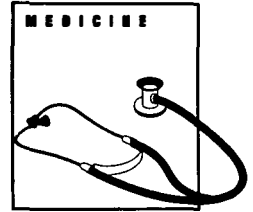


# Medical Board of California

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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 for 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. This responsibility includes enforcement of the disciplinary, administrative, criminal, and civil provisions of the Medical Practice Act. In this regard, DMQ—through its 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 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 take 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.

## Major Projects

### MBC Undergoes Sunset Review

During the fall of 1997, the necessity and performance of MBC were reviewed by the Joint Legislative Sunset Review Committee (JLSRC) and DCA under the "sunset review" process set forth in SB 2036 (McCorquodale) (Chapter 908, Statutes of 1994). Under the sunset process, the legislature inserts an expiration date into the enabling act of each DCA regulatory board; prior to that date, the JLSRC must review the need for and performance of the board, and the legislature must pass a bill extending the life of the agency or it ceases to exist. [15:4 CRLR 32] As required under the statute, MBC submitted a lengthy report describing its mission, functions, and activities on October 1, and representatives of the Board appeared and answered questions from JLSRC members at a hearing on November 17, 1997.

In its sunset report, the Board made several recommendations which were the focus of some discussion at the hearing. First, MBC sought legislative authority enabling the Board President or Executive Director to order summary suspension of a physician's license when certain egregious circumstances exist (so-called "single-signature" authority). MBC also recommended elimination of the oral examination requirement for foreign medical graduates; an increase in the number of years of approved postgraduate training required for initial licensure (from one year to two years); and an increase in physicians' biennial renewal fees in order to augment its investigative staff.

Several interest groups and individuals commented on the performance of the Medical Board at its sunset hearing. The Center for Public Interest Law (CPIL) submitted extensive testimony focusing on several issues of importance to consumers: (1) the excessive length of time it takes MBC to investigate a complaint, and its urgent need for more investigators; (2) the ineffectiveness of the Board's Diversion Program for substance-abusing physicians; (3) the need to rewrite Business and Professions Code section 805, which

requires hospitals and health care facilities to report certain adverse peer review actions against physicians to the Medical Board; and (4) the composition of the Medical Board.

First, CPIL noted statistics indicating that it takes MBC 2.8 years to process (from receipt of the complaint to final disciplinary decision) a serious complaint about a physician—statistics which CPIL called “extremely optimistic.” Whereas Business and Professions Code section 2319 requires MBC to set a goal of completing an investigation within 180 days from receipt of the complaint, the investigative stage alone took an average of 336 days in 1996–97. CPIL noted that the time consumed by every other step in the process except investigations has been reduced over the past five years, and noted that MBC investigators have a caseload of 34 cases each—far above the caseloads of 5–10 cases per investigator at other similar state agencies. Surveys of departing MBC investigators indicate that the high caseload is causing high turnover in investigative positions. CPIL concluded that the legislature should increase MBC’s licensing fees and require the Board to earmark the new revenue to increase the number of investigators and reduce average investigator caseloads to manageable levels.

Next, CPIL levied heavy criticism against DMQ’s Diversion Program, which “diverts” physicians who are abusing or addicted to drugs or alcohol from the disciplinary track into an in-house, Board-sponsored rehabilitation program paid for with the licensing fees of all California physicians. CPIL noted that, although the Program costs the Board approximately \$800,000 per year, very few physicians have participated in it since its creation in 1980; CPIL argued that its location within the Medical Board may be hindering physicians from seeking help from the Program. CPIL also disputed the amount and quality of the monitoring provided by the Program, the adequacy of the Program’s bodily fluid testing requirements, its lack of any standards whatsoever for treatment of relapse or recidivism, and the secrecy which shrouds the operations of the Program. CPIL noted that, during the 1980s, the former Auditor General issued three separate reports on the Diversion Program, all concluding that the level of monitoring provided by the Program was deficient; however, MBC has since failed to improve or strengthen the Program in any meaningful way. CPIL called for significant legislative restructuring of the Program (see FEATURE ARTICLE).

CPIL then noted apparent widespread noncompliance by hospitals with the reporting requirement in Business and Professions Code section 805. This provision requires hospitals to report to MBC when they take certain adverse peer review actions against the privileges of physicians for medical cause or reason. In 1987–88, hospitals filed 249 “section 805” reports with MBC. Despite the fact that CPIL and others sponsored legislation in the early 1990s which expanded the types

of events which must be reported, increased the penalty for failure to report, and afforded absolute immunity to mandated reporters, “section 805” reporting dropped to 112 reports in 1995–96 and 130 reports in 1996–97. CPIL argued that “if section 805 is that unclear to hospitals and their counsel, or if it is outdated because hospitals and their counsel have restructured the actual conduct of peer review so that their activities fall within loopholes in section 805, then perhaps section 805 should be rewritten to conform to the actual conduct of peer review.”

Finally, CPIL argued in support of a change in the composition of MBC to a public member majority. While Business and Professions Code section 2229 mandates that public protection is the highest priority of the Medical Board, CPIL asserted that “it is unclear how the consumer protection mandate of the Board can be consistently fulfilled if the Board is required to be dominated by physicians.” CPIL argued that the current “supermajority” of physicians on

the Board presents two problems: an apparent conflict of interest (in that the public does not trust regulatory boards which are controlled by members of the profession being regulated by that board), and an actual—if unintended—conflict of interest (in that physicians may not be neutral, unbiased decisionmakers when it comes to establishing standards that affect their own professional or pecuniary interests). In light of the facts that the medical profession is well-represented by physician trade associations at every MBC meeting, that the Medical Board is staffed with physicians who assist in decision-making, and that MBC must produce expert medical testimony from a physician in every quality of care enforcement case it entertains, CPIL stated “there is simply no reason to require that physicians be the decisionmakers as well.”

