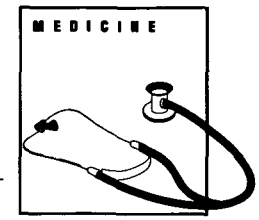
Medical Board of California



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The Medical Board of California (MBC) is a consumer protection agency within the state Department of Consumer Affairs (DCA). The 19-member Board consists of twelve physicians and seven public members. MBC members are appointed by the Governor (who appoints all twelve physicians and five public members), the Speaker of the Assembly (one public member), and the Senate Rules Committee (one public member). Members serve a four-year term and may be reappointed to a second term. The Board is divided into two autonomous divisions: the Division of Licensing and the Division of Medical Quality. The Board and its divisions are assisted by several standing committees, ad hoc task forces, and a staff of 250 who work from 12 district offices located throughout California.

The purposes of MBC and its divisions are to protect consumers from incompetent, grossly negligent, unlicensed, impaired, or unethical practitioners; enforce the provisions of the Medical Practice Act, Business and Professions Code section 2000 *et seq.*; and educate healing arts licensees and the public on health quality issues. The Board's regulations are codified in Division 13, Title 16 of the California Code of Regulations (CCR).

MBC's Division of Licensing (DOL), composed of four physicians and three public members, is responsible for ensuring that all physicians licensed in California have adequate medical education and training. DOL issues regular and probationary licenses and certificates under the Board's jurisdiction, administers the Board's continuing medical education program, and administers physician and surgeon examinations to some license applicants. DOL also oversees the regulation of medical assistants, registered dispensing opticians, research psychoanalysts, and lay midwives.

In response to complaints from the public and reports from health care facilities, the Division of Medical Quality (DMQ)—composed of eight physicians and four public members—reviews the quality of medical practice carried out by physicians and surgeons. DMQ's responsibilities include enforcement of the disciplinary, administrative, criminal, and civil provisions of the Medical Practice Act. DMQ's enforcement staff receives and evaluates complaints and reports of misconduct and negligence against physicians, investigates them where there is reason to suspect a violation of the Medical Practice Act, files charges against alleged violators, and prosecutes the charges at an evidentiary hearing before an administrative law judge (ALJ) from the special Medical Quality Hearing Panel within the Office of Administrative Hearings. In enforcement actions, DMQ is represented by legal counsel from the Health Quality Enforcement Section (HQES) of the Attorney General's Office. Created in 1991, HQES is a unit of deputy attorneys general who specialize in medical discipline cases. Following the hearing, DMQ reviews the ALJ's proposed decision and takes final disciplinary action to revoke, suspend, or restrict the license, or impose other appropriate administrative action. For purposes of reviewing individual disciplinary cases, DMQ is divided into two six-member panels (Panel A and Panel B), each consisting of four physicians and two public members. DMQ is also responsible for overseeing the Board's Diversion Program for physicians impaired by alcohol or drug abuse.

MBC meets approximately four times per year. Its divisions meet in conjunction with and occasionally between the Board's quarterly meetings; its committees and task forces hold additional separate meetings as the need arises.

Governor Gray Davis has made a number of appointments to MBC in recent months. In March 2000, the Governor appointed Gary Gitnick, MD, to DOL. Dr. Gitnick is chief of the Division of Digestive Diseases at UCLA, a position he has held since 1969. In April 2000, Governor Davis appointed Mitchell Karlan, MD, to DOL. Dr. Karlan, an oncologic surgeon from Beverly Hills, chairs the board of directors of the Southern California Physicians Insurance Company, a major medical malpractice insurer.

In May 2000, the Governor appointed Donna Gerber and Lorie Rice as public members to DOL and DMQ, respectively. Gerber has an extensive background in labor relations and is currently a member of the Contra Costa County Board of Supervisors. Rice is the associate dean of external affairs and assistant professor of clinical pharmacy for the UCSF School of Pharmacy, and has served at a number of DCA occupational licensing agencies in the past.

In June 2000, Governor Davis appointed three new physician members to DMQ. Mary McDevitt, MD, has been the medical director and senior vice president at Marin General Hospital since 1996. Margo Leahy, MD, has practiced child psychiatry in San Francisco since 1981. Ronald Moy, MD, is a dermatologist in private practice, and serves as editor-in-chief of the medical journal *Dermatologic Surgery*.

In December 2000, Governor Davis appointed Bernard Alpert, MD, to DOL; Dr. Alpert—a plastic surgeon from San Francisco—formerly served on DOL as an appointee of Governor Pete Wilson. Governor Davis also appointed Hazem Chehabi, MD, and Ronald Wender, MD, to DMQ. Dr. Chehabi is an assistant clinical professor at UC Irvine's Department of Radiological Sciences. Dr. Wender is co-chair of the Department of Anesthesiology at the Cedars-Sinai Medical Center.

At this writing, three of the Board's 19 slots are vacant; all three are public member positions.

MAJOR PROJECTS

Legislature Investigates Section 805 Compliance

On October 17, 2000, the Senate Business and Professions Committee, chaired by Senator Liz Figueroa, conducted an interim hearing on the level of compliance by hospitals and health plans with Business and Professions Code section 805, which requires such institutions to file a report with the Medical Board when they take certain adverse disciplinary ("peer review") actions against California physicians. A hospital peer review action is generally conducted in private, and affects the admitting privileges of a physician only at the hospital taking the action; the imposition of disciplinary action by a hospital does not affect the physician's ability to obtain or maintain privileges at other hospitals. However, the so-called "section 805 report" which must be filed with MBC alerts the Board to problem physicians, enabling the Board to investigate the underlying incident(s) and take disciplinary action against the physician's license, if appropriate. Hospitals must also file reports on adverse peer review actions with the National Practitioner Data Bank (NPDB), a federally-mandated database that includes information on hospital discipline, state medical board discipline, and malpractice insurance payouts against physicians and certain other health care practitioners. State medical boards, hospitals and HMOs, and insurers all have access to the database before they license, credential, or insure, respectively, so they can protect themselves from dangerous physicians who lie about their past records. Patients have no access to the NPDB (see below for additional discussion of the NPDB).

The Kaiser/McEnany case is illustrative of a serious problem recognized long ago by MBC—the failure of hospitals and HMOs to report adverse peer review actions to MBC as required by section 805.

The legislative hearing was prompted in part by an August 9, 2000 article in the *San Francisco Chronicle*. The article described the failure of San Francisco's Kaiser Hospital to report internal peer review action against Dr. Michael Terry McEnany, its chief of cardiovascular surgery, to the Medical Board. In late 1992, Kaiser became aware of many complaints by patients and hospital medical personnel about the behavior of Dr. McEnany, and instituted an internal investigation of the complaints and sought an external investigation of them. According to Kaiser's own documents, these complaints involved "two recent unexpected patient deaths, a higher than expected mortality rate for Dr. McEnany's patients, a higher incidence of surgical complications,...operating with inadequate assistance, scheduling cases in a manner that exceeds the threshold of his endurance, and an episodic history of dysfunctional relationships with colleagues both within and outside his own department." Based on its internal investigation, Kaiser imposed restrictions on Dr. McEnany's surgical privileges (which should have been the subject of a section 805 report to MBC) and notified him that the external investigation was under way.

In June 1993, while those restrictions were in place, Dr McEnany resigned "effective September 30, 1993" in order to move to Wisconsin. Prior to his resignation, however, the doctor and his lawyer wrote a letter to Kaiser demanding that the external investigation be terminated and that "no reports will be filed with any agencies concerning Dr. McEnany." In a June 25, 1993 letter, Kaiser officials agreed that "we will not file any report with any external agency concerning Dr. McEnany based on events that have occurred to date." Subsequently, MBC fined the individuals who agreed to violate the law in the June 1993 letter close to the maximum amount possible—$9,950 each—for intentional failure to file a section 805 report. However, the other consequences of their actions were more far-reaching. Dr. McEnany moved to Wisconsin to take a new job, and by 1996 was the subject of 25 medical malpractice lawsuits and had the third-highest surgical mortality rate in the state. Had Kaiser filed the section 805 report when required by law to do so, the Wisconsin hospital undoubtedly would not have hired Dr. McEnany.

The Kaiser/McEnany case is illustrative of a serious problem recognized long ago by MBC—the failure of hospitals and HMOs to report adverse peer review actions to MBC as required by section 805. *[15:1 CRLR 59–60]* According to recent data, there are over 550 hospitals in California. Yet section 805 reporting plummeted from 282 reports in 1988–89 to a record low 82 in 1998–99. Prior to the creation of the NPDB, the federal government anticipated that 5,000 hospital reports would be filed each year from hospitals across the nation; the American Medical Association predicted 10,000 hospital reports per year. In fact, as of July 1999, only 7,453 reports had been filed during the first eight years of the NPDB's history—less than 1,000 per year. Forty-four percent (44%) of California hospitals have never filed a report with the NPDB.

At the September 2000 hearing, MBC Executive Director Ron Joseph noted that the private "peer review" function and hospital compliance with section 805 provide essential information to MBC's physician discipline program. According to Joseph, "this is what led the Medical Board to pursue so vigorously the right to inspect the records of a peer review committee" in *Arnett v. Dal Cielo*, 14 Cal. 4th 4 (1996), a unanimous California Supreme Court ruling upholding MBC's authority to subpoena hospital peer review records (although they are immune from discovery in civil actions under Evidence Code section 1157) to ensure that reportable peer review actions are in fact being forwarded to MBC. Recognizing that the number of reports filed is "unquestionably lower than what might be reasonably expected in a state with nearly 600 hospitals and over 80,000 in-state physicians," Joseph noted that MBC would be considering at its Novem-

ber 2000 meeting three proposals to stimulate proper filing: (1) an increase in the civil penalty for failure to report from $5,000 to $50,000, "based on the Board's experience that a $5,000 penalty is an inadequate deterrent to nonreporting"; (2) as an alternative to 805 reporting where a physician has skills deficiencies that can be remediated, the implementation of a pilot program whereby hospitals and MBC would work in concert to identify and remediate that physician's skills without the filing of a section 805 report; and (3) amendment of section 805 to delete a provision allowing hospitals to wait to file the required report until 15 days after the reportable action or "after the exhaustion of administrative procedures." According to Joseph, exhaustion of administrative procedures can take two years or more, during which time MBC has no idea of the problem.

Center for Public Interest Law (CPIL) Administrative Director Julianne D'Angelo Fellmeth also testified at the hearing, noting that "the reporting requirement in section 805 is the critical link between the narrow, institution-specific private peer review system (which allows dangerous doctors to go on practicing because the institution has no jurisdiction to act outside its own walls) and the Medical Board's physician discipline system, which can remove the license entirely for the protection of the public." She related the facts of several cases that had been secreted from the Medical Board—cases that "illustrate not only some egregious incidents and the exposure of patents to incredible and totally unnecessary risk; they also illustrate the lengths to which hospitals and individual hospital administrators and their counsel will go to avoid reporting to MBC under section 805." She concluded her testimony with several recommendations for legislative change: (1) the statutory fines for failure to report to MBC should be significantly increased; (2) failure to report by a physician reporter should be unprofessional conduct and grounds for discipline of that physician's license; (3) if hospitals persist in noncompliance with section 805, Evidence Code section 1157 should be repealed to enable patients to hold hospitals and their peer review committees accountable; (4) a hospital should be strictly liable for injury due to a physician's professional negligence following its failure to report its own peer review action against that physician; (5) section 805 should be amended to require the reporting of all peer review actions to MBC; (6) MBC should be authorized to engage in random audits of hospital peer review records; and (7) section 805, which is loopholed and subject to evasion by hospitals and their counsel, should be completely overhauled. CPIL suggested that the state require an audit or comprehensive study of the way in which peer review is actually conducted, and then amend the statute accordingly.

Testifying on behalf of the California Medical Association (CMA), Dr. Loren Johnson argued that the sheer number of reports filed alone does not mean hospitals are not conducting peer review or are not reporting it; on the contrary, he said peer review is alive and well and improving the quality of medical care in California, and has resulted in a lower number of reports. Maureen O'Haren of the California Association of Health Plans complained that HMOs complete the long peer review process, file a report with MBC, and then hear nothing from MBC. She said health plans have a great interest in reducing the cost and "overlegalization" of the peer review process.

At its November 2000 and February 2001 meetings, DMQ discussed the three legislative proposals suggested by Ron Joseph at the October Senate hearing. Senator Figueroa attended the Division's February 2001 meeting to announce her introduction of four pieces of legislation to implement suggestions made at the October hearing, the centerpiece of which is SB 16 (Figueroa). As introduced, SB 16 would substantially increase the penalties for failure to file section 805 reports; specify that, for physician reporters, failure to file a section 805 report is unprofessional conduct and grounds for discipline; clarify when section 805 reports must be submitted; authorize the Department of Health Services to bring an action against a hospital, clinic, or health facility for failure to file a section 805 report; authorize MBC to perform random audits of hospital peer review records and review medical record information to identify instances of nonreporting; and require MBC, the Osteopathic Medical Board, and the Dental Board to establish a system of electronic notification that can be accessed by qualified subscribers to provide notification of the filing of an 805 report by a peer review body. The bill would also encourage MBC to work with interested parties to establish a pilot program for the early detection of potential quality problems and resolutions for physicians through informal intervention short of a peer review action (see 2001 LEGISLATION).

On behalf of CPIL, Julie D'Angelo Fellmeth urged the Board to support the legislation. According to Fellmeth, an 805 report "is a piece of information conveying the collective judgment of a group of presumably responsible physicians acting in good faith about the competence of a peer. These actions are not taken often, and they are not taken lightly. The peer review process is steeped in procedural due process protections for the accused physician, statutory protections for the institution taking the action, and statutory protections for the person required to file the report. A peer review report is undeniably one of the most reliable pieces of information MBC gets, because it comes from physicians interested in protecting their patients from dangerous doctors and their institution from tort liability. It's a critically important piece of information and without it, you cannot do your job of protecting the people of California."

