

MINUTES

MONTANA SENATE
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By Senator Tom Hager, on March 10, 1989, at
1:00 p.m., Room 410, State Capitol

ROLL CALL

Members Present: Senators Tom Hager, Chairman; Tom
Rasmussen, Vice-chairman; J. D. Lynch, Matt Himsl, Bill
Norman, Harry H. McLane, Bob Pipinich

Members Excused: None

Members Absent: None

Staff Present: Tom Gomez, Legislative Council
Dorothy Quinn, Committee Secretary

Announcements/Discussion: None

HEARING ON HOUSE BILL 437

Presentation and Opening Statement by Sponsor: Budd Gould,
Representative from House District #61, stated that he
is presenting two bills today. He stated that with his
personal experience of being a diabetic, the second
most important doctor to him is his podiatrist. Foot
care is extremely important to a diabetic. It is
vitally important that he go to a well-educated
podiatrist who has the ability to take care of his
feet. He believes the bills are self-explanatory, and
bring Montana law into conformity with what our
surrounding states have in effect.

List of Testifying Proponents and What Group they Represent:

Loren L. Rogers, D.P.M., Montana Podiatric Medical
Association
James Clough, D.P.M., Montana Podiatric Medical Assoc.
Cleveland C. Smith, D.P.M., Podiatric Association
Mona Jamison, Montana Chapter, Physical Therapy Assoc.
Scott De Mars, D.P.M., Montana Podiatric Medical Assoc.
David B. Huebner, Montana Podiatric Medical Associates
Matt Fettig, D.P.M., Montana Podiatric Medical Assoc.
Rick Tucker, Montana Podiatric Medical Assoc.
William C. O'Reilly, D.P.M., Montana Podiatric Medical

Association

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Loren L. Rogers, D.P.M., podiatric practitioner in Missoula for the past 15 years, stated he is past president of the Montana Podiatric Medical Association, represents the Northwest Region #7 of the National Podiatric Medical Association, past member of Board of Podiatric Medical Examiners and presently serves on the American Podiatric Medical Association House of Delegates and on the standing committee of Health and Welfare. He stated he is in support of HB 437. He read and presented written testimony to the committee which discussed four areas of consideration. (Exhibit #1)

Dr. James Clough from Great Falls stated he is the Secretary-Treasurer for the Montana Podiatric Medical Association speaking as a proponent for House Bill 437. He stated that all of his colleagues present today and he have received extensive training in the care of foot problems. He read and presented his written testimony to the committee (Exhibit #2).

Dr. Cleveland C. Smith, Helena, stated that his colleagues had said it well, and he believes they have no opposition as they did in the House. Therefore, he let his colleagues' words speak for him.

Mona Jamison, representing the Montana Chapter of the American Physical Therapist Association, stated they support this bill and think it is reasonable and that the statute must be changed. She urged passage of HB 437.

Dr. Scott DeMars, a podiatric practitioner from Billings, stated he is in agreement with his colleagues. He stated he is the newest podiatrist in Montana, practicing since November, and found it frustrating to come to Montana and find he cannot fully utilize his training. He submitted written testimony to the committee (Exhibit #3).

Dr. David B. Huebner, podiatrist practicing in Great Falls, stated he wished to express his support for HB 437. For the sake of expediency he added he supports the comments made by his colleagues in relation to this bill, and he feels that it will be in the best interest

of uniform podiatric care in the state of Montana if this bill is passed.

Dr. Matt Fettig, a podiatrist practicing in Billings, Montana, stated he is in support of HB 437. He stated he has practiced in the state for approximately one and a half years, coming from San Antonio, Texas. He found it somewhat frustrating in that he was one of 500 residents that trained in a multi-discipline environment; therefore, his expertise and training in surgical as well podiatric foot care was somewhat limiting without the hospital environment to work in conjunction with everyone. He feels this bill is in the best interest of their patients and they have patients who need the other multi-disciplines.

Rick Tucker, representing the Montana Podiatric Medical Association, stated that based upon his close association with Dr. James Clough, and a careful examination of HB 437 and HB 438, he is in favor of both bills being passed.

William Charles O'Reilly, D.P.M., of Billings, stated he is very much in favor of HB 437. He read and submitted his written testimony to the committee (Exhibit #4).

Questions From Committee Members: Senator Himsl asked how many podiatrists are in the state. He was informed there are approximately fifteen at the present time.

Senator Norman asked if the Board of Medical Examiners supports HB 437. He was informed that Dr. Hamill supports the bill. Senator Norman then asked why the bill is needed. He was informed that it is an antiquated bill which says a podiatrist cannot amputate a toe. By not allowing a broad scope of practice, the current law is a limitation on their scope of training. Senator Norman and Dr. Rogers entered into a discussion regarding the definition of the anatomical foot. Senator Norman then asked why the Board of Medical Examiners cannot do this by rule. He stated there are physicians, public, podiatrists, etc. on the Board to make such definitions. Dr. Cleveland Smith stated it was his understanding that the existing law was limiting. Senator Norman stated it was not limiting - it says "human foot". Dr. Clough stated that the present law as it defines human foot, is interpreted as meaning anatomical foot. They do proceedings on the foot which are affected by the function of the lower leg muscles. Dr. Norman and Dr. Clough engaged in a technical discussion regarding foot and leg muscles. Dr. Clough stated their intention in the bill did not

include treatment above the knee.

Senator Hager stated that it was pointed out by staff that in 1987 the language "may not amputate the human foot or toe" was inserted. He asked if any here present were involved with that amendment.

Dr. Fettig advised that when he came to Montana to practice, his role was not totally defined. He stated the word limitation indicates there is a boundary line. The word scope means it is within an encompassing factor. Therefore, they are asking that the wording be changed from limitation to scope. He further stated the words "anatomical" and "functional" are in a grey zone.

Senator Rasmussen noted that on Page 1, lines 13, 14 and 15, the definition of podiatry is stricken. He asked why that was done. Dr. Smith replied that the list was stricken to allow for technological advances, such as lasers; if such an advancement was not listed, they could not use since it could be questioned legally.

Senator Hager asked if this was model legislation, or did an attorney draw up this bill. Dr. Smith stated it closely follows the Washington bill and the national effort. Senator Hager added that by striking the definition of podiatry in 37-6-101, further parts of the law have been affected that rely on that definition. Dr. Smith stated that later in the law it is stated that podiatrists are allowed to practice by all systems and means, and they believed the language was redundant. Senator Hager said he would have the staff review it further.

Senator Norman stated that without a definition of podiatry they have no definition of who they are in this state.

Senator Hager stated the bill would require some further work.

Closing by Sponsor: Representative Budd Gould stated that in 1987 Attorney John Poston provided information to him to turn into the Legislative Council to be drafted for the Board of Medical Examiners, and they felt the term "scope" should be the terminology. Dorothy Cody carried the bill in 1987.

Hearing closed on House Bill 437.

HEARING ON HOUSE BILL 438

Presentation and Opening Statement by Sponsor: Budd Gould,

Representative from House District #61, stated he is the sponsor for HB 438. This is an act that would prohibit a hospital, except a hospital that employs its medical staff, from denying staff membership or privileges to osteopaths and podiatrists because they are not medical doctors.