In its sunset testimony, CPIL also noted several improvements made by MBC in the past several years, including its May 1993 revision of its public disclosure policy to reveal much more information to consumers about their physicians [13:2&3 CRLR 79–81]; its successful prosecution of *Arnett v. Dal Cielo*, which upheld the Board’s authority to subpoena hospital peer review records in disciplinary investigations [15:4 CRLR 95]; and its recent implementation of the “Deputies in District Office” (DIDO) program, under which deputy attorneys general work 1–2 days per week at each MBC district office (see below for further discussion).

The California Medical Association (CMA), which represents about 30,000 of MBC’s 105,000 licensees, also presented testimony at MBC’s sunset hearing. CMA argued that MBC has not kept pace with the changing environment in which physicians practice medicine; for that reason, CMA argued, MBC has not lived up to its consumer protection mandate. Specifically, CMA stated that MBC has not done all it should to preserve physician autonomy over patient care

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and treatment decisions in the face of managed care. CMA also complained about several aspects of MBC's physician discipline system, including the prosecution of cases by the Health Quality Enforcement Section of the Attorney General's Office, and "cost recovery" (the reimbursement by disciplined physicians of MBC enforcement and investigative costs incurred up to the date of the hearing) which is allowed under Business and Professions Code section 125.3. CMA believes that cost recovery unduly chills the right of a physician to demand full procedural due process, and that "in the hands of those who are less than careful, it can be used to coerce settlements." With regard to HQES, CMA argued that its attorneys are not working efficiently and are essentially overbilling MBC for an excessive number of hours (which may come back to haunt a disciplined physician in the form of cost recovery); CMA contended that MBC should be permitted to hire its own outside attorneys, to give the legislature a basis of comparison when evaluating the services provided by HQES.

As to the composition of the Board, CMA urged the JLSRC to preserve the *status quo* of twelve physicians and seven non-physicians. CMA noted that Public Citizen, a Washington, D.C.-based public interest organization, annually ranks state medical boards based on the number of disciplinary actions taken per number of physicians in the state, and—according to CMA—the top ten boards "consistently include boards with a heavy majority of physician members." CMA also argued that a physician-dominated board provides more consumer protection because proposed disciplinary decisions by administrative law judges which are nonadopted by physician-controlled DMQ panels are generally amended to include a harsher penalty than the one recommended by the ALJ.

The Union of American Physicians and Dentists also complained about MBC's "abusive" cost recovery system, stating that "MBC is somewhere between the IRS and the Gestapo on cost recovery." UAPD claimed that 65% of MBC disciplinary decisions are stipulated, and that cost recovery is "used as a club to bludgeon doctors into stipulating." UAPD told the JLSRC to either abolish cost recovery or "level the playing field—permit physicians to collect their fees from MBC if the physician prevails."

Also at the hearing, several physicians and consumers who support alternative medicine testified. These witnesses complained that MBC has no credible experts in alternative medicine in the pool of expert witnesses it uses in discipline cases, and that the Board is attempting to get rid of practitioners who practice alternative medicine. Numerous consumers who claimed to have had terminal illnesses but were cured through alternative medicine urged the JLSRC to require MBC to focus its enforcement system on incompetent and/or impaired physicians who genuinely hurt patients, not on alternative medicine practitioners who offer consumers alternatives to traditional, and usually invasive or toxic, remedies for illnesses such as cancer.

**As to Board composition, DCA recommended a public member majority.**

In February 1998, DCA released its report and recommendations on MBC. Preliminarily, DCA noted that "given the potential for harm to the public's safety and welfare, it is incumbent on the state to continue the regulation of physicians." DCA concluded that MBC should continue to regulate physicians, registered dispensing opticians, contact lens dispensers, spectacle lens dispensers, licensed midwives, and medical assistants. As to Board composition, DCA recommended a public member majority. Regarding "single-signature" authority, DCA supported a reexamination of the process by which MBC currently achieves interim suspension of a license, with a view toward identifying changes that may simplify and expedite interim suspension orders, consistent with due process, where potential patient harm is imminent. In response to CPIL's concerns, DCA also suggested that MBC, DCA, and other DCA boards with diversion programs for substance-abusing licensees research an appropriate approach to privatizing diversion programs.

In April 1998, the JLSRC released its final report and recommendations on the Board. The Joint Committee agreed with DCA that the state should continue to regulate physicians through MBC, and that MBC's existence should be extended through 2003. In this regard, the JLSRC noted improved performance on the part of the Board during the past six years, "prompted by significant legislative changes in the Medical Practice Act and related disciplinary laws, and the appointment of new Board members and management staff." The JLSRC also acknowledged "a significant increase in the number of complaints filed" with MBC between 1992-93 and 1996-97; yet, during that time period, the Board slashed its overall case processing time in most areas and increased its disciplinary output ("disciplinary action taken against licensees by the Board doubled from 149 in fiscal year 1992-93 to 340 by fiscal year 1996-97"). However, the JLSRC noted that the Board's investigative time is excessive, and is almost double the 180-day goal established in Business and Professions Code section 2319.