On behalf of CMA, Dr. Marie Kuffner congratulated the Senator for her effort to fix apparent problems in the peer review reporting process, but asked MBC to recognize that "we can be misled by numbers—statistics do not always tell the whole truth." She also called on the Board to understand the environment in which physicians practice today: "If a physician is the subject of an 805 report today, he is *de facto* excluded. No managed care organization will accept him."

She asked the Senator to transform SB 16 into a bill that improves the monitoring aspects of peer review and removes the "fear and paranoia" that hospitals and their personnel have of the Medical Board and its enforcement program.

Following discussion, MBC voted to support SB 16 in concept.

MBC Fee Increase Bills Die

In a disappointing end to time-consuming negotiations throughout 1999 and 2000, AB 265 (Davis) and SB 1045 (Murray)—two bills that might have increased MBC's licensing fees, enabling the Board to improve its enforcement program while maintaining a sufficient reserve fund—died at the end of the 2000 legislative year.

MBC licensing fees have not been adjusted since 1994. Since then, the Board has been forced to cope with a 20% increase in complaint volume with no increase in resources to augment its investigative staff. Since 1995, MBC has sought a legislative fee hike to increase the number of DMQ investigators and lessen their heavy caseloads, but CMA has blocked every attempt. In 1999, the Board sponsored AB 265 (Davis), which would increase biennial license renewal fees for physicians from $600 to $690. CMA countered with its sponsorship of SB 1045 (Murray), which would grant the Board an unspecified fee increase in exchange for a laundry list of 14 changes to the Medical Practice Act, some of which sparked intense opposition. When the two sides were unable to reach any agreement and the matter threatened to explode in the legislature in April 1999, Attorney General Bill Lockyer intervened and offered to serve as a "mediator" to facilitate a resolution. After that, a working group of representatives from MBC, CMA, the AG's Office, and several legislative committees met occasionally in an attempt to narrow the number of issues on the table. *[17:1 CRLR 32–33; 16:2 CRLR 24–25]*

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When those attempts failed, the working group expanded in 2000 to include representatives of the Center for Public Interest Law, Consumer Attorneys of California, and other groups. By January 2000, CMA had reduced its 14 demands in SB 1045 to five: (1) a redefinition of "repeated negligent acts"—which is grounds for discipline under Business and Professions Code section 2234(c)—to preclude discipline for actions "during a single course of treatment" unless the physician's actions constitute "a pattern of conduct likely to jeopardize patient care"; (2) an amendment to section 805 prohibiting hospitals from notifying the Board's enforcement program when a physician takes a leave of absence in order to enter substance abuse treatment; (3) imposition of a mandatory $6,000 cap on cost recovery (reimbursement of the Board's investigative costs by a physician who is ultimately disciplined) under Business and Professions Code section 125.3; (4) a requirement that MBC adopt regulations codifying enforcement program priorities that mandate "the prioritization of cases involving a serious risk to patient safety for investigation and prosecution"; and (5) a 50% reduction in initial license fees for physicians who are in residency programs. In exchange, CMA offered a $90 biennial fee increase ($45 per year).

That proposal pleased none of the other parties to the negotiations. The Attorney General's Office opposed the redefinition of repeated negligent acts. CPIL opposed the elimination of section 805 reports when physicians leave their hospital privileges to enroll in substance abuse treatment. Taking an "oppose unless amended" position on SB 1045 at its February 2000 meeting, MBC objected to reduced fees for residents and the cap on cost recovery, arguing that CMA is "giving with one hand and taking with the other," and that any cap or other significant change to cost recovery would have negative precedential implications for all other boards with cost recovery authority.

As the spring of 2000 wore on, the bill was amended to delete the provision eliminating section 805 reports for physicians who enter substance abuse treatment, increase the cap on cost recovery to $12,500 (and later to place a sunset date on the cap, to enable an evaluation on the effects of the cap), and require MBC to adopt "guidelines" (instead of regulations) establishing priorities for investigating and prosecuting enforcement cases. The provisions amending the definition of repeated negligent acts and mandating a 50% reduction in licensing fees for physicians enrolled in postgraduate training programs remained, as did the "oppose unless amended" position taken by MBC at its May 2000 meeting.

By the Board's July 2000 meeting, the working group had further honed the cost recovery provision and the bill was viewed as a finished product. In an attempt to make the cost recovery experiment "revenue-neutral," SB 1045 had been amended to cap cost recovery at $12,500 for a two-year period, during which time MBC renewal fees would be set at $700 (to make up for the projected loss in cost recovery). In addition, the bill required the Attorney General's Office to adhere to detailed "contemporaneous documentation" requirements in order to justify a cost recovery motion, and required a study on the effects of the cap and the extent to which it encourages or discourages settlements in physician discipline cases. The other provisions remained intact. CMA's Board of Trustees was scheduled to take a formal position on the bill on July 28, and MBC would follow with its own position on July 29.

By this time, however, the Davis administration's Department of Consumer Affairs, many DCA boards with cost recovery authority, and the Attorney General's Office had weighed in with their opposition to any cap on cost recovery. The cost recovery issue concerned many MBC members as

well. At MBC's July 29, 2000 meeting, public member Bruce Hasenkamp questioned the incentives the cap would place on respondent physicians and their counsel, and wondered if the presence of the cap might not encourage angry respondents to drive up the costs of their proceedings with full knowledge the Board could not recoup those costs. Hasenkamp put it succinctly: "Rather than assessing a bad doctor who has cost the Board a lot of money, CMA wants to assess the entire physician population for 'bad guy' costs run up by bad doctors." He then inquired of CMA lobbyist Bob McElderry as to the position taken by CMA's Board of Trustees on July 28. McElderry replied that "the issue was not discussed yesterday; we will discuss it early next week." With that, Board President Karen McElliott immediately moved that MBC oppose SB 1045.

In October 2000, MBC released its *1999–2000 Annual Report*, which reveals decreased case processing time but a measurable decline in enforcement output compared to its 1998–99 performance.

Executive Director Ron Joseph reminded MBC that Board staff and members had negotiated this fee increase with CMA for four years and that SB 1045 reflected a compromise on many issues. He noted that MBC's financial status was not as dire as it had been in recent years because the Board had not been forced to spend certain budgeted funds (for example, state employees had received no salary increases during the prior four years. Further, MBC did not have to contribute an anticipated $1 million for a new DCA computer system because the contract fell through), and unexpected revenues resulted in more solid financial footing (for example, cost recovery now approaches $1.5 million per year, and MBC's licensee base had increased from 44,000 to 46,000 renewals per year in the prior 18 months), such that he had been able to add ten new investigator positions to the 2000–01 budget. However, Joseph warned that employee salaries had just been raised, a new DCA computer system is on the horizon, and the Board must pay for the ten new investigators at the same time as SB 1045's cap on cost recovery and 50% license fee decrease for physicians in residency programs kick in. According to Joseph, the Board's job was to weigh whether the bill will actually increase resources for the Board's enforcement program and—if so—whether those increased resources are worth the concessions made in the bill. Following discussion in which SB 1045 was described as "an onerous set of compromises," MBC decided to oppose SB 1045 by a 9–3 vote.

Following MBC's vote, Senator Murray dropped SB 1045 because of the Davis administration's opposition to the cap on cost recovery, which portended a veto. Assemblymember Davis stated that she had committed to the Senate Business and Professions Committee that her AB 265 would be double-joined to SB 1045 when negotiations were complete. After negotiations broke down and MBC opposed SB 1045 in July 2000, she decided that she could not move AB 265 forward because of her commitment to the Senate members. Thus, she gutted AB 265 and used it for a different purpose, and MBC must live another year without a fee increase.

1999–2000 Annual Report Reveals Decline in Enforcement Output

In October 2000, MBC released its *1999–2000 Annual Report*, which reveals decreased case processing time but a measurable decline in enforcement output compared to its 1998–99 performance. *[17:1 CRLR 33–34]* And once again, other statistics in the *Annual Report* reflect inadequate MBC disciplinary activity compared with the level of physician negligence and incompetence detected by others.

In 1999–2000, MBC received 10,445 complaints and opened 2,083 investigations against physicians (as compared to 10,751 and 2,139, respectively, in 1998–99). It referred only 491 cases to HQES—considerably down from 618 a year earlier. HQES filed 290 accusations—compared to 392 in 1998–99. Total administrative filings were only 345, down from 501 in 1998–99. In 1999–2000, the Board took a total of 366 disciplinary actions (similar to its 1998–99 total of 359), including 55 revocations, 67 license surrenders, 17 probations with suspension, 109 probations, and 56 public reprimands. Additionally, the Board issued 250 citations and fines (down from 332 in 1998–99), and obtained 44 interim suspension orders (ISO) or temporary restraining orders (TRO), which suspend a particularly dangerous physician's license pending conclusion of the disciplinary process.

MBC's *Annual Report* also indicates that the average time spent by a complaint at the various processing stages of MBC's enforcement system decreased somewhat during 1999–2000, particularly at the investigative stage. On the average, cases remained for 44 days in the Board's Central Complaint Unit (CCU) before being forwarded to an MBC district office for investigation (down from 53 days in 1998–99 and 56 days in 1997–98); they then spent an average of 206 days under investigation before being dismissed or forwarded to HQES for accusation filing (down from 243 days in 1998–99, 313 days in 1997–98, and 336 days in 1996–97). The average time period from complaint receipt to disposition (which should be 180 days under Business and Professions Code section 2319) was 250 days (compared to 296 days in 1998–99, 369 days in 1997–98, and 400 in 1996–97). Fully investigated cases then spent an average of 97 days in HQES (up from 83 days in 1998–99) prior to accusation filing.

Although DMQ's improved performance in case processing time is encouraging, its overall decreased enforcement output is sure to be a topic of discussion at MBC's upcoming sunset review in December 2001. Further, DMQ's enforcement output still pales in comparison to the number of external complaints and reports of physician incompetence and misconduct received by the Board. In 1999–2000, DMQ received 1,206

reports of medical malpractice judgments or settlements in excess of $30,000; 29 autopsy reports from coroners indicating that the cause of death was physician gross negligence or incompetence; 28 reports that physicians had been charged with or convicted of crimes; and 110 reports of adverse peer review action taken against physicians by hospitals or health care facilities. Thus, over 10,000 physicians were the subject of consumer complaints and a total of 1,373 licensees were reported to DMQ for incompetence or misconduct in 1999–2000, compared with only 366 disciplinary actions by MBC.

In a related matter, Washington, D.C.-based Public Citizen released its annual rankings of the enforcement output of state medical boards in May 2000. Based upon number of serious disciplinary actions per 1,000 doctors, California ranked 20th in the nation in 1999. Although this is an improvement over its 27th-place ranking in 1998 and its 42nd-place showing in 1992, MBC's recent enforcement figures reflect a continuing performance problem in an area where incompetence, negligence, impairment, or misconduct can result in irreparable harm to patients.

MBC's Public Disclosure Policy Back on the Table

At its February 2001 meeting, DMQ discussed an October 2000 letter from CMA asking the Division to reevaluate its public disclosure policy in light of the emergence of the Internet as a major tool of communication.

MBC's public disclosure policy—the policy governing the types of information it discloses on its physician licensees to the public, and the way in which that information is disclosed—has evolved over the past eight years as a result of groundbreaking Board decisions and the codification of those decisions into a complex patchwork of statutes and regulations, all of which must be read in the context of the California Public Records Act, Government Code section 6250 *et seq.* (which specifies that most agency records are public information unless they fall within narrow enumerated exemptions), the Information Practices Act, Civil Code section 1798 *et seq.* (which limits public disclosure of personal information held by government agencies), and Article I, section 1 of the California Constitution (which was enacted to preclude unnecessary "government snooping" and the overbroad collection, retention, and misuse of personal information by government and business interests). A brief chronology of this evolution follows.

• Prior to 1993, MBC disclosed nothing about its licensees to the public except filed accusations and its own disciplinary decisions.

• In May 1993, the Board overhauled its public disclosure policy and decided to additionally disclose felony criminal convictions (but not misdemeanor convictions), medical malpractice judgments (but not settlements) over $30,000, disciplinary actions by other state medical boards, involuntary hospital disciplinary actions that result in the termination or revocation of privileges, and completed DMQ investigations once they are referred to HQES for the filing of an accusation. *[13:2&3 CRLR 80–81]* Public disclosure of hospital disciplinary actions required legislative amendment of Business and Professions Code section 805; such an amendment was inserted in SB 916 (Presley) in 1993, but was stricken by the Senate Business and Professions Committee at the behest of CMA. *[13:4 CRLR 1]* Additionally, CMA filed a lawsuit in November 1993 challenging the entire disclosure policy as violative of physicians' due process rights. A judge immediately denied CMA's motion for injunctive relief as to all components of the policy except completed investigations prior to the filing of the accusation. *[14:1 CRLR 50, 53–55]* That lawsuit eventually ended in 1995 when MBC decided to abandon that one provision of its public disclosure policy, and the court dismissed CMA's lawsuit as moot. *[15:4 CRLR 87–88, 95]*

• In the meantime, the remainder of MBC's May 1993 public disclosure policy was codified by SB 916 (Presley) (Chapter 1267, Statutes of 1993) in Business and Professions Code sections 803 and 803.1, which required MBC to adopt regulations governing the disclosure of medical malpractice judgments over $30,000, felony convictions, and MBC and other-state disciplinary actions including temporary restraining orders (TROs), interim suspension orders (ISOs), limitations on practice, public letters of reprimand, infractions, citations, and fines. *[13:4 CRLR 54–55]*

• In 1995, MBC adopted new section 1354.5, Title 16 of the CCR, which requires public disclosure of the following information on every licensee: (1) current status of the license, issuance and expiration date, and medical school attended and date of graduation; (2) any public document filed and any disposition thereof, including accusations, decisions, TROs, ISOs, citations, and public letters of reprimand; (3) medical malpractice judgments in excess of $30,000 reported to the Board after January 1, 1993; (4) discipline imposed by another state or the federal government reported to the Board after January 1, 1991; and (5) California felony convictions reported to the Board on or after January 1, 1991. *[15:4 CRLR 87; 15:2&3 CRLR 60–61]*

• The Board's 1993 disclosure policy was the most progressive in the nation until Massachusetts introduced its "physician profile" model available on paper and telephonically in 1996 and via the Internet starting in 1997. The Massachusetts "profile" discloses all of the information disclosed by MBC plus malpractice settlements and arbitration awards within the past ten years, "serious" misdemeanor criminal convictions as determined by the Massachusetts Board of Registration in Medicine, and revocation or involuntary restriction of hospital privileges within the past ten years. In disclosing malpractice settlements, Massachusetts combines them with judgments and arbitration awards into a "malpractice information" category; the profile discloses the fact of a payout but not the exact amount (instead, it characterizes the amount as "above average," "average," or "below average" in comparison with the average payout for other physicians in the same specialty).