List of Testifying Proponents and What Group they Represent:

Loren Rogers, D.P.M., Montana Podiatric Medical Association
James Clough, D.P.M., Montana Podiatric Medical Associates
Dr.. Cleveland C. Smith, Podiatry Association, Helena
Dr. Scott DeMars, Montana Podiatric Medical Assoc.
Rick Tucker, Montana Podiatric Association
Jerry Loendorf, Montana Medical Association
William Charles O'Reilly, D.P.M., Billings
Matt Fettick, Billings
Dr. David Huebner, Montana Podiatric Medical Associates

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Loren Rogers, Montana Podiatric Medical Association, distributed a handout for the committee's information concerning hospital privileges for podiatrists. (Exhibit #5). He said he stands in favor of HB 438. He believes this bill is needed because many hospitals in Montana have not addressed incorporating podiatric physicians and surgeons on their staffs. He read and presented his written testimony to the committee (Exhibit #6).

Dr. James Clough, Great Falls, said he is speaking as a proponent for HB 438. He believes a well qualified podiatrist should be given the same considerations as any other independent practitioner. He read and presented his written testimony to the committee (Exhibit #7).

Dr. Cleveland C. Smith, Helena, stated he is in support of HB 438.

Dr. Scott DeMars, Billings, stated that he believes the bill has been described fairly well and he urged support of HB 438. He presented written testimony (Exhibit #8).

Rick Tucker, representing Montana Podiatric Medical

Association, stated that group supports HB 438. He added that even though the credentialling portion of this bill as well as the credentialling process for podiatrists in general broadens their scope of practice, they still cannot perform those particular functions for which they are not trained or qualified to do.

Jerry Loendorf, representing the Montana Medical Association, stated that his group supports HB 438. It prohibits discrimination against podiatrists solely on the basis of licensing. However, it still allows hospitals to treat such persons the same as it does all other physicians or health care personnel applying for privileges in a hospital, with the hospital considering education, training, experience and the record of each of those people in determining what the scope of their privileges should be. He believes that virtually all doctors who apply for privileges in a hospital never receive complete privileges in the sense that they can do everything their license would allow them to do. He believes this is a good bill, and the AMA supports it.

William Charles O'Reilly, D.P.M., Billings, stated he was in favor of HB 438. He stated when he arrived in Billings, he applied to the two area hospitals, one of which gave him privileges and the other did not. His credentials in applying were the same for both hospitals. He believes there are some examples of discrimination. In his situation it did not make a great deal of difference except for the fact that some patients preferred one hospital over the other. He also pointed out that if he had moved to a community with only one hospital, he might have been in a worse situation.

Matt Fettig, a podiatrist from Billings, stated he wished to go on record as being in favor of HB 438.

Dr. David Huebner, Great Falls, stated he was appearing as a proponent for HB 438.

Donna Aline, P.T., did not testify but presented written testimony in favor of HB 437 and HB 438. (Exhibit #9)

Questions From Committee Members: Senator Himsl asked if this bill was passed, would that preclude the hospital from not allowing someone to practice. Dr. Rogers stated this would only preclude the hospital from denying an application to apply to that hospital. Once the application is received, then the credentialling process within that facility has the ability to

determine if that individual is trained adequately to have privileges at that institution.

Senator Norman voiced a concern that some group might come in and attempt to override staff by-laws and place themselves on the staff. The only protection people have in a hospital is that the staff is accountable. Dr. Rogers advised that the only people who are qualified under this amendment are people with the designation of physician or surgeon. The only people involved in this type of licensure are the people who do have a requirement of one additional post graduate year of training. He added that the bill basically asks that applications be accepted, considered fairly, and the determination is made by the hospital staff through their credentialing process.

Closing by Sponsor: Representative Budd Gould thanked the committee for their time.

DISPOSITION OF HOUSE BILL 438

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 252

Presentation and Opening Statement Oby Sponsor: Chairman Hager announced that he received word that Representative Wilbur Spring, Jr., sponsor of HB 252, was being hospitalized this afternoon so Mr. Loendorf agreed to carry the bill. Jerry Loendorf, representing the Montana Medical Association, advised that HB 252 is a housekeeping bill. The amendment is contained on Line 25, Page 1; lines 1 and 2 of Page 2, and it changes the name of the organization that approves accupuncture school graduates from the American Medical Association to the National Accreditation Commission for Schools and Colleges of Accupuncture and Oriental Medicine. The reason for that change is the AMA does not approve accupuncture schools whereas that national commission does.

List of Testifying Proponents and What Group they Represent:

Patricia Englund, Attorney, Board of Medical Examiners

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Patricia Englund stated that the Board of Medical Examiners support HB 252, and request the committee's favorable consideration.

Questions From Committee Members: None

Closing by Sponsor: Mr. Loendorf closed without further comments.

DISPOSITION OF HOUSE BILL 252

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 253

Presentation and Opening Statement by Sponsor: In the absence of Representative Wilbur Spring, Jr., sponsor of HB 253, Jerry Loendorf advised that HB 253 was also a bill requested by the Board of Medical Examiners. It amends the section of law that defines unprofessional conduct for purposes of the practice of medicine. It adds 14 additional activities to that section that would be included as unprofessional conduct. He believes they are presented in a straightforward manner and do not need explanation.

List of Testifying Proponents and What Group they Represent:

Patricia Englund, Attorney, Board of Medical Examiners
Dr. Don Harr, Executive Committee of the Montana
Medical Association

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Patricia Englund stated that the Board of Medical Examiners does support HB 253 and requests the adoption of it.

Dr. Don Harr, Billings, stated he would like to state that the field of medicine so often is held accountable for matters that arise involving a few individuals whereas the Board of Medical Examiners and medicine in general do not have any legal means of doing anything in regard to maintaining the safety of the community and the practice of medicine. Therefore, he stated he wished to support this bill and asked the committee to recommend passage.

Questions From Committee Members: Senator Norman asked why the Board of Medical Examiners does not do by rule what this bill attempts to do.

Ms. Englund stated that the Medical Practice Act defines unprofessional conduct by statute. Some of the other Practice Acts say that the Board has the power to discipline its licensees for unprofessional conduct, as defined by rule. However, that is not how it was originally set up. It was originally set up in the Practice Act and therefore, when additional kinds of violations begin to come to the Board's attention and a number of the issues addressed in this bill have come to the Board's attention in the form of consumer complaints or hospital information, etc., the Board would be powerless to act on the basis of the definition of unprofessional conduct that it presently contains.

Senator asked if with each additional complaint would there be another statute. Ms. Englund replied that when the Practice Act was enacted, it was apparently deemed wise to define by statute what was unprofessional conduct rather than give the Board discretion to change the standard on a more ready basis, which would be by rule.

Senator Himsel asked how much of a problem is there in this area. Ms. Englund advised that in the last nine months the Board has approximately 20 license discipline cases. There are other cases that are being prosecuted which may mean more severe penalties. The Board is actively and aggressively pursuing bad conduct at this stage.

Closing by Sponsor: Jerry Loendorf closed without additional comments.

DISPOSITION OF HOUSE BILL 253

Discussion: None

Amendments and Votes: None

Recommendation and Vote: Senator Himsl moved that HOUSE BILL 253 BE CONCURRED IN. Senators in favor, 6; opposed, 0. MOTION PASSED UNANIMOUSLY.

Senator Himsl will carry HB 253 to the Senate floor.

EXECUTIVE ACTION ON HOUSE BILL 252

Chairman Hager called for action on HB 252: Senator Hager advised that HB 252 is an act designating the national Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine as the entity authorized to approve schools of acupuncture.

Discussion: None

Recommendation and Vote: Senator Himsl moved that HOUSE BILL 252 DO BE CONCURRED IN. Senators in favor, 6; opposed, 0.

Senator McLane will carry HB 252 to the floor of the Senate

EXECUTIVE ACTION ON HOUSE BILL 102

Chairman Hager called for action on HB 102: Chairman Hager stated HB 102 was a bill permitting a regional mental health corporation board to set a fee schedule for mental health services if the Department of Institutions does not respond within a certain period to a request for a fee change.

