

Government of the District of Columbia

OFFICE OF THE CORPORATION COUNSEL

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OPINION OF THE CORPORATION COUNSEL (CORRECTED)

SUBJECT: Are the Director, certain Deputies, and other executives administering Department of Health programs required to hold a license to practice medicine in the District of Columbia?

Marlene N. Kelley, M.D.
Interim Director
Department of Health
825 North Capitol Street, N.E.
Washington, D.C. 20002

Judy D. Banks
Interim Director
D.C. Office of Personnel
441 4th Street, N.W.
Washington, D.C. 20001

Dear Dr. Kelley and Ms. Banks:

This responds to the request of Dr. Allan S. Noonan, Dr. Kelley's predecessor, for a formal opinion addressing the above-noted question insofar as it concerns Deputies and other executives who administer Department of Health ("DOH") programs. I understand, based upon conversations my staff has had with Thomas Brown, DOH General Counsel, that this issue remains relevant, and that DOH continues to desire a formal opinion of the Corporation Counsel on this topic. This also responds to the June 4, 1999 request from Ms. Banks regarding medical licensing requirements for the Director of DOH.

Conclusions

DOH officers and employees who are engaged in prevention, diagnosis, or treatment of the medical conditions of individual people – whether in the context of direct or indirect patient care – are engaged in the practice of medicine and, therefore, are required by District law to hold a valid D.C. medical license. The focus must be on the actions of the individual administrator, not his or her job title or identification as M.D.

DOH officers and employees who provide direct patient care are clearly engaged in the practice of medicine as defined by District law and must have a District medical license. In addition, DOH officials are required to have a D.C. medical license if in the exercise of their official duties they have a voice in making judgments concerning the prevention, diagnosis, or treatment of medical conditions of individual patients (including patients who have already been treated or who are deceased). This would include an official who reviews the propriety of medical treatment provided to, or diagnosis made of, a patient by another health care provider, or who is responsible for diagnosing the cause of death in a deceased individual. However, DOH officials whose duties solely involve the development or interpretation of policy, the establishment of procedures, or the direction of programs, without direct or indirect patient care, are not engaged in the practice of medicine and, therefore, are not required to obtain a D.C. medical license.

Analysis

The practice of medicine is defined in the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 ("Health Occupations Act"), D.C. Law 6-99, D.C. Code § 2-3301.2(7) (1994), as follows:

"Practice of medicine" means the application of scientific principles to prevent, diagnose, and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any woman and infant through pregnancy and parturition.

The Health Occupations Act provides, at D.C. Code § 2-3310.1, that "[n]o person shall practice, attempt to practice, or offer to practice a health occupation licensed or regulated by the District unless currently licensed, or exempted from licensing, under this act." None of the exemptions from the licensure requirements of the Health Occupations Act are applicable to practitioners employed by the District at a location within the city.¹

¹ Exemptions from District licensing requirements are found in section 502 of the Health Occupations Act, D.C. Code § 2-3305.2:

The provisions of this act prohibiting the practice of a health occupation without a license shall not apply:

(1) To an individual who administers treatment or provides advice in any case of emergency;

(2) To an individual employed in the District by the federal government, while he or she is acting in the official discharge of the duties of employment;

(3) To an individual, licensed to practice a health occupation in a state, who is called from the state in professional consultation by or on behalf of a specific patient to visit, examine, treat, or advise the specific patient in the District, or to give a demonstration or clinic in the District, provided that the individual engages in the

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Thus, if a District employee or official is engaged in the practice of medicine as defined in the Health Occupations Act, he or she must hold a current and valid license to practice issued by the Board of Medicine of the District of Columbia. The meaning of the phrase practice of medicine is not further defined in the applicable regulations implementing the Health Occupations Act, but the phrase has been construed in at least two decisions of the District of Columbia Court of Appeals.