• In 1997, then-Assemblymember Liz Figueroa introduced AB 103 (Figueroa) to replicate the Massachusetts "physician profiles" in California and to require Internet posting of enhanced information on physicians by MBC. CMA immediately opposed any disclosure of settlements, and that provision was stricken from the bill. As enacted and effective January 1, 1998, AB 103 added section 2027 to the Business and Professions Code, which requires MBC to post on the Internet the following information on its licensees: (1) the status of the license (including whether the licensee is in good standing or subject to a TRO or ISO); (2) prior discipline by MBC or the board of another state or jurisdiction; (3) any felony convictions reported to the Board after January 1, 1991; and (4) any current accusations filed by the Attorney General. In addition, AB 103 requires Internet posting of all malpractice judgments and arbitration awards reported to the Board after January 1, 1993 (thus eliminating the $30,000 threshold in SB 916) and—for the first time—requires public disclosure (and Internet posting) of "any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason." In addition, AB 103 requires MBC to formulate appropriate explanatory statements and disclaimers to accompany the posted information, and to post links to other organizations that provide information on specialty board certification.

Public Citizen's Health Research Group released its first-ever survey of the Web sites of state medical boards in March 2000.

The passage of AB 103 (Figueroa) did not end the debate on public disclosure of information related to physician competence—either in California or nationally. To date, several other states—including Florida, Connecticut, New York, and Tennessee—have enacted Massachusetts-style physician profile statutes requiring the public disclosure of numerous categories of information, including malpractice settlements.

On the national level, three developments have kept the public disclosure issue in the news. First, in 2000, U.S. Representative Thomas Bliley (R-Virginia) renewed his call for public access to the National Practitioner Data Bank, a national database of information on physician misconduct established in 1990 and maintained by the Health Resources and Services Administration within the U.S. Department of Health and Human Services. The NPDB contains (among other things) information from (1) insurers on physician malpractice payouts, (2) hospitals and managed care organizations on peer review actions against physician privileges and credentialing decisions; and (3) state medical boards on physician license denials and disciplinary actions. The Data Bank is open to federal and state health care regulators, hospitals, insurers, and HMOs—but is absolutely closed to the public. Bliley's "Patient Protection Act of 2000" (H.R. 5122) would permit consumers to access the same information and require federal regulators to restructure the database to be easier to navigate and understandable to consumers. At a September 20, 2000 hearing on the bill before the House Commerce Committee, the American Medical Association fiercely opposed the bill, arguing that the NPDB was never intended to be accessible to consumers and that public access to NPDB information would be unfair to physicians (especially those in high-risk specialties such as neurosurgery, obstetrics, and heart surgery) and misleading to the public because malpractice settlements do not necessarily indicate that malpractice has occurred. The bill was ultimately defeated, but interest in the issue has not waned.

Meanwhile, Public Citizen's Health Research Group (HRG) released its first-ever survey of the Web sites of state medical boards in March 2000. HRG surveyed the 51 boards that regulate medical doctors in the United States to determine whether and how they release information to the public on their licensees. HRG was specifically interested in how much information boards release on their own disciplinary actions, and graded boards based on whether they reveal (1) the doctor's name, (2) the disciplinary action taken by the board, (3) the offense committed by the doctor, (4) a concise summary narrative of the physician's misconduct, and (5) the full text of the board's disciplinary order. Only one state—Maryland—received an "A" for providing all five types of data. MBC's Web site received a "D" because it provides only the doctor's name and the disciplinary action taken; it offers no information on the nature of the conduct committed or the offense charged, nor does it link to the full text of the disciplinary order. HRG noted that MBC's Web site includes information on malpractice judgments and disciplinary actions taken by hospitals, and stated that "all states should include such data."

Finally, the Federation of State Medical Boards (FSMB) unveiled its database on 113,000 disciplinary actions taken against 35,000 physicians since the 1960s in January 2001. For $9.95, consumers can order a physician's credentials and disciplinary history over the Internet. Although the Federation's database does not include information on malpractice cases or criminal convictions, FSMB insists its database is more accurate than some commercial Web sites that offer information on physicians, and is releasing the information in recognition of "increased public demand for access to physician disciplinary information." According to FSMB, "obtaining this type of information is essential to your overall safety and well-being because it will enable you to make more informed decisions about the physicians you see."

Thus, CMA's October 2000 letter has reopened an issue of significant importance and public interest. At DMQ's February 2001 meeting, CPIL representative Julie D'Angelo Fellmeth agreed that the Division should reevaluate its public disclosure policy, and noted that her organization would seek expansion of the policy to require wider disclosure of information on physician misconduct, including misdemeanor criminal convictions and medical malpractice settlements. The

Division postponed discussion of the issue to its May 2001 meeting.

Alternative Medicine Committee

In July 2000, the impending passage of SB 2100 (Vasconcellos) prompted MBC President Dr. Ira Lubell to create a new Alternative Medicine Committee to hold hearings and make recommendations to DMQ on the implementation of the bill and to more generally respond to the increasing groundswell of interest in non-conventional medicine, as reflected in considerable public testimony presented at the Board's December 1997 sunset review hearing. *[16:1 CRLR 45]*

SB 2100 adds Article 23 (commencing with section 2500) to the Business and Professions Code. In section 2500, the legislature states that the Medical Board and the Osteopathic Medical Board of California "acknowledge the significant interest of physicians and patients alike in integrating preventative approaches and holistic-based alternatives into the practice of medicine, including, but not limited to, biopsychosocial techniques, nutrition, and the use of natural supplements to enhance health and wellness," and requires both boards to "establish specific policies in this regard and...review statutes and recommend modifications of law, when appropriate, in order to assure California consumers that the quality of medicine practiced in this state is the most advanced and innovative it can be both in terms of preserving the health of, as well as providing effective diagnosis and treatment of illness for, the residents of this state."

Specifically, SB 2100 requires the Medical Board, by July 1, 2002, to "establish disciplinary policies and procedures to reflect emerging and innovative medical practices for licensed physicians and surgeons." The Board must solicit the participation of interested parties in the development and preparation of these policies and procedures and consult technical advisors as necessary to fulfill the purposes of Article 23. MBC must assess the need for: (1) specific standards for informed consent, if any, in order for patients to be able to understand the risks and benefits associated with the range of treatment options available; and (2) standards for investigations to assure competent review in cases involving the practice of any type of alternative medicine, including but not limited to the skills and training of investigators.

The Alternative Medicine Committee—chaired by Dr. Mitchell Karlan and including Dr. Gary Gitnick and public members Donna Gerber and Lorie Rice—held its first meeting on November 2, 2000 in San Diego. Committee members reviewed background information on complementary and alternative medicine (CAM) and on MBC's prior activities related to CAM. MBC Medical Director Neal Kohatsu, MD, MPH, defined CAM as "those practices not presently considered an integral part of conventional medicine." He informed the Committee that the popularity of CAM is on the rise in the United States, and that—as of 2000—42% of the public (up from 33% in 1997) have utilized CAM approaches to satisfy their personal health care needs. The United States government has recognized the growing use of CAM (often in conjunction with traditional medicine) by creating the National Center for Complementary and Alternative Medicine (NCCAM) within the National Institutes of Health; NCCAM's funding has grown from $2 million to $67 million in the past decade. According to NCCAM, Americans spent $21.2 billion for CAM professional services in 1997, with at least $12.2 billion paid out-of-pocket. Following the staff presentation and overview, the Committee entertained public comment from several individuals who urged MBC to recognize CAM, look to non-physicians who practice CAM (including osteopaths, chiropractors, acupuncturists, and naturopaths) for advice on standards of care and practice, and to seek legislation enabling California physicians to offer CAM without fear of MBC disciplinary action.

At its February 2001 meeting, the Committee heard presentations from several California physicians who have integrated CAM into their medical practices and who urged MBC to recognize that knowledge of CAM by all physicians is of critical importance. According to Dr. Mary Hardy, Chair of the Alternative Medicine Department at Cedars-Sinai Medical Center, "it is mandatory that physicians who practice train themselves on the types of medicine their patients prefer. Over 40% of our patients take alternative medicine treatments in combination with prescription drugs and conventional medical treatments. We need to know what they're doing so we can detect conflicts." Dr. Elie Gindi, a senior internist at Cedars-Sinai, reported that he took a 300-hour alternative course at UCLA so he could "practice confidently for my patients." Despite the enormous popular demand for alternative medicine, Dr. Gindi opined that insufficient research money is available to study CAM treatments and modalities, physician training is inconsistent, toxicity issues remain regarding some substances, and "an atmosphere of mistrust and extremism among both medical and CAM providers" hinders progress in this area. Psychiatrist Hyla Cass, MD, stated that "it is incumbent on medical schools to begin research projects and to teach physicians in CAM—the tide is turning and there is no turning back. The physician community needs to develop standards of care for CAM because patients are demanding it." She also commented that the Board should appoint an advisory committee of physicians who practice CAM and can review individual cases and issues.

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Also in February 2001, the Committee reviewed a draft version of a document entitled "Proposed Operating Principles

Related to Integrative, Complementary and Alternative Medicine." Dr. Kohatsu explained that the draft principles "may serve as the basis of a policy statement on CAM that the Board may choose to adopt, sometime in the future, and after further discussion." The document notes that MBC does not establish standards of practice for the medical profession; "the medical community itself will continue to define the boundaries of medical practice." While the Board's role is to protect consumers from "unsound, invalidated, and/or fraudulent medical practice" and ensure they receive high-quality medical care (whether it be alternative or traditional), physicians who choose to employ innovative practices that could benefit patients should be given reasonable latitude to employ these practices in a responsible manner.

The "Proposed Operating Principles" document states that in order to be acceptable, physician-prescribed CAM modalities must meet certain conditions: (1) there must be evidence of effectiveness; (2) the physician believes that a particular patient may benefit; (3) the risk-benefit ratio is reasonable; and (4) the physician obtains written informed consent from the patient or patient surrogate. As with conventional medicine, CAM therapy should be linked with a history, physical examination, pertinent laboratory work, assessment, and plan (including appropriate follow-up), all of which are documented appropriately. Finally, the draft document notes that physicians, in taking a medical history, should ask about their patients' use of CAM, and discuss with their patients any medical issues raised by the use of CAM (such as potential drug interactions). Committee members noted the need to include physician education in any MBC policy that is eventually approved.

As part of its discussion, Committee members also reviewed CAM guidelines and policies which have been issued by New Zealand and the states of Georgia, Texas, and Colorado. Finally, the Committee reviewed a draft timeline for implementation of SB 2100 by July 1, 2002, and took public comment from about a dozen individuals, including several naturopaths who are licensed in other states (California does not license naturopaths) and who urged the Board to focus on harm to patients rather than strict adherence to traditional medical protocols. One witness stated that Pasteur developed pasteurization before science recognized that germs exist, and opined that "all truths pass through three phases—ridicule, violent opposition, and acceptance as self-evident."

Committee on Plastic and Cosmetic Surgery

MBC created its Committee on Plastic and Cosmetic Surgery in 1997 to address growing concerns over this expanding practice area, particularly the disturbing number of complications arising from elective cosmetic surgeries performed in non-hospital settings. *[16:2 CRLR 29–31; 16:1 CRLR 49–52]* In 1999, the Committee's work resulted in the passage of several bills imposing more stringent regulation on this area of medical practice, two of which require implementation work by the Medical Board.

◆ ***AB 271 (Gallegos).*** AB 271 (Gallegos) (Chapter 944, Statutes of 1999) is an MBC-sponsored bill entitled the Cosmetic and Outpatient Surgery Patient Protection Act. *[17:1 CRLR 39–40]* Among other things, the bill added section 2216.2 to the Business and Professions Code. Section 2216.2 requires physicians who perform surgery outside of a general acute care hospital to carry adequate malpractice insurance or participate in an interindemnity trust; the law further requires MBC to determine the amount of liability insurance that is considered "adequate." At its May 2000 meeting, the Committee agreed to recommend that such physicians carry a policy covering $1 million per incident and $3 million per year. Following a public hearing at its July 28, 2000 meeting, DOL adopted new section 1304, Title 16 of the CCR, which defines "adequate security" to mean not less than $1 million per incident and not less than $3 million per year. The Division also modified the proposed language to include a provision requiring it to reevaluate these amounts at least every three years. The Office of Administrative Law (OAL) approved these changes on December 15, 2000.