Discussion: Senator Hager asked if there were some amendments for HB 102. Tom Gomez advised that the Department of Institutions had prepared some amendments for HB 102. Copies of the amendment were distributed (Exhibit #10). Senator Rasmussen suggested that Curt Chisholm, Director, Department of Institutions, explain the amendment. Mr. Chisholm stated the amendment strikes the 30-day language. He advised that when the bill first surfaced in the house, there was concern about it because there was a proposal by the mental health centers to get the Department out of approving their rates. There have been some adversarial

positions taken between the Department and mental health centers. The main issue was the time frame, with the mental health centers suggesting the Department have 30 days to review a proposed set of rates. However, when the bill was heard before this Committee, he stated the issue was no longer "time"; it was regulation. He stated the Department wished to keep regulation to a minimum; however, the Department does grant the centers over \$5,000,000 in public funds, and at the same time they take in about \$2,500,000 worth of Medicaid funds. Mr. Chisholm believes the Department needs to intervene at times and encourage the centers to establish uniform methods of determining ability-to-pay. Currently a family with a gross income of \$80,000 or less can get subsidized care in Region 1, whereas in Region 2 or 5 if a family has an income higher than \$27,000, they cannot get subsidized care. He stated the regional mental health centers are being asked to establish a uniform method of determining who gets an ability-to-pay and who does not. He stated the Department does not wish to establish their rates.

Dr. Harr, Region 30 Mental Health Centers, advised that the Mental Health Centers are certainly not in opposition to the matter of the state being involved in whatever subsidizing occurs in their contract with the state. The contract with the State Department of Institutions establishes the amount that the state will pay for a specific service. Their concern was, as stated by Mr. Nesbo, of the South Central Montana Regional Community Mental Health Center, that the private, not-for-profit corporations be allowed to establish the fees as would be appropriate for individuals in those areas. He stated that in Region 3, because of the loss of certain monies having to do with their contract with the state, it was necessary to increase some of their fees as far as private payers and third party payers were concerned, but for those areas in rural distribution where there is not the ability to pay more, they did not increase those fees. They are in agreement with the amendments as they have been presented and they support HB 102.

Recommendation and Vote: Senator Rasmussen made a MOTION THAT THE AMENDMENTS BE ADOPTED. Senators in favor, 4; opposed, 3. MOTION PASSED, AMENDMENTS ADOPTED.

Senator McLane made a MOTION THAT HB 102 BE CONCURRED IN AS AMENDED. Senators in favor, 7; opposed, 0. MOTION PASSED UNANIMOUSLY.

Senator Norman will carry HB 102 to the floor of the Senate.

EXECUTIVE ACTION ON HOUSE BILL 197

Chairman Hager called for action on HB 197: This bill is an act to revise the procedure for the voluntary admission of minors to a mental health facility.

Discussion: Upon a request from Senator Lynch, Tom Gomez explained the amendment as it applied in the procedure of voluntary admission of a minor. He stated the amendment provides that the minor has a choice of individuals whom he might contact to discuss the meaning of his/her action in consenting to the admission or discharge, and that the mental health facility shall provide access to such agency or person. Copy of the amendments is attached (Exhibit #11).

Senator Lynch questioned why this amendment was not added in the House.

Senator Pipinich stated he wondered why the parent or guardian would not be notified. Senator Norman stated he believed they are addressing the concern of those whose situation cries for some third party to come in and sit down and really talk to the youngster.

Senator Hager stated that as he understands it, they put the rights of the minor in the law.

Senator McLane stated he believed the amendments needed further study.

Recommendation and Vote: Senator Norman made a MOTION THAT HB 197 BE PASSED FOR THE DAY FOR FURTHER CONSIDERATION. Senators in favor, 5; opposed, 0. MOTION PASSED.

EXECUTIVE ACTION ON HOUSE BILL 437

Chairman Hager called for action on HB 437: Senator Hager stated that HB 437 is an act revising the laws governing the practice of podiatry by defining the scope of podiatry practice.

Discussion: Senator Hager advised there are amendments to this bill. Tom Gomez explained these were technical amendments to try to clarify this bill. The first amendment defined "Podiatry". A copy of the amendments are included (Exhibit #12).

Recommendation and Vote: Senator Norman made a MOTION THAT THE AMENDMENTS FOR HB 437 BE ADOPTED. Senators in favor, 6; opposed, 0. AMENDMENTS ADOPTED.

Senator Rasmussen made a MOTION THAT HOUSE BILL 437 BE CONCURRED IN AS AMENDED. Senators in favor, 6; opposed, 0.

Senator Rasmussen will carry HB 437 to the floor of the Senate.

EXECUTIVE ACTION ON HOUSE BILL 438

Chairman Hager called for action on HB 438: Chairman Hager advised that HB 438 is an act to prohibit a hospital from denying staff membership or privileges to osteopaths and podiatrists because they are not medical doctors.

Discussion: None

Recommendation and Vote: Senator Rasmussen made a MOTION THAT HOUSE BILL 438 BE CONCURRED IN. Senators in favor, 6; opposed, 0. HB 438 IS CONCURRED IN.

EXECUTIVE ACTION ON HOUSE BILL 654

Chairman Hager called for action on HB 654: At the request of Senator Rasmussen the status of HB 654 was discussed. This bill would require certain liquor licensees to display a sign on the premises that warns of the effects of drinking alcohol during pregnancy. Senator Hager informed that HB 654 was tabled by a vote of 4 to 1 on March 3, 1989.

Discussion: Senator Pipinich stated he would not vote in favor of that bill because he believes it is unfair for the Department of Health to force tavern owners to post signs telling women not to drink. He believes the responsibility of informing lies with the doctors and with husbands, not with the Tavern Association.

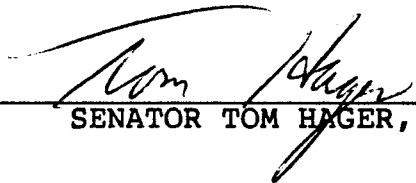
Senator Hager stated it was his understanding that sometime this summer Federal legislation will come into effect that requires notice of warning to pregnant women on containers of alcohol.

Recommendation and Vote: Senator Rasmussen made a MOTION THAT THE COMMITTEE'S ACTION ON HB 654 BE RECONSIDERED. Senators in favor, 1 (Rasmussen); opposed, 5. MOTION

FAILED.

ADJOURNMENT

Adjournment At: 2:45 p.m.



SENATOR TOM HAGER, Chairman

TH/dq

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SENATE STANDING COMMITTEE REPORT

March 13, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 437 (third reading copy -- blue), respectfully report that HB 437 be amended and as so amended be concurred in:

Sponsor: Gould (Raemussen)

1. Page 1, line 16.

Following: line 15

Insert: "(1) "Podiatry" means the diagnosis and treatment of ailments of the human functional foot as provided in 37-6-102."

Re-number: subsequent subsections

2. Page 1, line 17.

Following: "to"

Insert: "diagnose and"

Following: "of the"

Insert: "human functional"

3. Page 1, line 24.

Following: "may"

Insert: "diagnose and"

AND AS AMENDED BE CONCURRED IN

Signed: _____

Thomas O. Hager, Chairman

4.0.154
3/13/89
11.0.22

SENATE STANDING COMMITTEE REPORT


March 10, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 438 (third reading copy -- blue), respectfully report that HB 438 be concurred in.

Sponsor: Gould (Rasmussen)

BE CONCURRED IN

Signed: 
Thomas O. Hager, Chairman

Handwritten notes:
4/10/89
2:21 p.m.

SENATE STANDING COMMITTEE REPORT

March 10, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 252 (third reading copy -- blue), respectfully report that HB 252 be concurred in.