As to Board composition, JLSRC staff noted DCA's support for a public member majority, but opted instead for "better balance" between the number of physician and public members (while retaining the professional member majority). JLSRC staff recommended a 17-member board, consisting of ten physicians and seven public members. However, the Joint Committee rejected both recommendations and voted 4-1 to maintain the current Board composition, as urged by CMA.

In terms of the Board's enforcement program, the JLSRC agreed that DMQ should (1) expand the DIDO program, which has been shown to expedite the filing of accusations (see below); (2) seek amendment of statutes authorizing it to subpoena medical records from physicians and health facilities to increase the Board's access to these documents, increase the penalties for noncompliance with a proper DMQ subpoena, or both; (3) improve its capability to effectively document data relevant to the Board's specific enforcement functions,

particularly the activities performed and the amount of time expended at each stage of the disciplinary process, the specific costs related thereto, the difficulties encountered in pursuing effective discipline, and the disciplinary outcomes relative to various types of violations; and (4) take steps to eliminate the endemic vacancies in the Board's investigator positions, particularly in the Los Angeles area. As to "single-signature" authority, the Joint Committee agreed that MBC should be permitted to implement a pilot project allowing it to immediately suspend a physician's license where there is a clear indication that potential patient harm is imminent.

Regarding the Diversion Program, JLSRC staff agreed with DCA that MBC, DCA, and other boards with diversion programs should research an appropriate approach to privatizing their diversion programs, with special attention given to existing participants, and report to the JLSRC by September 1, 1999. However, the Joint Committee failed to adopt this recommendation by a vote of 3-3.

JLSRC staff noted that MBC has repeatedly—and unsuccessfully—sponsored legislation to require licensure applicants to complete two years of approved postgraduate training (PGT) prior to licensure, doubling the existing requirement of one year of PGT. However, Committee staff found no justification for the change, and recommended against a two-year PGT requirement; the JLSRC agreed. The Committee did agree, however, that the Board's oral examination for foreign medical graduate licensure could be eliminated.

As to the proposed licensing fee increase, JLSRC staff recommended that an increase be considered, but only after MBC provides appropriate justification to the policy and appropriations committees of the legislature. Staff also encouraged MBC to resolve its fiscal woes by considering privatization of the Diversion Program, requiring Diversion Program participants to pay for more of the overhead costs of the program than they currently pay, using employees other than high-cost investigators to monitor licensees who are on probation, and having probationers reimburse the Board for more of its probation monitoring costs. The Joint Committee, however, declined to adopt staff's recommendation by a vote of 3-2.

SB 1981 (Greene) (Chapter 736, Statutes of 1998) implements the JLSRC's recommendations by extending the Medical Board's existence to 2003, eliminating the oral examination for foreign medical graduates, and increasing the penalties on a physician for refusal to comply with a MBC subpoena for medical records during a disciplinary investigation (see LEGISLATION). No bill enacted during 1998 includes "single-signature" suspension authority.

## **MBC Enforcement Output at All-Time High in 1997-98**

In October, MBC released its *1997-98 Annual Report*, which revealed record high levels of output in several categories and somewhat decreased case processing time.

However, other statistics in the *Annual Report* again reflect inadequate MBC disciplinary activity compared with the level of physician negligence and incompetence detected by others.

Specifically, the Board registered record highs in the number of cases referred to HQES, number of accusations filed, number of formal disciplinary actions taken, and number of citations and fines issued. In 1997-98, MBC received 10,816 complaints and opened 2,154 investigations against physicians. It referred 676 cases to HQES, which filed 391 accusations. The Board took a total of 383 disciplinary actions, including 47 revocations, 86 license surrenders, 19 probations with suspension, 108 probations, and 50 public reprimands. Additionally, the Board issued 288 citations and fines, and obtained 31 interim suspension orders (ISO) or temporary restraining orders (TRO), which suspend a particularly dangerous physician's license pending conclusion of the disciplinary process.

The high number of investigations opened and cases referred to HQES is somewhat surprising in light of the fact that MBC has not augmented its investigative staff since 1992-93. Between 1992-93 and 1997-98, the Board experienced a 60% increase in the number of complaints received (from 6,749 in 1992-93 to 10,816 in 1997-98), yet has not correspondingly increased its investigative staff. Additionally, MBC investigators maintained an average caseload of 31 cases during 1997-98, higher than recommended by the Auditor General in 1991 [11:3 CRLR 48-49, 82-84] and much higher than caseloads carried by investigators at similar state agencies.

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 1997-98. On the average, cases remained for 56 days in the Board's Central Complaint and Investigation Control Unit (CCICU) before being forwarded to a MBC district office for investigation (down from 64 days in 1996-97); they spent an average of 313 days under investigation before being dismissed or forwarded to HQES for accusation filing (down from 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 369 days. Fully investigated cases then spent 110 days in HQES (down from 134 days in 1996-97) prior to accusation filing.

This last achievement is due to the full implementation of the "Deputy in District Office" (DIDO) program, which at long last implements Government Code section 12529(b)'s requirement that HQES assign deputy attorneys general (DAGs) to work onsite with MBC investigators "to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." The statute, which was enacted in 1990 [10:4 CRLR 79, 84] also requires HQES to ensure that an HQES DAG is "frequently available on location at each of

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the working offices at the major investigation centers of the board, to provide consultation and related services and engage in case review with the board's investigative, medical advisory, and intake staff."