AB 271 also added section 2240 to the Business and Professions Code; section 2240 requires physicians who perform a scheduled medical procedure outside of a general acute care hospital that results in the death of any patient to report the incident in writing on a form prescribed by the Board within 15 days of the occurrence. At its May 2000 meeting, the Committee approved the draft language of new section 1356.4, Title 16 of the CCR, to implement section 2240. Based on the Committee's recommendation, DMQ held a public hearing at its July 2000 meeting on its proposal to adopt new section 1356.4, which prescribes the precise information that must be included in the required report, including the patient's name, the name of the physician who performed the surgery, the date of the surgery, the name and address of the outpatient setting where the surgery was performed, and the circumstances of the patient's death. Following the hearing, DMQ unanimously adopted the proposed language. OAL approved new section 1356.4 on October 31, 2000.

Although not specifically covered in AB 271, another issue related to outpatient surgery that commanded the Committee's attention was clarification of the written transfer agreement requirement in Health and Safety Code section 1248.15. That section requires physicians performing surgeries in an outpatient setting to have either admitting privileges at a local hospital, a detailed procedural plan for handling emergencies, or a written transfer agreement with a local accredited or license acute care hospital. At its May 2000 meeting, the Committee approved draft language amending section 1313.4, Title 16 of the CCR, to clarify minimum standards for such a transfer agreement. Based on the Committee's recommendation, DOL held a public hearing at its July 28, 2000 meeting on its proposal to adopt new section 1313.4(a)(1), which requires a written transfer agreement to include a mechanism for patient transport, a plan for transfer of the patient's records, policies defining the role of each per-

son in handling an emergency, and a plan for continuity of the patient's care upon transfer of that care. DOL also amended section 1313.4(c), Title 16 of the CCR, relating to the accreditation agencies that it approves to accredit outpatient surgery settings. As amended, section 1313.4(c) requires an accreditation agency to provide to DOL a copy of any certificates of accreditation that it issues and any denial or revocation of a certificate of accreditation, within 14 days of issuance. For each setting whose accreditation it denies or revokes, the agency must provide reasons for its action to the Division in writing. OAL approved these changes on December 5, 2000.

◆ ***SB 450 (Speier).*** SB 450 (Speier) (Chapter 631, Statutes of 1999) added section 2259.7 to the Business and Professions Code, which requires MBC to adopt regulations establishing extraction and post-operative care standards in regard to liposuction procedures performed by a physician outside a general acute care hospital. Section 2259.7 requires the Board, in adopting those regulations, to "take into account the most current clinical and scientific information available." *[17:1 CRLR 40]* In preparation for discussion of this issue, the Committee directed staff at its November 1999 meeting to secure the liposuction practice guidelines of the American Society of Plastic Surgery (ASPS), the American Academy of Cosmetic Surgery (AACS), and the American Academy of Dermatology (AAD). The Committee also appointed former Board member and Committee chair Robert del Junco, MD, as its lead medical consultant on this project. *[16:2 CRLR 29]*

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On June 17, 2000, Dr. del Junco held an all-day special meeting of the Committee on proposed liposuction extraction and post-operative care standards. Based on his review of the practice guidelines of the three specialty societies, Dr. del Junco had prepared an outline of various issues that could or should be addressed in the regulations, including the types of preoperative screening tests that should be performed, based on the type of liposuction to be performed and the total amount of aspirate extracted; restrictions on surgical settings based on the amount of aspirate to be extracted and the type of sedation or anesthesia to be used; standards for monitoring of the patient based on type of sedation or anesthesia to be used; documentation standards for all patients; and discharge criteria. Representatives from over a dozen professional associations submitted testimony at the hearing. On September 13, Dr. del Junco met again with representatives from ASPS, AACS, and AAD, and reached apparent consensus on several issues, including the following:

• Purely tumescent liposuction (a technique that may be performed without a general anesthetic) under certain threshold levels should be treated differently than procedures utilizing intravenous (IV) sedation or general anesthesia. Under the draft consensus, purely tumescent liposuction involving the extraction of 150 ccs or less requires no preoperative screening tests, no IV access, no patient monitoring, and may be performed in any setting. Purely tumescent liposuction involving the extraction of between 150–5,000 ccs requires a standard blood test prior to surgery, IV access, and should be performed in a hospital or accredited setting or one that meets specified standards. In terms of patient monitoring, for volumes between 150–2,000 ccs, a pulse oximeter, blood pressure monitoring, placement of an IV line for possible administration of replacement fluids or drugs for resuscitation, and monitoring of fluid replacement must be available; for volumes over 2,000 ccs, the above-described monitoring techniques are required. Purely tumescent liposuction involving the extraction of 5,000 ccs or more should be done in a hospital.

• Liposuction involving IV sedation or general anesthesia should be treated the same in the regulations. This type of liposuction, if it involves the extraction of volumes under 5,000 ccs, requires specific preoperative screening tests and IV access, and must be performed in a hospital or accredited setting. Procedures involving the extraction of more than 5,000 ccs require additional preoperative tests and must be performed in a hospital. Dr. del Junco noted that there was not complete agreement on whether procedures involving the extraction of more than 5,000 ccs must be performed in a hospital; both ASPS and AACS expressed concerns that such a standard would preclude their members from performing such liposuction in their office-based surgical suites, although AACS finally agreed that such a limit was not unreasonable in the interests of public protection.

• The regulations should include an automatic review date at which point the Board would review them to ensure they conform to the latest data or scientific information.

• It should be made clear that the regulations establish minimum requirements, and that they do not absolve physicians from failing to adhere to higher standards where appropriate, consistent with good medical judgment and the community standard of care.

In a January 20, 2001 memo to the Committee, however, Dr. del Junco announced that ASPS had parted company from the rest of the working group and no longer agreed with the draft consensus—or any part of it—that had been developed. A November 2000 letter from ASPS indicated that the organization objected to virtually everything to which the working group had agreed, including the notion of separating purely tumescent liposuction from procedures involving sedation or general anesthesia. ASPS objected to the fact that the anesthesiology profession had not been included in the working group, and essentially opined that all liposuction should be performable in any accredited setting—regardless of volume or type of anesthesia used.

The issue of "accrediting" nonhospital settings has been a difficult one for the Medical Board. AB 595 (Speier) (Chapter 1276, Statutes of 1994) established the state's system for accrediting outpatient surgical facilities. AB 595 generally prohibits physicians from performing significant surgeries in the outpatient setting unless the setting is "accredited" by an accreditation agency approved by DOL. In this area, DOL's authority is limited to approving the accreditation agency (and it has approved four such agencies); the criteria used by these agencies to accredit outpatient settings are not codified, and they vary from agency to agency. Further, AB 595's threshold for required accreditation of outpatient settings has proven unworkable. The statute prohibits physicians from performing surgical procedures in unaccredited outpatient settings "where anesthesia...is used...in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes"—but the medical community does not agree on the meaning of that language. *[16:1 CRLR 50]* In 2000, Senator Speier had introduced SB 595, which would have required MBC to redefine the threshold for mandatory accreditation; if the Board failed to do so, the bill would have prohibited physicians from performing procedures in an outpatient setting using any type of anesthesia except local anesthesia, minor blocks, or minimal oral tranquilization. *[17:1 CRLR 41]* However, that bill died due to opposition by CMA and other physician organizations (see 2000 LEGISLATION).

In his January 2001 memo, Dr. del Junco reminded Committee members that "the primary role of the societies is to protect their members' interests, not to protect patients. The role of the Board is to provide protection to patients, not to protect the economic interests of physicians. For this reason, I would ask that members seriously consider the elements decided upon by the working group on September 13."

At its February 2001 meeting, the Committee accepted Dr. del Junco's report, but expressed concern that no input from anesthesiologists had been received and incorporated into the report's findings and conclusions. Committee Chair Tom Joas, MD, announced that the Committee would hold an additional meeting in June 2001 to again listen to the input of interested parties and attempt consensus.

Diversion Program Update

Throughout late 1999 and 2000, the Medical Board's Diversion Program Task Force continued its in-depth review of the Board's Diversion Program for substance-abusing physicians. The Diversion Program is a nondisciplinary track for physicians who have abused drugs or alcohol. Participants are required to sign a contract with the Program and adhere to all the terms and conditions in the contract, which include group meeting attendance, random urine testing, required abstinence from drug/alcohol use, and workplace monitoring. In exchange for compliance, participants are permitted to rehabilitate in absolute confidentiality from both MBC's Enforcement Program and public knowledge, and are immune from disciplinary action for self-abuse of drugs or alcohol (which is otherwise a disciplinable offense).

Since November 1997, the structure, functioning, secrecy, and lack of DMQ oversight of the Diversion Program have been the subject of criticism by the Center for Public Interest Law. CPIL cites Business and Professions Code section 2229, which provides that "protection of the public shall be the highest priority for the Division of Medical Quality....Where rehabilitation and protection are inconsistent, protection shall be paramount." However, CPIL has contended that DMQ, which is statutorily charged with administering the Program, failed to properly oversee the Program. The Center further contended that because of the secrecy that shrouds the Program, the lack of any substantive standards to guide Program decisionmaking, and the Program's own failure to comply with state law requiring comprehensive reporting about its decisions and its cost, "it is impossible for anyone to determine whether the Diversion Program protects the public from the state's most dangerous physicians. Yet that is exactly what the Legislature has demanded of the Medical Board in Business and Professions Code sections 2229 and 2340." DMQ created the Task Force in February 1998 to investigate CPIL's concerns and determine whether the Diversion Program provides the public protection demanded by law; the Task Force held a daylong hearing to take testimony from interested members of the public in January 1999. *[17:1 CRLR 34–37; 16:2 CRLR 27; 16:1 CRLR 1, 52]*

DMQ, the Task Force, and Diversion Program staff have recently been involved in a number of important activities, including the following:

◆ ***Decisionmaking Role of the Diversion Evaluation Committees***. Perhaps one of the thorniest issues tackled by the Task Force was the role of the Program's Diversion Evaluation Committees (DECs), regional committees composed of private parties appointed by the Division. Historically and by regulation, the Diversion Program has permitted members of the DECs to make decisions concerning Program participants—for example, the terms and conditions of their Program contracts, whether and under what conditions they should be permitted to practice medicine, sanctions for relapse, whether they have "unsuccessfully completed" the Program, and whether they constitute a threat to the public such that they should be referred to Enforcement. CPIL contended that no statute authorizes DECs to make these decisions, which are police power decisions that only government officials should make. According to CPIL, by delegating these decisions to private-party DEC members, DMQ and MBC were violating antitrust law (because no statute authorizes such decisionmaking and no state official independently supervises it) and the Constitution (unlawful delegation of governmental decisionmaking authority to private parties).

After months of legal wrangling between attorneys from CPIL and MBC, the Task Force—chaired by public member Karen McElliott and including Alan Shumacher, MD, and James Bolton, Ph.D.—took up the issue at its May 2000 meet-

ing when examining an organizational chart of the Program. Task Force members clearly told Diversion Program staff that they were uncomfortable with DEC decisionmaking. According to Dr. Shumacher, government decisions should be made by the Board; the Board may delegate some of those decisions to its staff, but it may not delegate them to private parties. The Task Force agreed that the DECs should function in an advisory capacity to the Diversion Program Manager.

By the July 2000 meeting, Program staff and CPIL had prepared draft statutory language implementing the Task Force's directive for insertion into SB 1554 (Committee on Business and Professions), which was then pending in the legislature (see 2000 LEGISLATION below). At the July meeting, the Task Force and DMQ agreed to support the clarifying language in SB 1554, and approved new organizational charts and revisions to the Diversion Program Procedure Manual to reflect the new decisionmaking process.

◆ ***Quality Assessment/Improvement Reporting at Quarterly Meetings.*** Beginning in July 2000, Diversion Program staff—under the leadership of Program Manager Janis Thibault—began to present detailed (but anonymous) information documenting three important quality assessment/quality improvement (QA/QI) measures for quarterly review by the Task Force: (1) the Program's intake process (including number of days consumed by each of several intake stages); (2) its identification of and responses to relapses into drug/alcohol use by Program participants; and (3) terminations from the Program—whether successful or unsuccessful. This information has been presented and refined at each successive meeting; it is intended to enable Board members to meaningfully oversee the Program as required by law, and to provide the Task Force and members of the public with sufficient data to ensure that the Program is functioning effectively and in a manner that protects the public.

For example, in the area of intakes, the information presented at the February 2001 meeting indicated that 30 physicians contacted the Diversion Program regarding admission during the third quarter of 2000. Of those 30, seven were not interested and left the Program before being admitted; the rest were pending at some stage of evaluation and/or admission at the end of the quarter. The QA/QI data also indicated whether Program staff are responding to requests for admission within target timeframes. From the date of the physician's initial contact with the Program, an average of 6.8 days elapsed before the first face-to-face contact between the physician and Program personnel (the Program's goal is four days); an average of 11.7 days elapsed between initial contact and the first intake interview (the goal is seven days); 12.7 days elapsed between initial contact and the physician's attendance at a group meeting (the goal is four days); an average of 10.5 days elapsed between initial contact and the physician's signature on an interim Diversion agreement (pending a meeting with a DEC and agreement to a final contract as recommended by the DEC) (the goal is seven days); and an average of 84 days elapsed between initial contact and the DEC meeting (the goal is 60–90 days). These data will be used in the future to determine whether the Program is adequately staffed.

The data indicated a total of eight relapses detected during the third quarter of 2000. A detailed report on each relapse reveals the date(s) of relapse, how the relapse was detected (*e.g.*, through a random urinalysis, workplace monitor observation, or self-reporting by the participating physician), how long the participant had been in the Program at the time of relapse, how long it took the Program to detect the relapse and confront the participant, the participant's response, the Program's response, and whether the participant was practicing medicine at the time of relapse. After reviewing these reports, Task Force members Rice and Leahy requested additional information on those who relapse, including the total number of relapses while in the Program and the Program's overall responses to those relapses.