Sponsor: Spring, Jr. (McLane)

BE CONCORRED IN

Signed: _____

Thomas O. Hager
Thomas O. Hager, Chairman

SENATE STANDING COMMITTEE REPORT

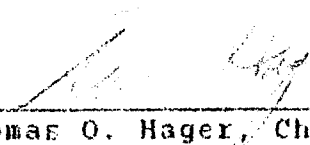
March 10, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 253 (third reading copy -- blue), respectfully report that HB 253 be concurred in.

Sponsor: Spring, Jr. (Hims1)

BE CONCURRED IN

Signed: 
Thomas O. Hager, Chairman

*H.C. 11
2/10/89
2:21 p.m.*

AN ACT REVISING THE LAWS GOVERNING THE PRACTICE OF PODIATRY, DEFINING THE SCOPE OF PODIATRY PRACTICE; AND AMENDING SECTIONS 37-6-101 AND 37-6-102

EXHIBIT NO. #1
DATE 3/10/8
BILL NO. 437

1. Revise the language to meet the current practice and education levels of present and future podiatrists.
2. Clarify the 'scope of practice' and the definition of the 'functional foot'.
3. To allow the full scope of practice relating to the continued educational improvements, and understanding of the functional foot.
4. To insure the public the delivery of 'all inclusive' foot care, by the most intensively trained in the specialty of foot care.

1. This revised language is continually in need of updating due to the astounding rate at which medical advancements are being made. When the initial practice act was written, much of the medical technology and diagnostic tools used by today's practicing podiatrists had yet to be developed. Our profession is continually up-grading its' educational base both at the graduate and post-graduate level, and will certainly continue to do so well into the future. To require modern podiatric physicians and surgeons to practice within the letters of educationally out-dated laws is limiting to the publics well-being.

While it may be argued that a revision of the existing law will allow an extreme expansion in the boundries of the body in which a podiatrist may practice, it MUST be pointed out that the 'functional human foot' is not an isolated entity in and of, itself. It is a complex functional unit of extreme intricacy that has as many, or more, muscles originating in the lower leg (below the knee) as it does within the foot itself. (NOTE: Chart on blue page)

Some may argue that with the revised law, podiatrists may be tempted to perform vascular, nerve, or other highly skilled procedures in the lower leg. While conceivably this is true, our present system dictates that a physician and surgeon of any specialty must undergo training, credentialling, proctoring, and the on-going process of peer-review in any hospital setting.

Another argument that may arise is that podiatric practitioners may perform some of the beforementioned procedures in his (or her) own office. We would suggest that this line of reasoning is totally without merit. Due in part, to the highly technological equipment which is required.

2. The clarification of the 'scope of practice' again, is to eliminate the continual need to modify the existing laws as technological advancements dictate.
3. The definition of the 'functional foot' is a necessary revision, not only to insure that the most inclusive and definitive treatment is rendered to the foot, but to allow existing expertise to be rendered without creating a "grey area", (a legal language trap), with the possibility of misinterpretation by the legal community. Thus, allowing the professional liability companies the ability to defend the podiatrist, without limitations.
4. 80% of Americans will some day require foot care. In the interest of this public, the profession wishes to be unencumbered by the antiquity of the existing laws, and to be allowed to deliver the most advanced medical care and technology, by the most intensively trained in the specialty of feet.

of the foot during this time, causing some supination around the midtarsal joint axes. M. flexor digitorum longus has some inconsistent activity during this phase, probably related to helping M. tibialis posterior decelerate subtalar joint pronation (Fig. 2.10).

Summary of Contact Phase

The important elements occurring during contact phase are: (a) sagittal plane shock absorption by knee flexion and ankle joint plantarflexion, (b) absorption of internal leg rotation through subtalar joint pronation, and (c) smooth transfer of body weight onto the contact limb.

Midstance

This is the portion of the gait cycle from 15% until the heel comes off the ground at 40%. The opposite foot has left the floor, and it is necessary for the body to maintain its balance over the single supporting limb and continue smooth progression of the center of gravity forward.

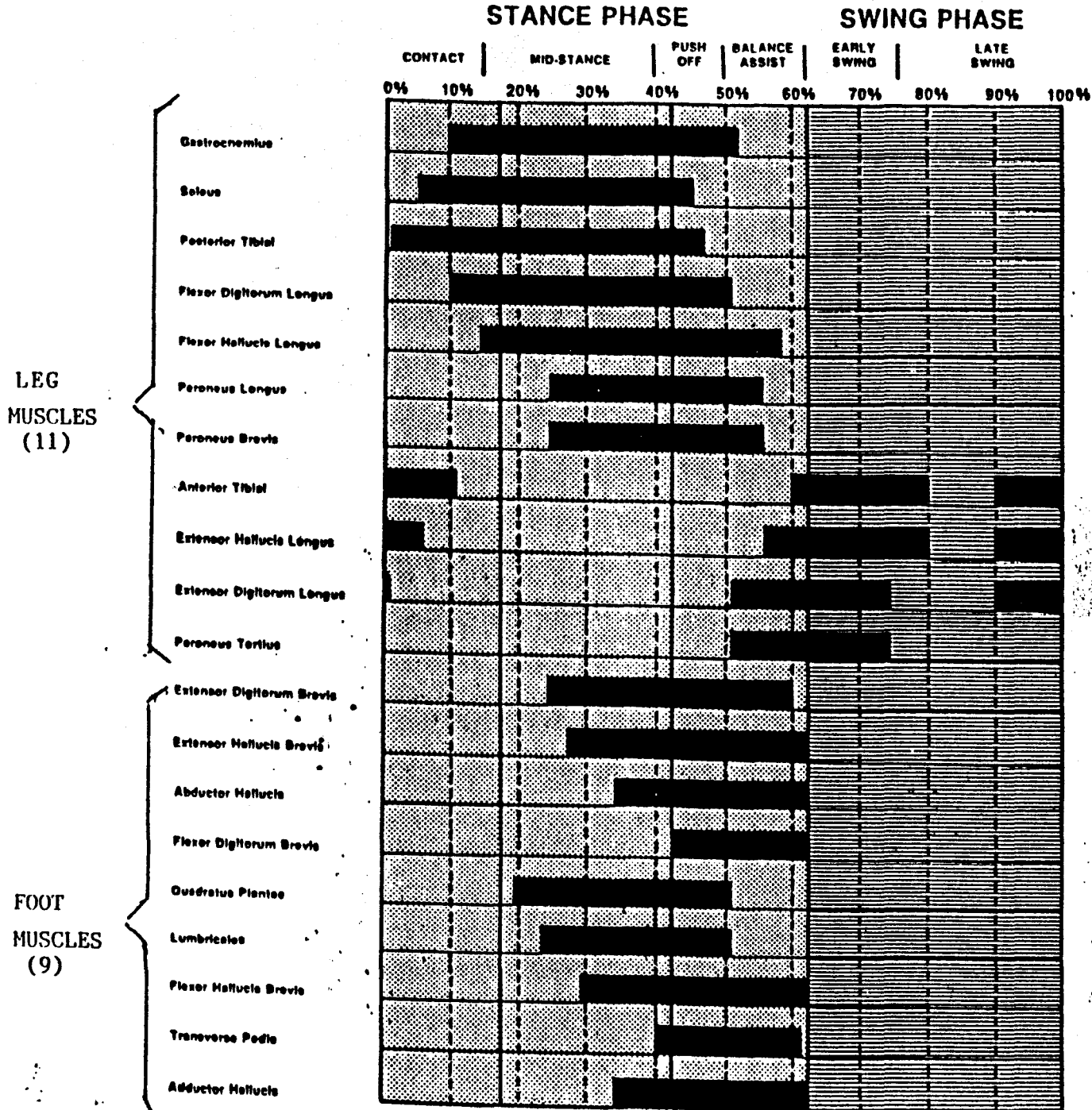


Figure 2.10. Phasic muscular activity. Graphic representation of muscular activity related to gait cycle.