In Joseph v. District of Columbia Bd. of Medicine, 587 A.2d 1085 (D.C. 1991), a physician challenged a final decision of the Board of Medicine imposing a reprimand and civil fine as discipline for misconduct in connection with the Doctor's testimony as an expert witness in a medical malpractice trial, on the ground that the Board erred in finding that his misconduct occurred in the practice of medicine as defined by the Health Occupations Act. Specifically, Dr. Joseph had misrepresented his credentials under oath in a wrongful death action arising out of a child's death during surgery. Because his involvement was limited to the review and analysis of the deceased child's medical records, Dr. Joseph argued that his misconduct did not occur in the practice of medicine as defined by District law. Dr. Joseph took the position that the statute's use of the words "prevent, diagnose, and treat" served to define the practice of medicine solely in terms of patient care. The Board of Medicine, however, construed the definition of practice as going beyond just patient care, and found that Dr. Joseph had engaged in "diagnosis" when he analyzed the decedent's medical records to determine the nature and cause of her condition and the reasons for her subsequent death.

(Continued)

consultation, demonstration, or clinic in affiliation with a comparable health professional licensed pursuant to this act;

(4) To a health professional who is authorized to practice a health occupation in any state adjoining the District who treats patients in the District if:

(A) The health professional does not have an office or other regularly appointed place in the District to meet patients;

(B) The health professional registers with the appropriate board and pays the registration fee prescribed by the board prior to practicing in the District; and

(C) The state in which the individual is licensed allows individuals licensed by the District in that particular health profession to practice in that state under the conditions set forth in this subsection.

(D) Notwithstanding the provisions of subparagraphs (A), (B), and (C) of this paragraph, a health professional practicing in the District pursuant to this paragraph shall not see patients or clients in the office or other place of practice of a District licensee, or otherwise circumvent the provisions of this act.

The Court began its analysis in Joseph by explaining the applicable standard of review:

The members of the Board of Medicine are presumed to have substantially greater familiarity than do judges with the meaning of terms like "the practice of medicine." The determination to be made is one that demands the type of agency expertise and informed discretion towards which we generally show great deference. Accordingly, we must give the Board's decision substantial weight. The Board's interpretation of the statute is binding on us unless it is plainly erroneous or conflicts with the language or purpose of the statute. In order to sustain the Board's decision, we "need not conclude that the agency's construction was the only one it permissibly could have adopted . . . or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." If the Board's interpretation can reasonably be reconciled with the statute, our task is at an end.

587 A.2d at 1088 (citations omitted). The Court then reviewed the facts of the case and determined that "[t]he Board reasonably concluded that Dr. Joseph's misstatements [in the course of his work as an expert witness] were made in the practice of medicine." 587 A.2d at 1091. The Court relied upon Webster's Third New International Dictionary (1969) ("Webster's"), which defines diagnosis as, among others things, "investigation or analysis of the cause or nature of a condition, situation or problem . . ." The Court stated "we do not think it would be plainly wrong for the Board to conclude that [Dr. Joseph] conducted an 'investigation' and 'analysis' of 'the nature of [the girl's] condition,' and specifically her cause of death." 587 A.2d at 1089 (quoting Webster's). Thus, although Dr. Joseph provided no patient care whatsoever (indeed, the patient was already deceased when he took the case) the Court held that the Board did not err in finding that Dr. Joseph's misconduct occurred within the practice of medicine as defined in District of Columbia law.

In a still more recent case, however, the Court found that the Board of Medicine had interpreted the language of the statute too broadly when it found that a medical director for Blue Cross insurance had engaged in the practice of medicine without a District license. In Morris v. District of Columbia Bd. of Medicine, 701 A.2d 364 (D.C. 1997), Dr. Gregory Morris was employed as Vice President and Medical Director for Health Affairs, and later as Senior Vice President for Health Care Delivery for Blue Cross. In both of his positions, Dr. Morris was responsible for building the network of Blue Cross providers and for managing the process for post-treatment claim review and appeal. Under the review and appeal process Dr. Morris sat as a staff person on the peer review committee. However, he took no part in the deliberations of the committee and had no vote in its recommendations. Dr. Morris applied for a license to practice medicine in the District, and the Board of Medicine issued an order denying such a license because of his perceived unlicensed practice. The Board of Medicine contended that Dr. Morris was engaged in "treatment" because "the practical effect of [his] activities as medical director of Blue Cross . . . was to influence the course of treatment of individual patients

and, hence, to 'treat' them within the meaning of the [Health Occupations] Act." 701 A.2d 367. The Court disagreed:

This definition of "treatment" is so open-ended that it cannot reasonably be squared with the statutory term. In normal medical usage, "treat" means "to care for . . . medically or surgically: deal with by medical or surgical means." Webster's Third New International Dictionary 2435 (1971). Conduct that merely "affects," "influences," or "substantially impacts" on the course of such care by others cannot itself be treatment . . . Equating "treatment" with any conduct that "practically affect[s]" it, in ways potentially involving no exercise of medical judgment, is contrary to any sensible interpretation of the statute.