As to terminations from the Program, a total of twelve participants were released during the third quarter of 2000—ten were successful and two were unsuccessful. Those who terminated successfully spent an average of five years and two months in the Program. Of those who terminated unsuccessfully, one committed suicide; the other was terminated for failure to comply with the Program's requirements and was referred to Enforcement.

At this writing, Program Manager Thibault intends to compile these data on a quarterly basis and to release the Program's first comprehensive report in July 2001.

◆ ***Creation of Standing Diversion Committee.*** Effective in November 2000, the Diversion Task Force was converted to a standing Diversion Committee, which will meet quarterly to review the QA/QI data compiled by Program staff and to consider all other policy issues related to the Diversion Program. Thus, for the first time, the Medical Board has created a standing committee to oversee the Diversion Program, consistent with its obligations under Business and Professions Code section 2340 *et seq.* At this writing, the Committee is chaired by public member James Bolton, Ph.D., and includes public member Lorie Rice and physicians Margo Leahy and Gary Gitnick.

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◆ ***Diversion Program Rulemaking.*** At its November 1999 meeting, DMQ held a public hearing on the Diversion Program's proposal to add new section 1357.9 and amend existing section 1357.5, Title 16 of the CCR. *[17:1 CRLR 36; 16:2 CRLR 57]*

SB 2239 (Committee on Business and Professions) (Chapter 878, Statutes of 1998) requires Diversion Program participants to sign an agreement permitting use of their diversion records if they are terminated from the Program for

reasons other than successful completion. New section 1357.9 was proposed to specify the kinds of records which will be kept by the Program, to include all intake reports and case analyses, all agreements and amendments thereto, all correspondence with the Enforcement Program, all DEC letters regarding a participant, all file notes and lab and incident reports, and computerized records derived from any of the foregoing types of documents.

The Division also sought to clarify the criteria for termination from the Diversion Program, at which point the above-described records might be referred to Enforcement. Under the draft amendments to section 1357.5, a Diversion Evaluation Committee may terminate a physician's participation from the Program for any of the following reasons: (1) successful completion; (2) the physician has failed to comply with the diversion agreement he/she signed, including but not limited to failure to comply with the prescribed monitoring or treatment regimen, use of alcohol or other unauthorized drugs, or refusal to stop practice when directed to do so by a DEC; (3) any cause for denial of admission into the Program under section 1357.4; or (4) a DEC determines that the physician will not benefit from further participation in or has not substantially benefitted from participation in the Program, or that the physician's continued participation in the Program creates too great a risk to the public health, safety, or welfare.

At the public hearing, CPIL's Julie D'Angelo Fellmeth commented on the proposals, noting that she has no objection to section 1357.9 or the proposed termination criteria in section 1357.5. However, she reiterated CPIL's position that section 1357.5, as written and as then effective, is unauthorized, inconsistent with state law, and may in fact conflict with federal antitrust law and the Constitution. According to Fellmeth, section 1357.5 authorizes the DECs to terminate participants from the Diversion Program for unsuccessful completion of the Program's requirements; however, nothing in Business and Professions Code sections 2352, 2018, 2350, 2351, or 2354 authorizes DECs to make that decision. Fellmeth reiterated CPIL's position that governmental decisionmaking by the private parties who make up the DECs violates federal antitrust law and the Constitution (see above).

DMQ member Alan Shumacher moved that the Division defer action on section 1357.5 until the Diversion Task Force completes its work. That motion failed by a vote of 3–4, and DMQ approved the proposed changes to section 1357.5 and 1357.9 by a 4–3 vote.

On May 10, 2000, OAL rejected the proposed regulatory changes, finding that they were "not clear, and susceptible to an interpretation that would be inconsistent with other applicable laws." In an attempt to clarify the language to meet OAL's concerns, DMQ thereafter released two modified versions of the proposed regulatory changes—one on June 19 and one on July 24—for additional 15-day comment periods. OAL finally approved the proposed changes on October 5, 2000.

By that time, SB 1554 (Committee on Business and Professions)—an MBC omnibus bill containing numerous clean-up changes to the Diversion Program statutes—had been enacted (see 2000 LEGISLATION). Among other things, SB 1554 clarifies that DECs are not decisionmaking bodies but act in an advisory capacity to the Diversion Program Manager; for purposes of successful completion of the Diversion Program, extends the minimum period of time a physician must remain free of the use of drugs or alcohol from two to three years; repeals a requirement that the DECs hold public meetings twice a year; instead requires them to provide information to the Board; and also requires the Board to hold a public meeting at least annually for the purpose of reviewing the data provided by the DECs.

On March 23, 2001, DMQ published notice of its intent to again amend its Diversion Program regulations to conform them with SB 1554. The Division proposes to amend sections 1357.1–.6, Title 16 of the CCR, to clarify the role of the Program Manager and the DECs. At this writing, DMQ is scheduled to hold a public hearing on these proposed regulatory changes at its meeting on May 11, 2001.

◆ ***Future Issues.*** At its quarterly meetings, the Task Force and subsequently the Diversion Committee have identified a number of issues pertaining to the Diversion Program which must be addressed in the near future. A threshold issue is the location of the Diversion Program within the Medical Board. Compared to statistical estimates of the extent of the chemical dependency problem among the physician population, participation in MBC's program is extremely low—and some believe more physicians would seek help if the Program were not located within the Medical Board (and directly adjacent to the Enforcement Program). Most other state medical boards contract the administration of their diversion programs to outside entities; MBC is one of only a handful of state medical boards that runs its diversion operation in-house.

Another difficult issue concerns self-referred physicians who contact the Program, admit to a serious problem, and then leave before being admitted to the Program.

Another difficult issue concerns self-referred physicians who contact the Program, admit to a serious problem, and then leave before being admitted to the Program. Although Medical Board Diversion Program staff are aware of a seriously ill physician who retains an unrestricted license to practice medicine, they are not permitted to contact Enforcement or do anything to protect the public from a potentially dangerous physician. This conflict has left Diversion Committee members very uncomfortable.

Another issue concerns the Program's "success rate." In the past, the Program has touted an approximate 69% "success rate" and has been criticized by CPIL for doing so. In CPIL's view, this "success rate" means only that 69% of the

physicians who enter the Program eventually complete it; the Program has no idea where the other 31% are and/or whether the 69% who "graduated" have remained sober. The Program does not monitor or track "graduated" participants in any way, so it is unclear whether these physicians are successfully practicing or have reverted to substance abuse in an unmonitored fashion. CPIL believes that the Program should attempt to track its graduates to determine whether the Program is effective in protecting the public in the long term.

Finally, Program supporters insist that the Diversion statutes should be amended to permit the Program to divert and monitor mentally ill physicians. Currently, the program is structured primarily to assist substance-abusing physicians, and the law permits the Board to divert substance-abusing physicians from the disciplinary track if they participate in the Diversion Program and comply with its requirements. While the law permits the Program to monitor mentally ill physicians, it does not technically permit the Program to divert them from discipline. The California Society of Addiction Medicine and CMA strongly support the diversion of mentally ill physicians from discipline; CPIL has urged caution because of the cost of such an undertaking. These and other issues will be taken up by the Diversion Committee at future meetings.

Committee on Internet Prescribing

MBC's Committee on Internet Prescribing recently tackled the complex issue of medical practice—and specifically prescribing—via the Internet. According to former Committee Chair Bud Alpert, MD, "pharmacies are shipping across state lines, physicians are writing prescriptions for people they've never met, patients are able to get access to prescription drugs for which they have no legitimate prescription, and some of these sites are not necessarily supervised or run by physicians who are licensed in any state." According to Dr. Alpert and Board staff, no government agency at any level has any kind of handle on this global problem. Following its first meeting in July 1999, the Committee instructed staff to take actions that are within the jurisdiction of a state medical board: (1) focus on defining "good faith examination" (without which a physician may not write a prescription for a patient in California) under Business and Professions Code section 2242, and publish a policy statement on the issue in the Board's *Action Report* newsletter; (2) attempt to determine where a California patient is being "treated" if she, for example, logs on to a Florida site and purchases drugs; (3) consider widening the composition of the Committee to include representatives from the legislature, the Board of Pharmacy, the Attorney General's Office, and the U.S. Department of Justice; and (4) add a warning to the Board's Web site concerning the dangers of purchasing drugs over the Internet.

The Committee met again in November 1999 and February 2000. Staff published an informational article on the Internet prescribing issue and published it in the October 1999 issue of the Board's *Action Report* licensee newsletter. The article noted that Business and Professions Code section 2242(a) precludes physicians from writing prescriptions "without a good faith prior examination and a medical indication therefor," and stated that "a reasonable person can interpret [this] to mean the physician has a supportable medical basis for prescribing the drug. Certainly there should be more than a series of 'yes' or 'no' questions on a questionnaire and a Visa card number. Clearly, completing a questionnaire with no tests, no scientific verification or evaluation, and no prior relationship cannot meet the good faith examination requirement. Enforcement of this law, when it comes to California-licensed physicians, is straightforward. If a doctor violates the law, disciplinary action may result."

Staff also drafted a notice to consumers regarding the dangers of purchasing drugs over the Internet for posting on MBC's Web site, and developed a comprehensive public education plan which will include the subject of Internet prescribing. In addition, staff conducted legal research and concluded that California law already addresses many of the issues related to Internet prescribing practices. According to staff, "public protection deficiencies reside not in inadequate California law, but in the lack of enforcement resources and jurisdiction problems between other states and the federal government." Nonetheless, MBC supported SB 1828 (Speier) in 2000, which added section 2242.1 to the Business and Professions Code. Section 2242.1 expressly prohibits the prescription and dispensation of dangerous drugs and devices on the Internet for delivery to any person in California without a good faith prior examination and medical indication therefor, and subjects violators to a fine or civil penalty up to $25,000 per occurrence (see 2000 LEGISLATION).

At its February 2000 meeting, the Committee decided that the best way to track national developments in the Internet prescribing issue is through the Federation of State Medical Boards. As such, the Committee disbanded after the February 2000 meeting.

DOL Ponders Foreign Medical School Application for Approval

At its July 2000 meeting, DOL reviewed an application for approval from St. Matthew's University School of Medicine (SMUSM), located on Ambergris Caye off the coast of Belize, Central America. The AMA's Liaison Committee on Medical Education (LCME) accredits medical schools in the United States, Canada, and Puerto Rico; graduates of LCME-accredited medical schools are deemed to have complied with the medical education requirements in the Medical Practice Act. Non-LCME-accredited schools may be individually reviewed and "approved" by DOL under Business and Professions Code section 2084. If a foreign school is approved by DOL, its graduates may enroll in clinical programs in California hospitals.

The approval process involves the school's completion of an extensive questionnaire that requests data on the school's institutional objectives, governance, administration, resources, educational program, medical students, and affiliated teach-

ing hospitals. After reviewing the written information submitted by the medical school, the Division usually conducts an onsite inspection of the school's facilities to determine compliance with the education requirements in Business and Professions Code sections 2089 and 2089.5.

St. Matthew's applied for approval in March 2000. Following past precedent, DOL asked Dr. Harold Simon of the UCSD School of Medicine to review SMUSM's application and provide written findings and recommendations concerning the school's medical education program. At its July 2000 meeting, DOL reviewed Dr. Simon's report, which raised several concerns about SMUSM. With regard to administration, Dr. Simon found that only one of the eight administrators is a physician, and it is unclear if any administrator has ever carried primary responsibility for a patient's medical care. According to Dr. Simon, "serious questions must be raised about [the administrators'] knowledge of curriculum planning and content, careers and career choices by medical students, and other issues pertaining to administering an academic medical institution."

Regarding SMUSM's faculty, Dr. Simon found the number of full-time faculty teaching preclinical basic science courses to be "unacceptably small." Further, SMUSM's practice of allowing currently enrolled students to teach basic science courses is also unacceptable. The faculty member responsible for teaching microbiology/immunology received only one year of postgraduate training in an infectious disease residency/fellowship, "a grossly inadequate background for carrying the responsibility for the education of medical students in these two critically important fields." Dr. Simon found that many faculty have little or no experience with American medical schools or students, and are not in a good position to offer advice on residency programs or career choices in the United States. Also, not one faculty member had produced a publication since the opening of SMUSM, thus precluding student exposure to scientific research. "Career choices involving medical research may very well be precluded from the students' horizons; they will not understand the complex research process; and they will not be able to acquire the ability to critically review and analyze the medical literature."

With regard to SMUSM's students and curriculum, the MCAT is not required, and almost one-fourth of the students have an undergraduate average of C (2.5) or less. Dr. Simon found that the anatomy classes use plastinated materials instead of cadavers, and noted ongoing debate in the United States as to whether this method, even together with audiovisual technology, can effectively substitute for cadavers. There is no biochemistry laboratory or component in the curriculum and no evidence that preclinical electives are offered. It appears that instruction in the basic sciences is given a "once over lightly" approach. Also, "introduction to clinical medicine" (ICM) is an important component of preclinical education; yet SMUSM students apparently have no direct access to a large patient population, which is necessary for effective ICM training.

As to SMUSM's library and affiliated institutions, Dr. Simon found that the school has "less than twenty-five single copy journal subscriptions" and a "minuscule number of basic texts." According to Dr. Simon, "the size of the library staff is grossly inadequate," the library does not engage in library exchanges, and it does not offer Medline and Physicians-on-Line resources to students. Only faculty and doctors recognized by the Belize Medical Council may use the electronic resources. Finally, while SMUSM's affiliate hospitals in the United Kingdom are "teaching hospitals in the best sense of the term, with excellent teaching staffs, patient and technological resources, and library facilities," this is not the case with SMUSM's affiliate hospitals in the United States.

Dr. Simon cautioned that "whether these students are adequately prepared for their clerkships is at least questionable," yet suggested that DOL undertake a site visit to SMUSM "to address the diverse concerns expressed about this venture."