MONTANA PODIATRIC MEDICAL ASSOCIATES, P.C.

Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

BILL 437

James G. Clough, D.P.M.
David B. Huebner, D.P.M.

SENATE HEALTH & WELFARE

EXHIBIT NO. #2

DATE 3/10/89

BILL NO. #437

I, like many of my colleagues present today, have received extensive training in the care of foot problems. We have four years of college, then podiatry school where the four year curriculum deals extensively with the human foot. Many of us, like myself, have also had postgraduate training in the surgical management of foot pathology. Our training is comprehensive relative to the management of foot problems. When different specialists are necessary for proper management, they are available and consulted. We work with a team approach, attending to the best interests of our patients.

The law, as it presently reads, does not allow modern podiatric practice which is consistent with our training. The two orthopedic surgeons whose testimony has been submitted can attest to this.

Credentialling of individual practitioners will continue to be the function of the hospitals where podiatrists are working. It is unreasonable to assume, for instance, that complex neurovascular surgery would be attempted by a podiatrist outside of a hospital environment due to the inconceivable equipment investment and liability. Hospitals will continue to control the podiatrist based on their education, training, experience, and demonstrated competence as they judge all other practitioners. Most M.D. and D.O. practitioners do not have the same limitations as posed to podiatry. Their licenses are unlimited in their scope. However, most limit their scope of practice because of their training and expertise. The same can be expected of podiatry.

I am sure it is no ones intention to prohibit a practitioner from practicing as he or she is trained. Unfortunately, this is the current situation.

I personally see this bill as having only a positive effect on podiatric patients and hope you have the same feeling. In the publics best interest I hope you will support this bill.

James G. Clough, D.P.M.

JGC:cms

SENATE HEALTH & WELFARE
EXHIBIT NO. # 3
DATE 3/10
BILL NO. HB 437

SCOTT G. DEMARS, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
926 MAIN STREET, SUITE 8, BILLINGS, MONTANA 59105
(406) 245-8122

March 8, 1989


Senate Committee on Public Health,
Welfare, and Safety

RE: Bill #437 Legislative change for the Montana Podiatric
Practice Act. Defining the scope of podiatric medical
practice.

This bill defines the scope of practice for a podiatrist (the
physician or surgeon treating disorders of the human functional
foot) by all systems and means. This will allow any properly
licensed podiatric physician in the state of Montana to treat
all disorders of the anatomical foot as well as any structure
directly attached to the foot which effects the foots function.
This treatment may be done by any system or means for which the
individual podiatrist is qualified to perform based on his or
her training. Many podiatrists, myself included, have completed
a hospital based surgical residency program and under the current
scope of practice law we are unfairly limited in how we may treat
the foot. This bill would allow us to fully utilize our training
and provide the best possible care to our patients.

Thank you for your support of this bill.

Sincerely,


Scott G. DeMars, DPM
rd

W. C. O'REILLY, D.P.M.

Podiatrist - Foot Specialist

SENATE HEALTH & WELFARE

EXHIBIT NO. #4

DATE 3/10

BILL NO. 437

COMMENTS ON THE PRACTICE ACT OF PODIATRY

Presently, the Practice Act reads "Podiatry means the diagnosis, medical, surgical, mechanical, manipulative, radiological, and electrical treatment of ailments of the human foot." The present Act will simplify the statement in stating that a podiatrist may treat ailments of the human functional foot by all systems and means. The Bill goes on and describes what the "functional foot" consists of. This Bill will help in some of the gray areas regarding the practice of podiatry. An example would be the repair or the lengthening of the Achilles tendon, in certain surgical procedures. It is my hope that the decision as to whether a podiatrist is able to perform this foot surgery, is based on his training rather than being left to a questionable area of whether it is foot surgery or leg surgery. There is a second incentive that I have for passage of this Bill. This second incentive is the future recruitment of well trained podiatrists for the Montana people. It is difficult to recruit an individual to Montana when he will not be able to practice his acquired skills to the full amount. Other states with different practice acts, then become more desirable.

It is my hope that with passage of this Bill, we will be able to recruit well trained podiatrists to Montana in the future. In addition, I would hope that the ability of an individual to perform a given foot surgery will be determined by his training and credentials and that gray areas within the Practice Act of Podiatry, can be eliminated.



W. C. O'Reilly, D.P.M.

WCO/jkl



Hospital Privileges and the Joint Commission

Dennis S. O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations, a prestigious and powerful group long held as the pinnacle of quality assurance of hospitals, dispels some myths about the commission's power to break down the barriers to full hospital privileges for podiatrists. Executive editor Judith A. Rubenstein conducted the telephone interview on December 2. An edited transcript follows.

What are the chief obstacles podiatrists face in gaining full hospital privileges?

Probably, more than anything else, it's human resistance to change. You have a lot of practitioners and a lot of healthcare organizations who have been through a pretty tough decade of change, almost all of which they had no control over. Throw one more piece of change on their plate and they get their backs up—that's human nature. I think podiatry has a pretty current successful track record in establishing itself within hospital settings. That doesn't mean a perfect world has been achieved, but a lot of physicians out there don't think a perfect world has been achieved relative to their practice in hospitals either.

And the key levers for change? In other words, who are the roadblocks?

The roadblock is resistance to change which comes from people—they are all human beings. They're saying, "We've been through enough here."

In setting up criteria for specialty care, cross specialty conflicts are likely to arise. What possible solutions to these conflicts do you propose?

I still think that the credentialing and privileging process has the capacity to address cross-specialty conflicts. It is inevitable that territorial issues will arise between specialties, particularly when you get down to the privileges process. But

there are various kinds of independent, valid ways that an individual demonstrates his or her competence. That doesn't require identical training or experience.

There should be ways to satisfy the medical staff in telling them that this individual is qualified to do a, b, or c. You either have gone through good training, specialty training following graduation, or have a lot of experience in doing something and someone else is willing to testify to that. Sometimes when an individual is reviewed, there remains some doubt in the minds of the medical staff. Then the logical thing would be to allow the individual to do it, but under supervision or monitoring, so that he can be observed in performing the procedure. With observation, it can be determined if he or she is doing the pro-

Q & A

cedure well, needs more monitoring, or should not be permitted to do that procedure. It's really a common sense approach that says you shouldn't make arbitrary or capricious decisions.

Have you noticed any change in the willingness of administrators to buck internal medical staff politics to obtain full privileges for podiatrists?

I really do not have any meaningful data on that. If there's a hot issue bubbling around out there, we usually hear about it. I haven't received any correspondence either from disgruntled medical staff or frustrated administrators concerning privileges for podiatrists in a long, long time. That doesn't mean the system is working, but it doesn't mean it's not working either.

Do you think it's a dead issue?

I don't think any issue is ever dead, maybe quiescent. It may mean that the organizations are becoming more facile in the credentialing and privileging process. Or that hospitals and their medical staffs are becoming more sophisticated in their understanding of these processes, which tends to make the process more objective and a

little bit less heated. People will kill over theoretical issues, but when you get down to nuts and bolts issues, the heat tends to dissipate.

Informed sources charge that in the credentialing process, a double standard prevails, that podiatrists are held to much higher standards than orthopedic surgeons.

That's an allegation. Others may see it quite differently.