At the urging of DMQ, HQES created the DIDO program on January 1, 1997; under the program, an HQES DAG physically works in Medical Board district offices one or two days per week to permit onsite prosecutor guidance of investigations. In addition to being available to MBC investigators for legal advice, the DIDO DAGs (1) review all new incoming cases, especially to determine whether the Board should seek an ISO or TRO; (2) at an early stage, become involved in subpoena enforcement to assist investigators in obtaining requested medical records; (3) review all completed investigations before their referral to HQES, to ensure that all investigative "loose ends" are tied up and that the matter is ready for pleading; (4) review all cases proposed for closure at the district office level; and (5) draft initial pleadings in investigations being transmitted from district offices to HQES for accusation filing.

The original hope was that the DIDO program would assist in cutting the time which fully investigated cases sit in HQES after transmittal by MBC and prior to the filing of the accusation from 134 days in 1996-97 to about 90 days. However, the results have been more dramatic. HQES phased in the program gradually; DIDO DAGs served five MBC district offices from January 1-June 30, 1997, and eventually the program was expanded to serve all 12 MBC district offices by July 1, 1998. Between January 1, 1997 and July 1, 1998, 289 cases were referred to HQES from DIDO DAGs. Of those, accusations had been filed in 261 cases by July 31, and the average number of days from receipt of the case by HQES to accusation filing was only 27.74 days.

The DIDO program is important because the filing of the accusation is the most crucial point in the process from a consumer protection standpoint—at that point, the case becomes a matter of public record and will be disclosed to an inquiring consumer. Prior to that point, MBC call handlers are not permitted to disclose the fact of a completed investigation, no matter how many are undertaken against a physician, the nature of the charges, or how close HQES is to filing the case. Thus, expediting the filing of the accusation—which the DIDO program is causing—provides enhanced consumer protection.

While DMQ's performance shows improvement in many areas, it still pales in comparison to external complaints and reports of physician incompetence and misconduct received by the Board. In 1997-98, DMQ received 1,285 reports of medical malpractice judgments or settlements in excess of \$30,000; 41 reports from coroners indicating that the cause

of death was physician gross negligence or incompetence; and 110 "section 805" reports of adverse peer review action taken against physicians by hospitals or health care facilities. As noted above, this last number is less than half the number of peer review actions reported in 1987-88, indicating severe underreporting by hospitals and health care facilities. Although peer review actions were underreported, almost 11,000 physicians were the subject of consumer complaints and a total of 1,436 licensees were reported to DMQ for incompetence or misconduct in 1997-98, compared with only 383 disciplinary actions. These figures reflect a continuing performance problem in an area where incompetence, negligence, impairment, or misconduct can result in irreparable harm to patients.

## CMA Kills Proposed MBC Fee Increase

As promised in its sunset report, MBC sought a fee increase in 1998 primarily to finance more investigators, reduce its investigators' caseloads to manageable levels, and retain more of its experienced investigators rather than losing them to other agencies with lower caseload burdens. During the spring of 1998, Senator Richard Polanco agreed to carry a fee increase provision for MBC in SB 1930 (Polanco); the provision sought an increase in MBC's biennial license renewal fee from its

existing level of \$600 to \$690. In other words, MBC sought an additional \$45 per physician per year.

In mid-June, CMA prevailed upon Senator Polanco to remove the provision from his bill. In a June 19 letter, CMA confirmed its opposition to the bill, blaming "unresolved concerns regarding the costs and efficiency of the Attorney General's Office in its representation of the Board in enforcement matters." CMA conceded that the AG, "as a constitutional officer separate from the Governor, is not directly accountable to the Administration for services undertaken on its behalf," but objected to the fact that MBC lacks "day-to-day control" over a case's

progress and disposition once it is turned over to HQES. Further, CMA argued that "the Attorney General does not provide quality detailed billing in order for the Board to understand exactly what it purchases as the HQES pursues a case." Even though a new billing system has recently been implemented, according to CMA "it does not provide more than a rudimentary level of detail which is insufficient to determine activities and time spent on specific cases." As a result of CMA's opposition, Senator Polanco deleted MBC's fee increase provision from SB 1930, and no other legislator agreed to carry the provision in light of CMA's position.

At the full Board's August 1 meeting, MBC Executive Director Ron Joseph explained the situation to Board members. He stated that the proposed fee increase is necessary to

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maintain operations at their current level; hire new investigators to address the Board's longtime problem of excessive investigative caseload and delay (see above); cover the increased costs of doing business (such as the expected salary increase for state employees in 1999–2000, and a projected \$1 million MBC contribution toward DCA's new computer system); and address emerging issues, such as the Board's desire to enforce the bar on the corporate practice of medicine. Joseph also characterized the problem as one of "lost opportunities," because the Medical Board's enforcement program has improved significantly over the past 3–5 years and has a desire to capitalize on that momentum and keep moving forward. According to Joseph, "without a fee increase, the Board will not only not be able to move forward; its current level of services will also decline." In the absence of a fee increase, he noted the need to closely scrutinize Board programs which can be eliminated; Joseph also stated that if, due to insufficient resources, MBC cannot adequately protect consumers from incompetent or otherwise dangerous physicians, it has a duty to consider and support other methods of helping consumers protect themselves in order to fulfill its consumer protection role.