At its July 2000 meeting, DOL considered Dr. Simon's report and reviewed responses to the report submitted by Dr. Jerry Thornton, SMUSM's Vice President for Academic Affairs. Dr. Simon and Dr. Thornton also spoke at the meeting. Dr. Thornton explained that SMUSM has many students from California who wish to return to California to begin their practice. He wanted DOL to identify SMUSM's weaknesses so the administration could correct them, placing SMUSM in a position for future approval. In response, DOL President Dr. Tom Joas stated that SMUSM should have corrected the school's weaknesses before applying. DOL concluded that SMUSM must submit further program and resource information including a full application, as current as possible, with photographs before an onsite inspection can be authorized.

Thereafter, Dr. Thornton worked to address all issues raised by DOL with the intent to submit additional information for consideration at DOL's November 2000 meeting. However, on October 2, 2000, Hurricane Keith battered Belize and Ambergris Caye with 130 miles-per-hour winds and 30 inches of rain. According to a January 2001 letter written by Dr. Thornton, several SMUSM buildings (including student housing) were damaged by the hurricane, and the school taught its fall semester at a medical school in Orlando, Florida. Dr. Thornton asked for additional time in which to provide DOL with the information it requires. DOL set a new deadline of April 1, 2001 for receipt of SMUSM's materials, and—at this writing—is scheduled to further discuss SMUSM at its May 2001 meeting.

DMQ Rulemaking

The following is a description of rulemaking proposals published and considered by the Division of Medical Quality during recent months, some of which are described in more detail in Volume 17, No. 1 (Winter 2000) of the *Reporter*:

◆ ***Citations and Fines.*** In June 2000, DMQ published notice of its intent to amend sections 1364.11 and 1364.15, Title 16 of the CCR, which pertains to MBC's citation and fine program. Section 1364.11 lists various statutory provisions the violation of which is grounds for a citation and/or

fine. DMQ proposed to add six new statutory provisions to the list in section 1364.11: (1) Business and Professions Code section 2216.1, which establishes staffing requirements in outpatient settings; (2) Business and Professions Code section 2240, which requires physicians who have performed a scheduled medical procedure outside a general acute care hospital that results in the death of a patient to report the death in writing to the Board; (3) Business and Professions Code section 2244, which pertains to the safe and secure storage of biological specimens collected for clinical testing or examination; (4) Health and Safety Code section 1248.15, which makes it unprofessional conduct for a physician to willfully and knowingly violate any provision pertaining to outpatient surgery settings; (5) Health and Safety Code section 103785, which pertains to a physician's duty to fill out death certificates and deliver them to those who are charged with the duty of registering them; and (6) 16 CCR 1399.545, which sets standards for a physician's supervision of physician assistants. DMQ also proposed to delete Business and Professions Code section 651 from the list in section 1364.11. Effective January 1, 2000, SB 836 (Figueroa) (Chapter 856, Statutes of 1999) authorizes MBC to impose fines up to $10,000 for violations of section 651, whereas fines for the violations listed in section 1364.11 are limited to $2,500; thus, MBC proposed to delete section 651 from the list in section 1364.11.

DMQ also proposed to amend section 1364.15, which relates to public disclosure of the issuance of citations, to state that citations that have been resolved by payment of the administrative fine or compliance with the order of abatement shall be purged five years from the date of resolution.

Following a public hearing at its July 2000 meeting, DMQ adopted the proposed amendments. OAL approved them on November 8, 2000.

◆ ***Precedent Decisions.*** Also at its July 2000 meeting, DMQ held a public hearing on its proposal to adopt new section 1364.40, Title 16 of the CCR, which implements Government Code section 11425.60, part of the Administrative Procedure Act which governs DMQ's conduct of disciplinary proceedings. Section 11425.60 authorizes agencies to designate certain disciplinary decisions (or portions of such decisions) as "precedential" to guide ALJs, deputy attorneys general, and others in addressing recurring factual and legal issues. New section 1364.40 authorizes DMQ to designate "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur" as a precedential decision upon which the Division may rely and to which parties may cite in their argument to the Division and courts. In addition to its own decisions, the new regulation authorizes DMQ to designate as a precedent decision "any precedent decision issued by another California state government agency." Prior to designating a decision as precedential, the regulation requires DMQ to publish notice of its intent to do so and consider the written comments of interested persons. Following the public hearing, DMQ adopted new section 1364.40 with one minor change. OAL approved the new section on November 6, 2000.

◆ ***DMQ Acceptance of Amicus Curiae Briefs in Disciplinary Matters.*** Following a public hearing at its November 1999 meeting, DMQ adopted new section 1364.31, Title 16 of the CCR, which permits an interested non-party to file an *amicus curiae* brief in a Medical Board disciplinary matter. *[17:1 CRLR 38; 16:2 CRLR 32–33]*

Under the new regulation, a prospective *amicus* may seek to file a "friend of the court" brief at three points in the process: (1) when a DMQ panel has nonadopted a proposed decision submitted by an ALJ after an evidentiary decision, (2) when a DMQ panel has received a petition for reconsideration of a prior decision, and (3) when a DMQ panel has granted a petition for reconsideration of a prior decision. Under the new regulation, the filing of an *amicus* brief regarding whether a panel should nonadopt a proposed decision is not permitted. A person who seeks to file an *amicus* brief must submit the proposed brief along with a one-page request to the Board's Executive Director specifying the points to be argued in the brief and indicating why additional argument on those points is necessary or would be helpful to the panel. Upon receiving the request, the Executive Director must immediately transmit it to the chair of the panel; the decision whether to grant the request will be made by the panel chair and one panel member designated by the chair. If the vote is not unanimous, the request is deemed denied. If the request is granted, the Executive Director must then transmit a copy of the brief to each panel member.

The regulation also sets timeframes for two of the three situations in which an *amicus* brief may be filed. Where DMQ has nonadopted a proposed ALJ decision or has granted reconsideration of one of its own decisions, a request to file an *amicus* brief must be received no later than 45 days prior to the date on which oral argument is scheduled (or the matter is to be considered by the panel if no oral argument has been requested). The draft language contains no deadline for filing a request after DMQ has received a petition for reconsideration; however, Government Code section 11521 requires DMQ to act within a very limited timeframe after receiving a petition for reconsideration, so prospective *amici* should be prepared to file quickly as well. OAL approved new section 1364.31 on April 7, 2000.

◆ ***Revisions to DMQ's Disciplinary Guidelines.*** On January 27, 2000, OAL approved DMQ's changes to section 1361, Title 16 of the CCR, which now require the Division—in reaching a decision in a disciplinary matter—to consider the 1999 version of its *Disciplinary Guidelines and Model Disciplinary Orders*, and incorporates those guidelines by reference. *[17:2 CRLR 38; 16:2 CRLR 33]*

DOL Rulemaking

The following is a description of rulemaking proposals published and considered by the Division of Licensing during recent months, some of which are described in more detail in Volume 17, No. 1 (Winter 2000) of the *Reporter*:

◆ ***Licensed Midwifery Program Regulations.*** On July 28, 2000, DOL held a public hearing on its proposal to amend section 1379.10, Title 16 of the CCR, which sets forth the instructions for an individual to apply for licensure as a midwife, references the form that must be completed, and incorporates the form by reference. DOL proposed to amend the application form to include questions that are common to other health care licensing programs. The revised form requires applicants to submit information on colleges and universities attended (and to include official transcripts), any approved midwifery school(s) attended (and to include official transcripts), official examination scores from challenge candidates, and healing arts licenses held in other states or countries (and to include letters of good standing). Additionally, candidates must disclose whether they have been denied a license to practice midwifery or any other healing art in another state, whether they have been charged with or found to have committed unprofessional conduct in another state, and whether they have been convicted of or pled nolo contendere to any criminal charge. Following a public hearing, DOL unanimously approved the revised form. OAL approved the amendments on November 6, 2000.

On March 23, 2001, DOL published notice of its intent to amend sections 1379.20, 1379.22, and 1379.26, Title 16 of the CCR, which also relate to midwifery licensing, in compliance with SB 1479 (Figueroa) (Chapter 303, Statutes of 2000). SB 1479 added section 2508 to the Business and Professions Code, which expands disclosure requirements for licensed midwives (see 2000 LEGISLATION). Under DOL's proposed amendments to section 1379.20, licensed midwives must disclose, both orally and in writing, the following information to a client on the first visit or examination: (1) the midwife's name and license number; (2) the client's name; (3) whether the midwife has liability coverage and, if so, the name of the liability coverage provider; (4) the name of an alternate midwife or certified nurse-midwife to provide backup services; (5) the name of a physician who provides medical/obstetric consultation, if necessary; (6) the name of a hospital, should emergency transfer be required; (7) the name of an emergency medical service provider, and (8) methods available through MBC to verify health care provider licensure and complaint process. The disclosure must be signed and dated by both the midwife and the client, and placed in the client's file. DOL also proposed some technical changes to sections 1379.22 and 1379.26. At this writing, DOL is schedule to hold a public hearing on these proposed regulatory amendments at its May 11, 2001 meeting.

◆ ***Registered Dispensing Optician Fees.*** At its July 28, 2000 meeting, DOL held a public hearing on its proposal to amend sections 1399.260, 1399.261, and 1399.263, Title 16 of the CCR; these changes generally lower the renewal license fees for registered dispensing opticians and contact lens dispensers, and establish an initial registration fee and renewal fee for spectacle lens dispensers. Following the public hearing, DOL adopted the proposed fee changes; OAL approved them on November 28, 2000.

◆ ***Postgraduate Training Exemption Period.*** On February 10, 2000, OAL approved DOL's adoption of new section 1320, Title 16 of the CCR, which states that all approved postgraduate training (PGT) shall count toward the two-year exemption period provided in Business and Professions Code sections 2065 and 2066, including any training obtained within or outside of California, whether a full or partial year of training, and regardless of whether the training was successfully completed. *[17:1 CRLR 38–39]*

◆ ***Postgraduate Training Requirement for Graduates of Foreign Schools.*** On January 19, 2000, OAL approved DOL's amendment to section 1321(d), Title 16 of the CCR, which clarifies that all applicants for physician licensure must have completed one continuous year of approved PGT in a single program. The one year may be interrupted in cases due to illness or hardship. With respect to an applicant who qualifies for licensure by completing at least two years of PGT, the second year must be one continuous year in a single program, which may be the same or a different program than the first year. The second year may be interrupted in cases due to illness or hardship. *[17:1 CRLR 39]*

2000 LEGISLATION

SB 1554 (Business and Professions Committee), as amended August 22, 2000, is an MBC-sponsored bill that makes the following changes with respect to the Medical Board: (1) extends the period of time a foreign medical school graduate may practice medicine within an approved PGT program prior to getting licensed from two to three years; (2) extends the minimum period of time a physician must remain free of the use of drugs or alcohol from two to three years in order to successfully complete the Diversion Program; (3) repeals a requirement that the Diversion Program's Diversion Evaluation Committees (DECs) hold public meetings twice a year and instead requires them to provide specified information to the Board, and requires the Board to hold a meeting at least annually for the purposes of reviewing the data provided by these committees; and (4) specifies that the DECs operate in an advisory role to the Diversion Program Manager and clarifies the role of the Diversion Program Manager (see MAJOR PROJECTS). Governor Davis signed SB 1554 on September 28, 2000 (Chapter 836, Statutes of 2000).

AB 2571 (Campbell), as amended March 30, 2000, provides that the statute of limitations on disciplinary actions filed by the Board does not apply when a physician intentionally conceals his/her incompetence, gross negligence, or repeated negligent acts. Governor Davis signed this bill on August 30, 2000 (Chapter 269, Statutes of 2000).

SB 648 (Ortiz), as amended August 29, 2000, revises the definition of the term "venereal disease" to include chlamydia, and authorizes a physician to prescribe, dispense, furnish or otherwise provide prescription antibiotic drugs to the partner(s) of a patient diagnosed with chlamydia without performing a good faith prior examination of the partner(s).

SB 648 was signed by the Governor on September 29, 2000 (Chapter 835, Statutes of 2000).

SB 1479 (Figueroa), as amended August 7, 2000, increases the requirements for informed consent that a licensed midwife must provide to a client. MBC must create a standardized form specifying what the midwife is authorized to do, whether the midwife has liability insurance, specific arrangements for transfers, access to emergency care, and procedures for reporting a complaint. The forms must be signed by both the midwife and client and a copy placed in the medical record (see MAJOR PROJECTS). This bill also allows midwives to register the birth of infants they deliver. SB 1479 was signed by the Governor on September 1, 2000 (Chapter 303, Statutes of 2000).

SB 2100 (Vasconcellos), as amended August 25, 2000, adds Article 23 (commencing with section 2500) to the Business and Professions Code, entitled "Alternative Practices and Treatments." In the bill, the legislature makes findings regarding "the emergence amongst thousands if not millions of [Californians] a fascination with and commitment to the philosophies and methodologies of alternative ways of health and healing, commonly known as holistic health, integrative medicine, humanistic medicine, or complementary health," and "the emergence of more and more providers who are committed to these alternative modalities of health and healing, while there has been far too little effort expended to understand and appreciate both the alleged benefits and the alleged damages attendant to those practices."

SB 2100 calls on MBC and the Osteopathic Medical Board of California to engage in a comprehensive review of the emergence of holistic health treatments and whether the boards should redesign their systems of operation to meet the health care needs of individuals seeking emerging modalities of health care.