How does a hospital or the Joint Commission set meaningful standards for credentialing any specialty, podiatry included, whose practitioners are allowed to perform foot and ankle surgery?

Let's make some semantic distinctions here. We set standards relative to organization, structure, and function. Those are different from clinical standards or clinical criteria which, in accordance with our standards, we say the organization—in this case, the medical staff—must set. We expect those clinical criteria to be applied even handedly, depending on what kind of privileges we're talking about.

The criteria do differ depending upon the kind of privileges. If you take care of diabetics, you don't need surgical training,

but if you want to do surgery, you need surgical training. We require the organization to set the criteria. We expect the criteria to be used in such a fashion to ensure comparable care. It is not reasonable to expect the criteria to be identical. An orthopedic surgeon has training that is different from a podiatrist. The two types may well be comparable, but that is a judgment the hospital makes, not the Joint Commission.

Can the commission ever act to resolve conflict among specialties?

We would probably serve as a convener of a group to promote resolution of the issues. We've certainly had lots of experience doing that before. But on the front end we don't want to presume there will be conflict on every area of clinical indicator development.

Just what does the Joint Commission do?

Fundamentally, the Joint Commission has four roles. (1) Standard setter. We have been setting standards for hospitals and other kinds of healthcare organizations for about seventy years—if you include the hospital standardization program of the American College of Surgeons. The Joint Commission has always enjoyed a unique advantage as a convener. Generally speaking,

when a determination is made that it is appropriate to write new standards in a given area in order to reflect state of the art practices, we try to bring in outside experts from around the country who can speak to the standards area question. But it goes beyond that. Health professionals feel a responsibility to participate in the standards program.

(2) Evaluator. All our evaluation activities are based on our standards. However, today not all our evaluation activities lead to an accreditation decision. We conduct some evaluations under contract with third parties such as state evaluators of managed care organizations, particularly HMOs and state agencies responsible for Medicaid programs. They have an obligation to ensure that Medicaid patients are receiving good care.

(3) Decision maker. We make accreditation decisions. We evaluate against our standards, analyze our findings, and come to a conclusion as to whether the organization should be accredited, accredited with contingencies, or not accredited. Basically, amongst hospitals, one percent are accredited without contingencies, approximately one percent or more are not accredited, and ninety-eight percent are accredited with contingencies. The contingencies may range from one to many. Almost all

the ninety-eight percent successfully address their contingencies. In some cases, resolving it is relatively straightforward. About eight percent of this group enter an informal status, called tentative non-accreditation. We don't publicize it. Tentative non-accreditation means they are not performing acceptably in our view. About seven out of eight in that group resolve their problems.

(4) Educator and consultant. We work with hospitals to improve their performance, to assist them in resolving the problems they have. Our surveys have also been in part evaluation and in part consultation, suggesting ways that hospitals who are not in compliance with standards can get themselves into place and in compliance.

Is accreditation voluntary?

I don't think anybody absolutely must use our services. In that sense, anyone who comes to us for any of our services does so on a voluntary basis, but there are compelling incentives, particularly for hospitals and, to some degree, other types of healthcare organizations to seek our services. Hospital accreditation in particular is linked to the governmental regulatory process both at the federal and state levels such that the Medicare program accepts accredita-

tion as meeting the conditions of participation. We have a relationship with forty-two states that accept Joint Commission accreditation as meeting their state hospital licensure requirements. In addition, hospitals that have graduate medical education programs must be accredited by the Joint Commission. Practice insurers like to see that the institutions they insure are accredited. Some people who loan money to hospitals in particular like to see them accredited. Health insurers like to see the organizations to whom they provide reimbursement accredited. So there are many incentives for hospitals to seek accreditation. But obviously there are hospitals that are not accredited and they are doing just fine—at least some of them are.

What authority, if any, does the commission have and by whom is it empowered?

The Joint Commission is essentially a private sector, professionally based organization, not empowered by anybody. It was created by the health professionals out of a sense of responsibility to do everything possible to stimulate and promote high quality care in hospitals and, now, other health organizations as well. It gained a lot of credibility, so a number of

continued on page 64

Q & A

responsible government agencies felt the Joint Commission could do the external evaluation better than they could and came to depend upon it to do that job.

Where does its funding come from?

Basically, it is self supporting. Organizations that are surveyed pay survey fees; educational seminars are put on for a registration fee; publications and consultation services are sold. Approximately two-thirds of our revenue comes from survey fees, which, from our standpoint, is the cost of doing business. It's not unlike the annual audit that an organization goes through. There is a financial audit, this is a quality of care audit that happens to occur every three years, although we visit problematic hospitals much more frequently.

To whom is the commission responsible?

To its board of commissioners, which is made up of representatives of the five member organizations: the AMA, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the American Dental Association. Once the organization enters into certain statutory or contractual relationships, it has certain contractual obligations and accountability in terms of those relationships. This is also true in our relationships with the forty-two states and other contractual relationships, such as reviewing managed care facilities for states.

We are told that a special meeting was held last March at which a task force on anaesthesia was proposed. What is the status of that committee?

[Dr. O'Leary did not recall the specific meeting.]

Well, we were informed that the intent was to convene members of the various specialties and disciplines within the healthcare delivery system to propose better ways to deliver care to the patient populace.

Basically we said we were going to put together clinical indicator task forces and put the best people around the table, which might involve people with different background. There were no podiatrists in that anaesthesia group—and no surgeons, either.

Have you set up such task forces with

respect to podiatry and orthopedics?

Not yet.

Do you intend to?

I don't know. We had three special task forces last year: obstetrics; anaesthesia; and hospital-wide generic indicators, which cuts across all sorts of services. We created three more this year: cardiovascular, oncology, and trauma. And we have three more that are next in line: long-term care; dental health care; and general surgery. We have not picked the next grouping. I think our long-term feeling is the Joint Commission should not be the sole locus for clinical indicator development, because if that is the case, when all the clinical indicators are developed, they will be ours and that is pretty narrow. The purpose of clinical indicators is to set screens to evaluate the quality of patient care.

Then it seems the key issue is how to promote the active involvement of a variety of other professional groups and organizations for clinical indicator development.

We've learned a lot about doing clinical indicator development, but it's not so profound that only the Joint Commission can do it. The investment of other organizations becomes important because it would promote professional ownership of these indicators.

Will podiatrists be consulted and included in the development of clinical indicators on foot care?

I don't know, but that doesn't preclude the effort. Podiatrists could sit down and develop clinical indicators.

Would the Joint Commission accept them?

Yes, if they are good. We want to develop effective tools for evaluation that support the provision of high quality care. We are an advocate primarily for the patient and not an arbitrator between professional groups. If the man in the moon developed effective indicators relative to foot care, we'd probably use them.

Who would make this decision?

We have a pretty sophisticated research and development department that knows how to look at indicators. If we think they are conceptually sound, we have a basis for conceptually testing them. It is a painfully objective process.

What recommendations could the Joint Commission make to ensure that such a credentialing process is

equitable and standard for all specialties who are allowed to perform foot and ankle surgery?

I don't think anyone would ever be foolish enough to require that they be the same—only that they should be comparable. The orthopedic surgeon trains longer than the podiatrist does. It would be to the podiatrist's great disadvantage to clamor for the same criteria to be applied.

Has there been a change in the past few years?

I don't have any basis for making that kind of judgment. We're not hearing a lot of complaints and problems, in fact, virtually nothing. Our standards are appropriately permissive in that respect. Judgment is up to the hospital. If there is a conflict or an anti-trust concern, that's more likely to be resolved in the courts. I haven't even seen a lot of litigation activity in the past couple of years.