Following Joseph's presentation, Board members unanimously condemned CMA for what they characterized as its refusal to negotiate in good faith. Board Vice-President Karen McElliott noted that CMA's "negotiation" started not with a single demand or request but with a 14-point "talking paper," including actions which would limit consumer protection. According to McElliott, "that we will not do." She urged her colleagues to explore all its options to both conserve money and help consumers help themselves—including abolition of the \$800,000-per-year Diversion Program, expanded cost recovery against physicians to recoup MBC's investigative costs, increased fines, a change in the Board's composition to a public member majority, disclosure of all malpractice judgments and settlements on the Internet (MBC currently discloses no malpractice settlements), and raising or repealing the statutory cap on noneconomic damages in medical malpractice actions under the Medical Injury Compensation Reform Act (MICRA) of 1975.

Former Board President Alan Shumacher, MD, was not present at the August 1 meeting, but submitted a letter which was read into the record. Dr. Shumacher asserted that a recent editorial about MBC's fee increase proposal in CMA's monthly magazine was "inaccurate, uninformed, distorted, and inflammatory....It is, in short, a declaration of war on the Medical Board." Shumacher lamented that "this unfortunate war will be an unequal contest. We do not have CMA's financial resources and we cannot 'raise dues' or make a 'special assessment' to cover the costs of making our case. We are constrained by law from lobbying and from making political contributions. We have our discussions and make our decisions in a public meeting...and we must answer to the people of California through the legislature. Nevertheless, this is a war we can and must win if California is to continue to have a viable medical board as an agency of public protection." Like McElliott, Shumacher called on his colleagues to abol-

ish the Diversion Program and "support upward modification of the MICRA cap so that California's citizens would, lacking administrative redress, have greater access to civil redress." He also supported full utilization of the Internet to provide information on malpractice settlements as well as judgments and arbitration awards.

Member after member rose to chastise CMA for its action; many questioned why CMA's position is the determining factor in the legislature. According to public member Phil Pace, "when the only way to get the legislature to act is to get the approval of the regulated people, that's like the fox guarding the henhouse."

Board President Thomas Joas, MD, invited CMA President Robert Reid, MD, to explain the association's opposition. Dr. Reid acknowledged that CMA had started with 14 demands which, after negotiation with MBC, were whittled down to four which could not be resolved. Dr. Reid characterized the four issues as follows:

- CMA is concerned that HQES is "overcharging" in its disciplinary accusations; that is, characterizing a single incident or course of treatment as gross negligence, repeated negligent acts, and incompetence under Business and Professions Code section 2234; and taking a single course of treatment and breaking it up into "repeated negligent acts" in order to avoid having to prove gross negligence.
- CMA wanted a "joint MBC/CMA statement on peer review" on the post-*Dal Cielo* use of hospital peer review records by the Medical Board. In *Arnett v. Dal Cielo*, the California Supreme Court unanimously upheld—over CMA's strenuous objection—the authority of MBC to subpoena hospital peer review records during a disciplinary investigation. [15:4 CRLR 95]
- CMA sought a new statutory reporting system for physicians who "voluntarily" take a leave of absence from hospital privileges in order to check into drug/alcohol treatment programs; in other words, rather than hospitals being required to report such leaves to MBC's enforcement program under Business and Professions Code section 805, CMA would prefer that the report be directed to the Board's Diversion Program under Business and Professions Code section 821.5.
- CMA wanted a full review of the costs charged by and the efficiency of the Attorney General's Office.

Dr. Reid and CMA legislative advocate Scott Syphax stated that "time simply ran out" on the Medical Board during 1998, and that CMA is not finished negotiating with the Board and hopes the parties can reach some agreement on these important issues.

Center for Public Interest Law Administrative Director Julianne D'Angelo Fellmeth ended the long discussion by reminding MBC that it first voted to seek a fee increase to obtain new investigators in November 1995 [15:4 CRLR 85–87], and that CMA had successfully blocked it for three years for a constantly changing litany of reasons—some of which are clearly beyond the Medical Board's control. For example, CMA opposed a fee increase in 1997 because managed care

entities unfairly penalize or fire physicians investigated or disciplined by MBC. Fellmeth stated that even if this is true, this problem is clearly out of the hands of MBC, and the solution is to fix the regulation of managed care in California—not emasculate the Medical Board's physician discipline system and its critical consumer protection role.

Fellmeth reminded that Board that CMA is not an ordinary trade association with no stake in public protection. In 1975, the medical profession struck a bargain with the legislature. That year, the medical profession successfully advocated MICRA, which caps noneconomic damages and enacts numerous other provisions which discourage the filing of medical malpractice cases. In exchange, and in the same bill which created the cap on damages, the medical profession agreed to support and properly resource the physician discipline system of the Division of Medical Quality of the Medical Board. According to Fellmeth, "that is the deal CMA cut—one for the other. From the above record of consistent opposition to a well-justified fee increase proposal for constantly shifting reasons, and from its pattern of citing problems outside the Medical Board's control and yet holding the Board responsible for them by opposing necessary fee increases, I can only conclude that the medical profession has reneged on its part of the MICRA bargain.... This fee increase and the MICRA cap are integrally related. Without one, you should not support the other. If it chooses not to adequately support the Medical Board's physician discipline system, the medical profession should not be entitled to MICRA's cap on damages. It's just that simple."

