicensingreport.org Editor: Anne Paxton. Associate Editor: Kai Hiatt. ISSN 1043-2051. Listed, Legal Newsletters in Print.

Subscriptions, which include both printed and PDF copies of each issue, are $198 per year, $372 for two years, $540 for three years, $696 for four years. Online access to PLR content is included in the subscription price; online-only subscriptions are $179 per year. Additional print subscriptions for individuals (within the same physical office or board only) are $40 each per year and include a license to distribute a PDF copy to a single person. Licenses to distribute extra PDF copies only, to individuals within the same physical office or state licensing board, are $15 per recipient per yea