Podiatrists perform up to seventy-five percent of all the foot and ankle surgery in this country. They have a meaningful role in more than fifty percent of the hospitals in this country. Therefore, why is it that as a profession, podiatry does not have direct input into the Commission? Why isn't the profession directly involved with the commissioners in helping to establish and maintain high standards of foot and ankle care within hospitals?

The podiatrists do have input. They do sit on at least one professional and technical advisory committee, long-term care, I think. We're in communication with the podiatrists, as we are with a lot of groups.

What would be your position on non-M.D. healthcare providers within the hospital setting? Should they have privileges? Should they also have complete and full activity on the medical staff?

We define a group of people as licensed, independent practitioners. From our standpoint, those individuals are eligible to be members of the medical staff and, therefore, must be privileged. Whether or not the hospital decides to have those people on staff, or on the executive committee, or involved in the governance process is also the hospital's determination.

Thank you, Dr. O'Leary. ■

Podiatric Services in a Hospital: An Overview

By MARIE M. KIERNAN

The integration of foot care by doctors of podiatric medicine into a hospital setting has been shown to be beneficial to both the patient's well-being and the hospital's revenues. Hospital accreditation standards issued by the Joint Commission on the Accreditation of Health Care Organizations (Joint Commission) and the American Osteopathic Association (AOA) provide for the granting of active staff membership to doctors of podiatric medicine at the discretion of the individual hospital. Statutes, i.e., administrative or judicial actions providing for the nondiscriminatory treatment of the medical staff applicant, exist in the District of Columbia and more than 25 states.

There is an economic benefit to a hospital and its patients when doctors of podiatric medicine are staff members. Podiatric services are easily incorporated into the structure of a hospital. Doctors of podiatric medicine can use the existing surgical suites and equipment; thus, there is little or no initial capital expenditure on the part of the hospital.

Hospital Accreditation Standards

The 1988 standards of the Joint Commission provide that the medical staff:

"Includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital." Standard Ms.1, Required Characteristic Ms.1.1, *Accreditation Manual for Hospitals*, 1988 Edition, AMH/88.

The Joint Commission defines the licensed independent practitioner as:

"Any individual who is permitted by law and who is also permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

State law is key in determining the eligibility of the practitioner to perform patient care services independently. All states, Puerto Rico, and the District of Columbia recognize the legal authority of the doctor of podiatric medicine to perform patient care services independently within a specific scope of practice. No state or jurisdiction requires the supervision of the doctor of podiatric medicine in performing podiatric services as defined in state law. Indeed, several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the hospital medical staff, to hold clinical privileges within hospitals, and to have responsibility for patient care. Statutes exist in the District of Columbia and the states of Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The standards of the Joint Commission stress the uniform application of professional criteria for the granting of privileges:

"Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants or medical staff members constitute the basis for granting initial or continuing staff membership." Standard Ms.1, Required Characteristic Ms.1.2.

The Joint Commission standards further state that the purpose of the criteria is to assure quality patient care. The criteria should be reasonable, related to quality care, and pertain to "evidence of current licensure, relevant training and/or experience, current competence, and health status." (Standard Ms.1, Required Characteristic Ms. 1.2.3).

In July 1988, the American Osteopathic Association, the accrediting organization for osteopathic hospitals, revised the standards for staff membership and privileges in osteopathic hospitals to allow active staff membership to practitioners other than doctors of osteopathy:

"The organized professional staff must include that category of active staff membership. This category may, at the discretion of the individual hospital, be expanded to include other practitioners as indicated in Section 4 a.) (ii) and (iii) below.

a.) A doctor of osteopathy or medicine;

b.) A doctor of dental surgery or dental medicine who is licensed to practice dentistry by the state and who is acting within the scope of his or her license;

c.) A doctor of podiatric medicine, who is licensed to practice podiatry by the state and who is acting within the scope of his or her license."

The standards of the American Osteopathic Association, like those of the Joint Commission, require that membership and privileges be based on the qualifications and demonstrated ability of the applicant.

The American Podiatric Medical Association (APMA) supports the practice that the granting of medical staff membership and clinical privileges to doctors of podiatric medicine be based on the individual's education, training, experience, and demonstrated competence and judgment within the legal scope of practice for podiatric medicine. Further, APMA recommends that the credential committee of a hospital evaluate the experience and training in podiatric procedures on an individual practitioner basis. This position is consistent with that of the Joint Commission, AOA, and the American Medical Association (AMA).

The Future

The benefits of foot care by doctors of podiatric medicine to hospitals have been well documented. Recent studies by the Johns Hopkins University and ELM Services report significant cost benefits due to the doctor of podiatric medicine's lower professional charges and more efficient use of hospital ancillary services. Hospital administrators and managers have noted that podiatric physicians represent a preferred patient mix—short length of stay, low acuity, high functional outcome. And doctors of podiatric medicine are substantial users of day surgery and outpatient services. It is expected that rapid growth in the elderly population and the popularity of specific sports will create more demand for the services of doctors of podiatric medicine. Given these documented facts, foot care by doctors of podiatric medicine will become an increasingly attractive patient resource for US hospitals.

Loren Rogers

- A. The need for House Bill 438 exists because many hospitals in ~~Montana~~ Montana have not 3/10/89 addressed incorporating Podiatric physicians and surgeons on ~~their~~ staffs. 438 BILL NO.

The training and skills of the more recent podiatric physician and surgeons have advanced to the degree that their practice certainly would be limited by the denial of staff privileges. The present hospital credentialing process is very capable of judicating the proper level of privileges an applicant may be given.

The joint commission on hospital accreditation has recommended since the mid-60's the inclusion of podiatrists on hospital staffs. The present system recommends co-admission with a M.D.

- B. Some fear that other allied health professions will use similar methods to obtain privileges, this would be addressed by the fact that M.D.'s D.O.'s and D.P.M.'s are the only professions with the designation of 'Physician and Surgeon'. It should be noted that these three (M.D.'s, D.O.'s and D.P.M.'s) require a minimum of 1 year post-doctorate training, in contrast to all others licensed under title 37.

- C. Those who would oppose this bill, should realize that it is being introduced in the best interest of the public. The use of hospitals, and the inherent peer review process, is the most effective method for the medical profession to insure quality health care.

- D. We (Podiatric Physicians and Surgeons) feel that with over 50% of the states now under comparable law, and another 20% on the verge of passing similar law, it is timely for our state to follow their lead. The people of the great state of Montana deserve the BEST foot care available.



MONTANA PODIATRIC MEDICAL ASSOCIATES, P.C.

James G. Clough, D.P.M.
David B. Huebner, D.P.M.

Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

SENATE HEALTH & WELFARE
EXHIBIT NO. # 7
DATE 3/10/89
BILL NO. # 438

BILL 438

This bill is introduced to mandate hospitals to give consideration to podiatrists and for privileges and staff membership based on their training, education, experience, and demonstrated competence and judgement within the legal scope of podiatric medicine.

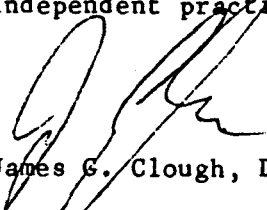
We as a group are defined as independant practitioners in all 50 states, the District of Columbia, and Puerto Rico. We also meet the Joint Commission of accreditation of hospital's definition of an independent practitioner which states, "Any individual who is permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

Several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the medical staff, to hold clinical privileges within the hospitals and to have responsibility for patient care similar to the provisions as set forth in this bill. That 28 state total includes the District of Columbia, Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The guidelines of the JCAH stress this uniform application of professional criteria for the granting of privileges. This bill certainly is not in conflict with any JCAH policy.