MBC vowed to return to the legislature in 1999 with another proposal for a fee increase. Its need is now exacerbated by a new statute of limitations law which took effect on August 17, 1998. AB 2719 (Gallegos) (Chapter 301, Statutes of 1998) now requires MBC to file an accusation within three years of its discovery of acts which are the basis of disciplinary charges or within seven years of the acts—whichever occurs first (see LEGISLATION). If MBC does not succeed in obtaining additional investigators, its chances of completing complex medical investigations and filing cases within the limitations period substantially diminish. Without a fee increase and with a new statute of limitations law complicating its operations, MBC and its consumer protection mandate are in jeopardy.

### **MBC's Committee on Plastic and Cosmetic Surgery**

In 1997, the Medical Board formed a Plastic and Cosmetic Surgery Committee to address growing concerns over this expanding practice area. In recent years, technological advances and growth in discretionary income, coupled with society's emphasis on youth and beauty, have led more and more patients to seek plastic surgery. For the physician, cosmetic surgery remains one of the last bastions of fee-for-service medicine in an era of capitation and managed care. As a result, it inevitably draws some financially-motivated prac-

tioners who are unprepared or ill-equipped to perform the procedures they attempt, sometimes with disastrous results.

The Board became particularly concerned about the disturbing number of complications arising from elective surgeries performed in non-hospital settings. At the forefront was high-volume and mega-volume liposuction, in which up to 15 liters of fat (about 30 pounds) are removed in a single procedure, often in a physician's office. From 1992 to 1997, the prevalence of liposuction tripled, and as many as 100 United States patients died from the procedure in 1997. In one high-profile case in 1997, a La Habra woman bled to death following 10 hours of surgery during which 14 pounds of fat were removed.

**The Board became particularly concerned about the disturbing number of complications arising from elective surgeries performed in non-hospital settings.**

During its first meeting in October 1997, the Committee—composed of physicians Robert del Junco (Chair), Bernard Alpert, Jack Bruner, and Thomas Joas, and public members Stewart Hsieh and Karen McElliott—identified the lack of reliable statistical information on outpatient surgery outcomes as one of the key issues the Committee would address. Other issues include guidelines for procedures performed in various outpatient settings; training, supervision, and accountability requirements for those performing liposuction and other high-risk procedures; medical malpractice insurance requirements for physicians who perform elective surgeries in outpatient settings; cosmetic surgery advertising standards; and non-physician performance of some types of procedures, such as cosmetic surgeries performed by dentists and the use of lasers for hair, tattoo, and spider vein removal by non-physicians.

During 1998, the Committee requested input and data from various professional organizations, including medical schools, outpatient surgery accreditation agencies, insurance carriers, coroners, and professional plastic surgery societies, as well as from patients. The Committee held an all-day public hearing on June 20, 1998 to receive information and testimony from interested parties; its goal is the eventual introduction of legislation to more strictly govern plastic and cosmetic surgery, especially in the outpatient setting. The following is a brief outline of the Committee's progress in its various areas of inquiry.

♦ **Plastic Surgery Outcome Data Collection.** At its June 1998 public hearing, the Committee discussed data collection procedures and problems associated with outpatient cosmetic surgery procedures. Committee members heard from a variety of stakeholders during the all-day session. Discussions focused on liposuction, especially its high morbidity and mortality rates. In California, more than 97% of such procedures are performed in non-hospital settings, and at least 130 deaths have resulted in the United States since 1993. Yet these data may significantly underestimate the problem, because reporting mechanisms in non-hospital settings are not as rigorous as those in hospitals.

Another problem is the fragmentation (or, conversely, the lack of centralization) of data collected. Individual private plastic surgery organizations, including the American

Society for Aesthetic and Plastic Surgery (ASAPS) and the American Society of Plastic and Reconstructive Surgeons (ASPRS), compile data reported by their members. Many procedures and adverse outcomes, however, are not reported because they are performed by non-members. Furthermore, data collection methods among these private organizations differ, making statistical comparisons difficult. The Committee requested that ASAPS, ASPRS, and other societies provide information and guidance on standards for comprehensive data collection on liposuction in general and large-volume liposuction in particular. At this writing, the Committee plans to meet in early 1999 to discuss the establishment of a coordinated reporting system and guidelines for these procedures.

In addition, following its June meeting, the Committee called for a moratorium on mega-volume liposuction procedures in outpatient settings until safety can be assured. Committee Chair Robert del Junco, MD, called the procedure "too risky to be performed in free-standing, unregulated offices until there is greater scientific data" on how to conduct it safely.

♦ **Non-Hospital Surgery Settings.** AB 595 (Speier) (Chapter 1276, Statutes of 1994) added section 1248 *et seq.* to the Health and Safety Code. These sections generally prohibit physicians from performing surgical procedures "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" in unaccredited outpatient settings. [14:4 CRLR 69] The statutes also set forth minimum standards and requirements for outpatient surgical settings which desire to be accredited, charge MBC's Division of Licensing with adopting additional standards for accreditation, and require DOL to approve accrediting agencies to perform accreditation of outpatient settings. The statute specifically excludes from its coverage settings where only sedation or analgesia are used, and dental offices which are issued general anesthesia/conscious sedation permits by the Board of Dental Examiners.