701 A.2d at 367. The Court was more sympathetic to the Board's contention that Dr. Morris's work as medical director for an insurer required him to engage in "diagnosis," much as Dr. Joseph did in the earlier case. Indeed, Dr. Morris apparently conceded that if he had a voice as a doctor (rather than as a mere administrator) in the recommendations of the Blue Cross medical advisers and review committee responsible for analyzing patient files and making recommendations concerning payment of claims and/or possible inappropriate treatment, his participation would constitute the practice of medicine for purposes of District law. The Court concluded, however, that because the record in the case contained no substantial evidence that Dr. Morris had a voice as a doctor in those recommendations, there was no evidence that he was engaged in the type of diagnosis found in the Joseph case.²

Despite its holding that Dr. Morris was not engaged in the practice of medicine as Medical Director for Blue Cross, the Court in the Morris case cautioned that,

This does not mean, of course, that on other facts a medical administrator of a health insurer such as Blue Cross which monitors and regularly questions treatment decisions by physicians, may not be found to have practiced medicine as defined in [District law]. The focus must be on the


² I understand that, on remand from the Court of Appeals, the Board of Medicine had the option of rehearing the case or evaluating Dr. Morris's application consistent with the Court's finding that he did not practice medicine at Blue Cross. The Board chose to reevaluate Dr. Morris's application, which – given the Court's decision and his testimony – was the application of a physician who had not practiced medicine for over six years. With this fact established, the Board instructed Dr. Morris to take an examination to demonstrate current clinical competency, just as would be required of any other applicant who had been so long absent from the practice of medicine. I also understand that, while Dr. Morris initially appealed this determination of the Board to the Court of Appeals, he ultimately obtained a voluntary dismissal of his appeal and withdrew his application for a license.

actions of the individual administrator, not his job title or identification as "M.D."³

701 A.2d at 368.

Taken together, the Joseph and Morris cases clearly stand for the proposition that a person engaged in prevention, diagnosis, or treatment of a disease, disorder, or condition as those terms are defined in Webster's, is engaged in the practice of medicine for purposes of District law, and must hold a valid District of Columbia medical license. The practice of medicine for purposes of District law is not limited to patient care. On the other hand, the mere fact that a person's work affects, influences, or even substantially impacts the treatment a patient will receive is not the practice of medicine unless the person is also engaged in the exercise of medical judgment with respect to individual patients amounting to prevention, diagnosis, or treatment within the dictionary definition of those terms.

Sincerely,


Jo Anne Robinson
Interim Corporation Counsel

³ The Court also rejected the Board of Medicine's contention that Dr. Morris had improperly used the title "M.D." in violation of D.C. Code § 2-3310.3(g), which makes it unlawful for a person not licensed in the District to "use or imply the use of the words . . . medical doctor [or] M.D. . . . or any similar title or description of services with the intent to represent that the person practices medicine." The Court concluded that the letters to which Dr. Morris had affixed the title "M.D.", taken as a whole and in context, did not convey the impression that "the opinions therein stemmed . . . from Dr. Morris's own exercise of medical judgment ('application of scientific principles')." 701 A.2d at 369. The Court suggested, however, that even so, "Dr. Morris would have been better advised . . . to disclaim his licensure in the District or list the jurisdictions in which he was licensed to practice medicine," and that "[t]he result might have been different had the letters been directed to an unsophisticated portion of 'the public' instead of to [the Maryland State Medical Board]." 701 A.2d at 369. The case suggests, accordingly, that the use of the title M.D. by a physician not licensed in the District is prohibited if used in such a way as to convey the impression that the user is licensed to practice – or is practicing – medicine in the District, and that this impression is more likely to occur if the title M.D. is used in a communication directed to the public at large rather than to a sophisticated audience.

cc: Thomas Brown
General Counsel
Department of Health

E. Jacqueline Edgett
Associate Director of Personnel