SB 2100 calls on MBC and the Osteopathic Medical Board of California to engage in a comprehensive review of the emergence of holistic health treatments and whether the boards should redesign their systems of operation to meet the health care needs of individuals seeking emerging modalities of health care. This bill requires MBC and the Osteopathic Board to establish disciplinary policies and procedures to reflect emerging and innovative medical practices, solicit participation of interested parties, and consult with technical advisors on or before July 1, 2002. Specifically, MBC and the Osteopathic Board must assess: (a) "specific standards for informed consent, if any, in order for patients to be able to understand the risks and benefits associated with the range of treatment options available"; and (b) "standards for investigations to assure competent review in cases involving the practice of any type of alternative medicine, including, but not limited to, the skills and training of investigators (see MAJOR PROJECTS). Finally, the bill requests that the University of California review cancer treatments and therapies for purposes of assisting the Governor and legislature in assuring that California consumers diagnosed with cancer have the best range of treatment and therapeutic choices. SB 2100 was signed by the Governor on September 26, 2000 (Chapter 660, Statutes of 2000).

AB 1792 (Villaraigosa), as amended August 29, 2000, authorizes the Department of Motor Vehicles to request that MBC enforcement staff review medical records of individuals subject to an audit of their disabled parking permit, where there is a question of whether those individuals should be in possession of such a permit for their medical condition. AB 1792 was signed by the Governor on September 19, 2000 (Chapter 524, Statutes of 2000).

AB 1820 (Wright), as amended August 23, 2000, supplements physician education requirements. The bill requires all applicants for a medical license after January 1, 2004 to have completed coursework in geriatric medicine in medical school or in postgraduate training. AB 1820 requires general internists and family physicians who have a patient population of which 25% or more are 65 or older to complete at least 20% of all mandatory continuing education courses in the field of geriatric medicine or the care of older patients. This bill also requires DOL to encourage physicians to take a course in geriatric medicine as part of their continuing education training. Finally, this bill requires the University of California to establish academic geriatric resource programs and encourage the development of expanded educational and community service programs in geriatric medicine at its medical schools. AB 1820 was signed by the Governor on September 13, 2000 (Chapter 440, Statutes of 2000).

AB 2394 (Firebaugh), as amended August 30, 2000, establishes a Task Force on Culturally and Linguistically Competent Physicians and Dentists. The bill names the MBC Executive Director as a member of the Task Force, along with at least 13 others. Duties of the Task Force include developing recommendations for continuing education programs that include language proficiency standards; identifying key cultural elements necessary to meet cultural competency; assessing the need for voluntary certification standards; holding hearings and meetings to obtain input from ethnic minority groups; and reporting its findings to the legislature by January 1, 2003. The bill also creates a subcommittee of the Task Force, which must examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas. The subcommittee must report its findings to the Task Force by March 1, 2001, and the Task Force must forward that report and any additional comments to the legislature by April 1, 2001. Finally, this bill requires MBC and the Dental Board to pay for the administrative costs created by this bill. AB 2394 was signed by the Governor on September 28, 2000 (Chapter 802, Statutes of 2000).

SB 1988 (Speier), as amended August 25, 2000, is an insurance fraud bill and primarily deals with automotive repair. However, it contains three provisions relating to MBC:

(1) it requires MBC to investigate any licensee against whom an indictment has been filed alleging insurance fraud, so long as the district attorney does not object to the initiation of an investigation; (2) it requires MBC to revoke a license for ten years upon a second conviction of insurance fraud; and (3) it adds new section 2417 to the Business and Professions Code, which provides that (with enumerated exceptions) "any type of business organization that holds itself out to the public as an organization practicing medicine, or that a reasonably informed person would believe is engaged in the practice of medicine, shall be owned and operated only by one or more licensed physicians and surgeons," and further provides that "a physician and surgeon who knowingly practices medicine with a business organization not owned or operated in compliance with subdivision (a) shall have his or her license to practice permanently revoked."

Governor Davis signed SB 1988 on September 28, 2000 (Chapter 867, Statutes of 2000). However, in a signing message, the Governor expressed concern about new section 2417, which was contained in Section 9 of the bill. According to the Governor, the provision "restricts most businesses engaged in the practice of medicine to 100% ownership by licensed physicians and surgeons, unless an exemption is provided by the Director of the Department of Health Services. Additionally, for the physician or surgeon who practices in a business which is not in compliance, the penalty is mandatory and permanent revocation of his or her license to practice medicine. I am concerned that these far-reaching mandates could have severe consequences for the health care system because organizations such as medical groups could be required to cease operating or their physician members could lose their licenses. I am therefore directing the Department of Health Services to immediately issue an across-the-board waiver for any professional corporation that meets the ownership and management requirements in Section 13401.5 of the Corporations Code. I am also directing the Department to pursue legislation in the 2001 session to correct the problems created by Section 9 of SB 1988, related to ownership requirements for private medical groups. By taking this action, I can assure Californian's [sic] receive the important auto fraud protections without risking the unintended interruptions of health care services."

SB 1828 (Speier), as amended August 11, 2000, adds section 2242.1 to the Business and Professions Code, which prohibits the prescription, dispensation and furnishing of drugs over the Internet without a prior medical examination, medical indication, and prescription. Violators may be subject to a $25,000 fine. This bill was supported by the Medical Board. The Governor signed SB 1828 on September 24, 2000 (Chapter 681, Statutes of 2000).

AB 751 (Gallegos), as amended June 20, 2000, specifies that an existing misdemeanor provision prohibiting any person from dispensing or furnishing prescription drugs or devices without a license also applies to any item represented as, or presented in lieu of, a prescription drug or device. AB 751 also eliminates a January 1, 2001 sunset date on a provision of law permitting local health officers to take certain actions against persons selling prescription drugs or devices without a license, including closing a business upon the second offense. This bill was sponsored by Los Angeles County, supported by MBC, and is intended to remedy problems associated with "backroom clinics" and pharmacies that sometimes dispense substances that are illicit counterfeits and contain no active ingredients. Governor Davis signed AB 751 on September 7, 2000 (Chapter 350, Statutes of 2000).

AB 265 (Davis) and **SB 1045 (Murray)**, as introduced in February 1999, would have increased biennial license fees for physicians. AB 265 was sponsored by the Medical Board and would have amended Business and Professions Code section 2435 to increase the biennial license renewal fee for physicians from $600 to $690. SB 1045 was CMA's competing fee bill which would have revised the biennial license renewal fee for physicians while imposing numerous conditions and requirements on the Medical Board. Both bills stalled in committee in 1999, and were the subject of lengthy negotiations among MBC, CMA, CPIL, the Attorney General's Office during 2000. When no agreement was reached, Senator Murray dropped SB 1045 and Assemblymember Davis converted AB 265 to a bill relating to the Public Utilities Commission (see MAJOR PROJECTS).

The following bills reported in Volume 17, No. 1 (Winter 2000) died in committee or otherwise failed to be enacted during 2000: **AB 827 (Baldwin)**, relating to alternative medicine; **AB 1592 (Aroner)**, which would have allowed a terminally ill patient to request medication to end his/her life in a humane and dignified manner; **SB 7 (Figueroa)** and **SB 18 (Figueroa)**, which would have required persons making medical necessity or appropriateness decisions to be properly licensed; **SB 422 (Figueroa)**, which would have required health plans to communicate denials or modifications of prior authorizations to enrollees in writing; **SB 595 (Speier)**, which would have clarified the definition of "outpatient setting" for purposes of accreditation and MBC regulation; and **SB 837 (Figueroa)**, relating to outpatient settings for cosmetic surgeries.

The following bills reported in Volume 17, No. 1 (Winter 2000) were subsequently amended and are no longer relevant to the Medical Board: **AB 1418 (Strom-Martin)**, **SB 1305 (Figueroa)**, and **SB 362 (Alpert)**.

2001 LEGISLATION

SB 16 (Figueroa), as amended April 17, 2001, would make a number of changes to ensure that hospitals and other mandated reporters file so-called "section 805 reports" (see MAJOR PROJECTS).

Among other things, SB 16 would: (1) increase the penalty for intentional failure to file a section 805 report from $10,000 to $100,000, and increase the penalty for failure to file a section 805 report from $5,000 to $50,000; (2) specify that, for physician reporters, failure to file a section 805 report is unprofessional conduct and grounds for discipline; (3) add disability insurers that contract with physicians to the list

of those required to file section 805 reports; (4) require a section 805 report to be filed when a physician withdraws or abandons his/her application for staff privileges or membership upon receipt of a notice of either an investigation or the impending denial or rejection of their application for a medical disciplinary cause or reason; (5) authorize the Department of Health Services to bring an action against a hospital, clinic, or health facility for failure to file a section 805 report; (6) preclude a health plan from automatically excluding or deselecting physicians who have been the subject of an 805 report; (7) authorize MBC to perform random audits of hospital peer review records and review medical record information to identify instances of nonreporting; and (8) require MBC, the Osteopathic Medical Board, and the Dental Board to establish a system of electronic notification that can be accessed by qualified subscribers to provide notification of the filing of an 805 report by a peer review body. The bill would also encourage MBC to work with interested parties to establish a pilot program for the early detection of potential quality problems and resolutions for physicians through informal intervention short of a peer review action. *[S. B&P]*

SB 149 (Figueroa), as amended April 30, 2001, is another product of the Senate Business and Professions Committee's October 2000 hearing on compliance with section 805. SB 149 would provide that a peer review body that fails to file a required 805 report on a licensee shall be strictly liable for the injuries and damages caused by the licensee, if the licensee causes harm to a second patient through actions substantially similar to the conduct that should have been the subject of the original 805 report. *[S. Jud]*

SB 724 (Committee on Business and Professions), as introduced February 23, 2001, is an omnibus bill that would: (1) clarify that the two-year exemption from licensure as a physician during PGT is cancelled and participation in the PGT program must cease if DOL denies the individual's application for licensure; (2) clarify that the two-year exemption from licensure for physicians who are recruited to practice in state and county institutions is not allowed without the approval of DOL; (3) codify a current practice of referring applicants for a psychiatric evaluation or an oral clinical competency examination when there is clear and convincing evidence in the applicant's background that a condition has affected the individual's ability to practice safely or has resulted in a disciplinary action; and (4) clarify and specify that certain reports shall include the name and license number of the responsible physician and surgeon. *[S. Appr]*

AB 487 (Aroner), as amended April 16, 2001, would require DMQ to investigate a complaint alleging that a physician has failed to adequately prescribe, administer, or dispense pain control therapies. Upon a finding of undermedication or failure to adequately treat pain, the Division would be required to order the physician to complete a pain management education program. *[A. Appr]*

AB 1045 (Firebaugh). AB 2394 (Firebaugh) (Chapter 802, Statutes of 2000) established the Task Force on Culturally and Linguistic Competent Physicians and Dentists (see above). As introduced February 23, 2001, AB 1045 is a spot bill that would require the Task Force subcommittee's report on the feasibility of a pilot program allowing Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in medically underserved areas in California to be incorporated into law by the enactment of a statute. *[A. Health]*

AB 1586 (Negrete McLeod), as introduced February 23, 2001, would require physicians to report their specialty board certifications and practice status to MBC at the time of licensure renewal. *[A. Health]*

AB 269 (Correa), as amended April 5, 2001, would create the Division of Enforcement Oversight within DCA. Under the direction of the DCA Director, the Division would monitor and evaluate the consumer complaint and discipline system of each DCA board (including MBC). Further, the bill would require the executive officer of each DCA board to be appointed by a three-member panel comprised of a representative of the board, the DCA Director, and the Governor's appointments secretary. *[A. B&P]*

SB 129 (Burton), as amended March 27, 2001, would provide that a physician who refuses to attend an execution at the invitation of the warden of the prison where the execution is to take place may not be disciplined or subject to a negative job performance citation based on the refusal. *[A. PubS]*

AB 1589 (Simitian), as amended April 30, 2001, would require MBC to consult with the Board of Pharmacy and commission a study that evaluates the electronic transmission of prescriptions by physicians and report its results to the legislature by January 1, 2003. The bill would require the Board's report to include recommendations to encourage physicians to use this method to transmit prescriptions and identify systems to protect patients, including the issuance of a digital certification, as defined. *[A. Appr]*

SB 1000 (Johannessen), as amended April 26, 2001, would state the legislature's intent to eliminate the triplicate prescription requirement for Schedule II controlled substances when a secure stand-alone electronic monitoring system is in place. This bill would direct the Attorney General to prepare a report describing how the existing Controlled Substance Utilization Review and Evaluation System (CURES) would have to be modified in order to make it a secure stand-alone electronic monitoring system, and would require the Department of Justice to dedicate two employees with peace officer status to investigate persons who improperly prescribe Schedule II controlled substances. *[S. Appr]*

AB 1311 (Goldberg), as amended April 16, 2001, would entitle all patients to a copy of their medical records, at no charge, upon presenting to their providers a written request with proof that the records are needed to support a claim or appeal regarding eligibility for public benefit programs. This bill would require providers to ensure that the copies are transmitted within 30 days of receiving the request. *[A. Appr]*

AB 1616 (Wright), as introduced February 23, 2001, would exempt an allegation of sexual misconduct against a licensed health professional from the time limits for filing an accusation. *[A. Appr]*

SB 111 (Alpert), as amended April 17, 2001, would allow medical assistants to perform certain services as authorized by and under the supervision of a physician assistant, nurse practitioner, or certified nurse-midwife in specified licensed clinics. *[S. Floor]*

SB 1080 (Bowen), as introduced February 23, 2001, would require a physician, during a patient's annual gynecological examination, to provide the patient with information about the availability of diagnostic procedures or methods for the detection of ovarian cancer if any of the following conditions are present: (a) the patient is over 55 years of age; (b) the patient manifests clinical symptomology of ovarian cancer; (c) the patient is at an increased risk of ovarian cancer, breast cancer, or has a family history of any type of cancer; or (d) the information is medically necessary. The bill would specify that failure to provide the patient with such information constitutes professional misconduct. *[S. B&P]*

LITIGATION

In ***Leone v. Medical Board of California***, 22 Cal. 4th 660 (Apr. 3, 2000), the California Supreme Court reversed a decision of the Second District Court of Appeal and upheld the constitutionality of Business and Professions Code section 2337, which requires a physician to contest a superior court decision affirming DMQ's discipline of a medical license by way of a petition for an extraordinary writ rather than a direct appeal. Section 2337 was amended in a series of bills sponsored by the Center for Public Interest Law during the early 1990s following its 1989 study indicating that the typical physician discipline case consumes six to eight years—during which time most physicians continue to practice with an unrestricted license. *[9:2 CRLR 1]* The extraordinary writ procedure permits the appellate court to reject a nonmeritorious case after full briefing, but without the oral argument and written decision required by a direct appeal. The Second District had invalidated the statute, finding that the extraordinary writ procedure violates a provision of the state constitution guaranteeing to courts of appeal "appellate jurisdiction" in cases where superior courts have original jurisdiction.