AB 595 was enacted in response to increasing concerns in the health care community about the risks posed to patients undergoing surgery in non-hospital settings. During the past decade, outpatient surgery has grown significantly: More than 85% of all surgical procedures—including most cosmetic surgeries—are now performed outside hospitals. In 1996, DOL adopted regulations implementing AB 595 in Article 3.5 (sections 1313.2–1313.6), Title 16 of the CCR. This article sets forth application procedures and fees for accrediting outpatient settings, and renewal of such accreditation certificates every three years, but generally defers to the statute on minimum standards for accreditation. [15:4 CRLR 91; 15:2&3 CRLR 63–64] Pursuant to these regulations, DOL has approved four agencies which currently accredit outpatient surgery settings: the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care, the Institute for

Medical Quality, and the Joint Commission on Accreditation of Hospitals and Health Systems.

However, AB 595's regulatory scheme has proven difficult to administer. The primary issue raised by AB 595 is its threshold for mandatory accreditation. The medical community disagrees over the precise level of anesthesia which would place a patient "at risk for loss of the patient's life-preserving protective reflexes"—language which has been called "vague, unworkable, and unenforceable" by MBC staff. When AB 595 was passed, the legislature chose, for practical reasons, to draw the line for accreditation at the level of anesthesia, assuming prevailing standards in the medical community would suffice to define "life-preserving protective reflexes." However, that has not been the case.

At the Committee's November 5 meeting, Dr. Thomas Joas indicated that, despite confusion in the medical community at

large, anesthesiologists generally interpret AB 595's "life-preserving protective reflexes" language to mean situations in which the patient is at risk of losing his airway. He stressed the need for two professionals ("one devoted to the procedure, and another devoted to the patient") and adequate equipment to monitor patient's vital signs and resuscitate the patient if necessary. In his opinion, however, AB 595's language is inadequate to define settings which should require accreditation, noting that heavy sedation could place patients at significant risk but does not fall under the umbrella of AB 595's protections and could, therefore, be legally performed in a physician's office without accreditation. The Committee and its staff have concluded that clean-up legislation must be drafted to clarify this key issue.

The Committee has also questioned whether the AB 595 accreditation process and the ongoing monitoring of non-hospital surgery settings by the accrediting agencies is adequate and consistent under the current statute and its implementing regulations. Committee members expressed similar concerns regarding data reporting and analysis. Of interest, it became apparent that the four different accrediting agencies apply four different sets of accreditation criteria to the settings they accredit. For example, one agency requires that physicians who perform outpatient surgeries have hospital privileges; the others do not.

In September, MBC staff—including Medical Board Consultant Patricia Chase, MD, who is coordinating the research on AB 595 issues for the Committee—met with representatives of the four accrediting agencies. Staff and the accrediting agencies reached consensus on a number of issues, including mandatory reporting of deaths and other data (although no agreement was reached on which state agency should receive these reports); the required posting of a setting's certificate of accreditation; and the necessity of an agreement between an outpatient surgical center and a hospital (and at least one physician with privileges at that hospital) for the transfer of patients needing inpatient care. However, no agreement was reached on other issues, including the complaint

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process—which raises the fundamental issue of the role of the accrediting agencies vs. the Medical Board in carrying out enforcement.

Committee members agree that accreditation does not guarantee patient protection in the absence of monitoring and enforcement. Committee Chair del Junco related his observations of outpatient facilities which rent equipment necessary to pass an accreditation inspection and then return it after the inspectors leave. Furthermore, outpatient facilities often push the limits of current regulations prohibiting patients from staying overnight—existing regulations proscribe stays of 24 hours or more, but not those of 23 hours and 59 minutes. Committee members have agreed that state regulatory standards in all of these areas are in need of enhancement and clarification.

◆ **Required Malpractice Insurance.** Following its June hearing, the Committee agreed that MBC should seek legislation requiring physicians who perform significant surgeries in outpatient settings to carry medical malpractice insurance. Such a requirement would help to ensure that patients can collect damages if a procedure is botched; more importantly, it may discourage physicians who lack the proper training from undertaking such procedures in the first place. At this writing, MBC is working with Assemblymember Martin Gallegos, who chairs the Assembly Health Committee, to develop mandatory malpractice insurance language for a bill to be carried by Gallegos during 1999.

◆ **Evaluation of Plastic Surgery Training Courses.** During the course of its work, the Committee has become aware that some physicians who are not professionally trained or skilled in cosmetic surgery nonetheless offer to perform cosmetic procedures after taking minimal “weekend” courses in certain procedures. The Committee plans to visit and evaluate cosmetic procedure training courses that are not accredited by the Accreditation Council on Graduate Medical Education (ACGME). At the Committee’s November meeting, Committee Chair del Junco questioned whether such visits should be announced or unannounced; DCA legal counsel Anita Scuri responded that the Board lacks authority to make unannounced visits. Following additional discussion, Dr. del Junco directed staff to collect more information about the courses offered, their marketing, and the appropriate qualifications for consultants who will perform the site visits to courses.