As a matter of fact, none of the JCAH policies would be violated by this bill. If anything, they could be made more clear to the hospitals of Montana.

The burden of credentialling individual practitioners will remain within the scope of hospital staffs. However, shouldn't a well qualified podiatrist be given the same considerations as any other independent practitioner?


James G. Clough, D.P.M.

JGC:cms

SCOTT G. DEMARS, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
926 MAIN STREET, SUITE 8, BILLINGS, MONTANA 59105
(406) 245-8122

SENATE HEALTH & WELFARE
EXHIBIT NO. #8
DATE 3/10/88
BILL NO. HB 438

March 8, 1989

Senate Committee on Public Health,
Welfare, and Safety

RE: Bill #438 Legislative change for the Montana Podiatric
Practice Act. A nondiscriminatory clause.

This bill is intended to prevent a hospital from denial of
privileges to a properly licensed physician based on his or her
degree or type of practice. Therefore, hospitals will grant
privileges based on the applicants training and qualifications.
A podiatric physician such as myself, who has completed a
hospital based surgical residency, should be given privileges
accordingly as are similarly trained physicians in other
specialities.

Thank you for your support of this bill.

Sincerely,



Scott G. DeMars, DPM
rd

Did Not See

SENATE HEALTH & WELFARE

EXHIBIT NO. #9

DATE 3/10/89

BILL NO. HB 438

Committee on Business and Economic Development

I recommend that you support House bills 437 and 438.

As a physical therapist, I work closely with the two podiatrists in Helena and feel they are outstanding medical professionals. They refer appropriately to not only physical therapists but physicians of various specialties. I am impressed with their team approach and know from experience that they practice within their scope.

Specifically addressing HB 438, I feel it is important for the public to be able to follow with their choice of medical professionals in or out of the hospital. Hospitals are under numerous regulatory systems that ensure quality care to the public and podiatrists would be required to prove quality and appropriateness of care like all services.

As a consumer I find it discriminatory that medical providers like podiatrists are excluded from our community hospital. It is our right to choose a podiatrist to perform various procedures for foot problems and I feel that it would be often more appropriate to be in a hospital for such procedures.

Sincerely,

Donna Aline P.T.

Donna Aline, P.T.

DA:jb

Department of Institutions
Proposed Amendment to
House Bill 102, Third Reading Copy

SENATE HEALTH & WELFARE
EXHIBIT NO. #10
DATE 3/10/89
BILL NO. HB 102

Page 5, Line 7

Following: "shall"
Insert: "annually"

Page 5, Line 7

Following: "establish"
Strike: "a" on line 7 through "Effective" on line 11.
Insert: "fees and a uniform method for determining the ability to pay for persons whose services are supported by department funds."

SENATE HEALTH & WELFARE
EXHIBIT NO. #11
DATE 3/10
BILL NO. 197

Amendments to House Bill No. 197
Third Reading Copy

Requested by Representative Kelly Addy
For the Senate Committee on Labor and Employment Relations

Prepared by Tom Gomez, Staff Researcher
March 10, 1989

1. Page 2, line 17.
Following: "of"
Strike: "the"
Insert: "both the minor and his"

2. Page 2, lines 18 and 19.
Following: "for"
Strike: remainder of line 18 through "age" on line 19
Insert: "his care, if the minor is under 16 years of age"

3. Page 3, lines 9 and 10.
Strike: "if he is 16 years of age or older"

4. Page 4, line 10.
Following: line 9
Insert: "(8) In any form or application for admission of a minor to a mental health facility, there must be contained a notice informing the minor of the right to contact an advocacy service, attorney, agency, or person of choice to independently discuss the potential admission or discharge. Each mental health facility shall provide a minor access to such agencies or persons chosen to assist him as provided under this subsection."
Renumber: subsequent subsection

Amendments to House Bill No. 437
Third Reading Copy

For the Senate Public Health, Welfare and Safety Committee

Prepared by Tom Gomez, Staff Researcher
March 10, 1989

1. Page 1, line 16.
Following: line 15
Insert: "(1) "Podiatry" means the diagnosis and treatment of ailments of the human functional foot as provided in 37-6-102."
Renumber: subsequent subsections
2. Page 1, line 17.
Following: "to"
Insert: "diagnose and"
Following: "of the"
Insert: "human functional"
3. Page 1, line 24.
Following: "may"
Insert: "diagnose and"

COMMITTEE ON

Public Health

DATE

3/10/89

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Jerry Loeberk	Mt. Med Assn	292 253,438	✓	
Jerry Loeberk	Mt Med Assn	437		✓
James Clough	MT. Pod. Med. Assn.	437,438	✓	
Cleveland C. Smith	Podiatry Assoc.	437,438	✓	
David Huebner	Montana Podiatric Medical Associates	437,438	✓	
Scott DeMars	Mt. Pod. Med. Assoc.	437,438	✓	
Matt Fitty	MT Podiatric Med Assoc	437,438	✓	
Wm. O. O'Reilly	Mt. Pod. Med. Assoc	437,438	✓	
Mona Jamison	Mt Cheyenne Physical Therapy	437	✓	
P. England	Bd of Med. Ex.	252 253,437		
Colt Rogers	Mont Pod Med Ass	437 437	✓	
Don Harr	MMA-	HB253	✓	

(Please leave prepared statement with Secretary)

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. HB 253 Time 2:05

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	X	
Sen. Matt Himsel	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Sen. Himsel moved that
HB 253 Be Concurred In
6 - 0

Sen. Himsel will carry

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10 Bill No. 252 Time 2:02

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	-	
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Dorothy Quinn Secretary Sen. Tom Hager Chairman

Motion: HB 252 Senator Himsl
Do BF Concurred In
In Favor 6, 0, opp
Sen McLane
will carry

ROLL CALL VOTE

No Standing
Com. Report
for HB 102
not reported out.

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. 102 ^{AB} Time _____

NAME	YES	NO
Sen. Tom Hager		X
Sen. Tom Rasmussen	X	
Sen. Lynch		X
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich		X

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: by Rasmussen
That Amendment Be Adopted
4 in favor - 3 opposed.
Motion failed.

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. 102 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	X	
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: by To Concur In as
Mc Lane Amended
Favor 7-0
Mr. Norman

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. 197 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	-	
Sen. Matt Himsel	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	-	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Sen. Norman Pass Consideration for
day 5 - 0
in favor opposed.

ROLL CALL VOTE

PUBLIC HEALTH

SENATE COMMITTEE _____

Date 3/10/89 Bill No. HB 437 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. J.D. Lynch		
Sen. Matt Himsel	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Secretary Dorothy Quinn Chairman Tom Hager

Motion: Sen. Rasmussen Moved that
HB 437 Be Concurred in as
amended. In favor, 6
Opposed, 0

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. ^{HB} 437 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. J. D. Lynch	-	
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

D. Quinn
Secretary

Tom Hager
Chairman

Motion: Senator Norman made Motion THAT
AMENDMENTS for HB 437 BE ADOPTED.
In favor 6, opposed 0

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. HB 438 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	-	
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Senator Rasmussen moved
the HB 438 Be Concurred In
Senators in Favor 6
opposed 0

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. HB 654 Time _____

NAME	YES	NO
Sen. Tom Hager		X
Sen. Tom Rasmussen	X	
Sen. Lynch	-	
Sen. Matt Himsl		X
Sen. Bill Norman		X
Sen. Harry McLane		X
Sen. Bob Pipinich		X

Dorothy Quinn
Secretary

TOM HAGER
Chairman

Motion: Sen. Rasmussen made Motion
THAT Committee's Action ON HB 654
BE RECONSIDERED. In favor 1 (Rasmussen)
Opposed - 5.
Motion failed