Relying on *Powers v. City of Richmond*, 10 Cal. 4th 85 (1995), the Supreme Court reversed, finding that nothing in the "appellate jurisdiction" provision conveys an intention to grant litigants a right of direct appeal from judgments in proceedings within the superior courts' original jurisdiction. According to the court, the term "appellate jurisdiction" is "simply the power of a reviewing court to correct error in a trial court proceeding." The legislature is free to "specify the mode of appellate review" so long as it does not "substantially impair the constitutional powers of the courts, or practically defeat their exercise." The Supreme Court held that "nothing in section 2337 substantially impairs a Court of Appeal's ability to effectively exercise its power to review and correct error in superior court administrative mandate decisions in physician discipline matters," such that the provision does not offend the "appellate jurisdiction" provision in the state constitution.

Dr. Leone also challenged section 2337 on due process and equal protection grounds. Because these challenges were outside the issue on which the Supreme Court granted review, the Court remanded the matter to the Second District for further proceedings. However, on June 14, 2000, the Supreme Court dismissed its review in ***Landau v. Superior Court (Medical Board of California)***, a companion case to *Leone*. In *Landau*, the First District Court of Appeal considered and rejected the due process and equal protection issues *[16:1 CRLR 59–60]*; the Supreme Court's June 14 order also mandated the publication of the First District's decision in *Landau*, 60 Cal. App. 4th 940 (1998). On August 9, 2000, the Second District issued an order noting the Supreme Court's order regarding the *Landau* decision, and indicating its agreement with the First District's analysis in *Landau*.

On February 18, 2000 in ***Lorig v. Medical Board of California***, 78 Cal. App. 4th 462 (2000), the First District Court of Appeal held that there is no legal basis for enjoining the Medical Board from posting its licensees' address of record on its Web site. Plaintiff psychiatrist alleged that the posting of a licensee's name and address of record on the Board's Web site violates the Information Practices Act, Civil Code section 1798 *et seq.* and the California Public Records Act, Government Code section 6250 *et seq.* Plaintiff argued that the Board's disclosure of names and home addresses of its licensees violates its licensees' protected privacy interests. The court found that providing public access to a physician's address of record serves significant public interests. It enables patients to locate medical records maintained by former physicians. It establishes a certain and reliable address for service of process. It helps to accurately identify a particular physician about which a consumer may wish to inquire. The court also found that because licensees are free to designate their place of business or a post office box rather than their home address as their address of record, the Board is not violating the Information Practices Act or the California Public Records Act by posting the information.

In ***American Academy of Pain Management v. Joseph***, 2000 U.S. Dist. LEXIS 6496 (E.D. Cal. Apr. 14, 2000), the U.S. District Court for the Eastern District of California granted summary judgment to defendant Ron Joseph, who was sued in his capacity as the Executive Director of the Medical Board. Plaintiff American Academy of Pain Management (AAPM) challenged DOL's 1997 denial of its application for approval as a specialty board under Business and Professions Code section 651. This denial prevents AAPM members from advertising themselves as "board certified" in California. AAPM argued that section 651 and the Board's regulations implementing this section are unconstitutional in that they impermissibly infringe on the commercial speech

rights of its members under the first amendment. *[17:1 CRLR 47; 16:2 CRLR 39]*

At trial, the district court applied the four-part *Central Hudson* test for determining the constitutionality of commercial speech regulation: (1) whether the speech being regulated concerns a lawful activity and is not misleading; (2) whether the asserted government interest underlying the regulation is substantial; (3) whether the regulation directly advances the government interest; and (4) whether the regulation is not more extensive than necessary to serve that interest. The court upheld the Medical Board on all counts. Citing *Peel v. Attorney Registration and Disciplinary Commission of Illinois*, 496 U.S. 91 (1990), the court found that "States can require an attorney who advertises 'XYZ certification' to demonstrate that such certification is available to all lawyers who meet objective and consistently applied standards relevant to practice in a particular area of the law," and that "to the extent that potentially misleading statements of private certification or specialization could confuse consumers, a State might consider screening certifying organizations...." In amending section 651 to require MBC to screen private organizations that certify physicians, the court found that "the State, having recognized the potential for misleading the public inherent in the use of board certification language, has done precisely what the Supreme Court has allowed, namely established standards. Having failed to meet California's standard, an advertisement of board certification is misleading and can be prohibited."

On April 28, 2000 in ***Zabetian v. Medical Board of California***, 80 Cal. App. 4th 462 (2000), the Third District Court of Appeal interpreted Business and Professions Code section 2234(c), which permits MBC to take disciplinary action against a physician for "repeated negligent acts." Plaintiff Zabetian argued that section 2234(c) requires proof of more than two negligent acts. After a thorough review of the legislative history of section 2234(c), the court disagreed and found that the history "supports a construction of the phrase 'repeated negligent acts' to mean two or more."

In ***Rademan v. Superior Court***, 86 Cal. App. 4th 447 (Jan. 22, 2001), the Second District Court of Appeal held that, to the extent the crime/tort exception (Evidence Code section 1018) to the psychotherapist-patient privilege applies, the psychotherapist-patient privilege (Evidence Code section 1014) is unavailable, and any information in patient files within the exception may be made available to the Medical Board for its investigation into a complaint of illegal activity by a psychotherapist.

In this case, a pharmacist filed a complaint with the Medical Board alleging that a psychotherapist had written an unusual number of prescriptions for controlled substances for two patients, one of whom was an admitted addict. As part of its investigation of the complaint, MBC sought the medical records of both patients from the therapist. Both patients refused to consent to the release of their records. Similarly, the therapist refused to release the patient records to the Medical Board, citing patient confidentiality and the psychotherapist-patient privilege. MBC obtained an order from the trial court ordering the psychotherapist to release the records to the Board. The psychotherapist then sought a writ of mandate to vacate the trial court's order. The court of appeal agreed that the crime/tort exception applies to criminal activity or wrongdoing by the therapist and the patient. However, the court vacated the trial court's order to release the patient files in their entirety to the Board and directed the trial court to conduct an *in camera* review of the files to determine which portions of the files, if any, corroborate the allegations of criminal activity, and release only those portions of the records that are excepted from psychotherapist-patient privilege under the crime-tort exception. On April 11, 2001, the California Supreme Court denied review but ordered depublication of the Second District's opinion.

In a 4–3 decision in ***Potvin v. Metropolitan Life Insurance***, 22 Cal. 4th 1060 (May 8, 2000), the California Supreme Court held that, under certain circumstances, a physician is entitled to the common law right to fair procedure before he may be removed from an insurer's preferred provider list—and despite an at-will termination clause in the underlying contract.

In 1992, MetLife terminated physician-plaintiff Potvin's preferred provider status. At first, MetLife declined to give a reason for the termination. After further requests, Potvin was told that he did not meet MetLife's standard for malpractice history. At the time, MetLife would not include or retain on its preferred provider lists any physician who had more than two malpractice lawsuits, or who had paid an aggregate sum of $50,000 in judgment or settlement of such actions; Potvin's patients had sued him four times, resulting in one $713,000 settlement. Potvin sued MetLife for violating his right to fair procedure and for "devastating his practice" because no other managed care plans would retain him and physician groups "dependent on credentialling by MetLife" ceased referring patients to him. The superior court granted MetLife's motion for summary judgment but the Second District Court of Appeal reversed, holding that MetLife should have given Potvin notice of the grounds for its action and a reasonable opportunity to be heard. *[17:1 CRLR 21; 16:2 CRLR 13; 16:1 CRLR 33]*

The Supreme Court affirmed the appellate court's reversal of the trial court's grant of summary judgment to MetLife, but disagreed with the appellate court's holding that insurers and health plans must necessarily comply with the common law right of fair procedure. Writing for the majority, Justice Kennard stated that "when the right to fair procedure applies, the decision making must be both substantively rational and procedurally fair." Here, Kennard found that the right to fair procedure applies under *James v. Marinship Corp.*, 25 Cal. 2d 721 (1944); *Pinsker v. Pacific Coast Society of Orthodontists*, 12 Cal. 3d 541 (1974); and *Ezekial v. Winkley*, 20 Cal. 3d 267 (1977). In these cases, the decisions of private organizations to exclude or expel a member affected the public interest because the organization exercised a virtual monopoly

over the supply of labor in that field (a labor union, associations of orthodontists, and a hospital offering a surgical residency program, respectively). As a result, each organization was subject to the common law right to fair procedure. From this precedent, Kennard concluded that an insurer wishing to remove a doctor from its preferred provider list must comply with the right to fair procedure only "when the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest." The court found that if participation in a health plan is a practical necessity for physicians and if removing physicians from preferred provider networks that have a virtual monopoly on managed care significantly impairs those physicians' practice of medicine, then removal must be substantially rational and procedurally fair. Finally, the court clarified that a "without cause" termination clause in an employment contract is unenforceable if it limits an existing right to fair procedure under the common law.

The three-member dissent led by Justice Janice Rogers Brown charged that the majority has, in effect, declared "that it is the public policy of this state that physicians are entitled to a minimum income and, therefore, if removal of a physician from an insurer's preferred provider list would reduce the physician's income below that guaranteed minimum, the physician is entitled to a hearing and to the judicial review that would inevitably follow upon an adverse decision. What is the majority's authority for declaring this public policy, for singling out physicians for such special treatment?" The dissent also opined that the majority's decision is unclear and unworkable, "in the sense that decisions under it will be unpredictable. As a consequence, insurers will be forced to forego cost-cutting measures like MetLife's malpractice policy, or be prepared to grant hearings to all physicians terminated under such policies." Additionally, insurers will be unable to predict with confidence whether their decisions will invoke the common law right to fair procedure—"in theory, a physician in Riverside might be entitled to a hearing before being terminated by a given insurer, while a physician in Fremont might not be...." Finally, the dissent argued that Dr. Potvin had signed a contract with an at-will termination clause, and that such clause should be enforced.

In ***Khajavi v Feather River Anesthesia Medical Group***, 84 Cal. App. 4th 32 (Oct. 10, 2000), a wrongful termination action filed by an anesthesiologist against his employer that arose after plaintiff engaged in an altercation with a surgeon over the wisdom of proceeding with a cataract operation, the Third District Court of Appeal found that the trial court erred in granting the employer's motion for nonsuit as to plaintiff's claim that he was discharged in retaliation for advocating medically appropriate health care in violation of Business and Professions Code section 2056. The appellate court said that the language of the statute does not limit its protection to disputes by physicians over decisions by third-party payors or concerning cost containment, but that the declaration of public policy set forth in section 2056(c) expresses an unambiguous legislative intent to apply the statute broadly to protect physicians' exercise of their professional judgment in advocating for medically appropriate health care, without limitation over the basis of the dispute. On January 24, 2001, the California Supreme Court denied the employer's petition for review.

RECENT MEETINGS

DOL was forced to cancel its February 2000 meeting because it lacked a quorum. *[17:1 CRLR 31–32]*

At its May 2000 meeting, MBC elected Ira Lubell, MD, MPH, as its new president, public member Rudy Bermudez as vice-president, and Anabel Anderson Imbert, MD, as secretary. DOL elected Thomas Joas, MD, as president and James Bolton, Ph.D., as secretary. DMQ selected Dr. Lubell as president, Dr. Anderson Imbert as vice-president, and Mr. Bermudez as secretary. Board members bade farewell to MBC's longtime Enforcement Chief John Lancara and HQES Chief Al Korobkin; both retired after long and distinguished careers in state service.

At its November 2000 meeting, MBC welcomed Neal Kohatsu, MD, MPH, as its new Medical Director. Dr. Kohatsu has primary staff responsibility for coordinating development of MBC's health care policy agenda; developing issues of health care management under consideration by the Board's various committees; establishing liaison services with medical schools and medical societies; and representing the Board in various fora. Prior to joining the Medical Board staff, Dr. Kohatsu served as acting associate director for medical quality at the state Department of Health Services.

On March 16–18, 2001, MBC held an educational retreat in Santa Rosa, primarily to educate its new members on the mission and many regulatory programs of the Board. Members listened to presentations on the history of the Medical Practice Act and the recent changes to the Board's enforcement program. Board attorneys explained the rulemaking and legislation processes and the requirements of the Bagley-Keene Open Meeting Act and the California Public Records Act. Board staff explained the licensing and enforcement processes, and discussed the Diversion Program, the Board's public information and consumer education programs, and MBC's outpatient surgery and specialty board advertising laws.

FUTURE MEETINGS

2001: July 26–28 in Burlingame; November 1–3 in San Diego.

2002: January 31–February 2 in Los Angeles; May 9–11 in Newport Beach; August 1–3 in Burlingame; September 27–28 in Los Angeles (strategic planning session); November 7–9 in San Diego.

2003: January 30–February 1 in Los Angeles; May 8–10 in Sacramento; July 31–August 2 in San Francisco; November 6–8 in San Diego.