◆ **Cosmetic Procedures Performed by Non-Physicians.** On May 28, Committee Chair del Junco requested a legal opinion from DCA regarding cosmetic procedures performed by dentists. Dentists are among the many non-physician practitioners performing lucrative cosmetic procedures in their offices. On September 21, Derry L. Knight, DCA Deputy Director of Legal Affairs, responded that Business and Professions Code section 1625 confines the practice of dentistry to regions of the head. Thus, procedures performed on other parts of the body are clearly beyond the scope of practice for dentists, with the exception of procedures which are authorized to be performed without a license (such as tattooing and body piercing). Further, cosmetic procedures performed by dentists on the head are permitted by section 1625 only

insofar as their purpose is to treat or correct a dental condition. Mr. Knight noted that DCA has previously addressed issues of dentists performing procedures such as rhinoplasty and septoplasty, and has concluded that such procedures are outside the scope of dentistry; treating fractures of the maxilla or mandible, however, may be performed by a dentist. Similarly, DCA has found laser removal of hair, wrinkles, scars, or moles to be outside the scope of dentistry unless necessary to treat a dental condition.

At the Committee’s November meeting, Kimberly S. Davenport, representing the California Association of Oral and Maxillofacial Surgeons, objected to DCA’s legal opinion on the scope of dental practice and requested a retraction. She argued that the Board of Dental Examiners (BDE) is the agency rightfully charged with licensing and regulating dentists, which includes interpretation of the statutes governing the scope of practice for dentists. Thus, Davenport contended, this issue should properly come before BDE rather than MBC. She urged MBC to consult BDE and at least let its members know why the opinion was sought and how it might be used. Davenport stressed that inappropriate use of this opinion could subject dentists to criminal prosecution for actions their own licensing board did not consider wrongful. She invited MBC to discuss this issue with BDE’s Subcommittee on Oral and Maxillofacial Surgery.

The recent DCA legal opinion has served to heighten the debate over a problem of which both MBC and BDE are acutely aware. Under provisions in the Dental Practice Act, Business and Professions Code section 1638 *et seq.*, oral and maxillofacial surgery is defined as “the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects, which involve both functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.” BDE may issue a special permit to practice oral and maxillofacial surgery to (1) a person licensed as a physician under the Medical Practice Act, and who possesses a license to practice dentistry in another state but is not a licensed dentist in California; or (2) a licensed dentist who furnishes satisfactory evidence that he/she is currently certified or eligible for certification in oral and maxillofacial surgery by a specialty board recognized by the Commission on Accreditation of the American Dental Association. However, single-degreed DDS-trained oral and maxillofacial surgeons (OMS) who hold the special permit to engage in oral and maxillofacial surgery are bound by the definition of dentistry set forth in section 1625, while “double-degreed” physicians (MD/DDS) who hold the Board’s special permit are not so bound. For years, single-degreed oral and maxillofacial surgeons have argued that section 1625 prevents them from utilizing the full scope of their oral and maxillofacial surgery training.

In the past, BDE’s position has been that if the dentists represented by CAOMS want legislative clarification of this matter, they should approach the legislature directly; further, BDE has left it to the Medical Board to pursue dentists who are exceeding the scope of their OMS permit. However, due to the issuance of the DCA legal opinion, representatives of BDE, MBC, and CAOMS met with Anne Sheehan,

Undersecretary of the State and Consumer Services Agency, on December 9 to discuss the matter. The parties agreed that, as a first step toward resolution of this matter, BDE must become involved in this issue, and should assume some responsibility for enforcing the scope of practice of its OMS permit. Thus, BDE must develop a reasonable standard against which to measure the appropriate scope of practice of the OMS as soon as possible (see agency report on BOARD OF DENTAL EXAMINERS for related discussion).

♦ **Public Education on Cosmetic Surgery.** At all of its meetings and hearings, the Committee has discussed the proliferation of advertising of cosmetic surgical procedures which bombards California consumers. Members reviewed telephone directory and magazine ads promising "a new body tomorrow," using deceptive "before and after" photographs, and containing misleading references to cosmetic surgery specialty boards by practitioners. Although the Committee entertained much discussion about the extent to which a government agency may regulate advertising (inasmuch as it is considered "commercial speech" and entitled to some protection under the first amendment), no consensus was reached. During its November 5 meeting, the Committee discussed an alternative to advertising restrictions—a proposed public information campaign about cosmetic surgery as a means to increase consumer awareness and safety. However, the Committee felt that the cost (estimated at \$400,000) was prohibitive and the task is perhaps beyond the scope of MBC's duty. Committee member Karen McElliott called on the legislature to appropriate additional funds for this effort from the general fund.

**The Committee has discussed the proliferation of advertising of cosmetic surgical procedures which bombards California consumers.**

### **DMQ Creates Diversion Task Force**

In February 1998, DMQ decided to create a Diversion Task Force to investigate the charges asserted by the Center for Public Interest Law against the Board's Diversion Program for substance-abusing licensees during MBC's 1997 sunset review hearing (see above; see also FEATURE ARTICLE). In creating the task force, DMQ members noted that the Division has been "dancing around" several very serious issues related to the Diversion Program for a number of years, and expressed a desire to come to grips with them and address them once and for all.

The task force—chaired by public member Karen McElliott and including Alan Shumacher, MD, Robert del Junco, MD, Kip Skidmore, and Phil Pace—held meetings on June 3 and November 5. During the meetings, task force members questioned Diversion Program staff about the procedures and operations of the Program, and formulated a list of issues it wants to address. In addition to gaining an overall understanding of the procedural operations of the Program and the many levels on which it makes decisions, the task force wants to explore several "macro" issues, including an investigation of the way other state medical boards run their diversion programs for substance-abusing licensees; whether the Program

and impaired physicians are best served by locating the Program within the Medical Board; the possibility of privatizing the Diversion Program's operations; the lack of an overall guiding philosophy or principles for the Program; and methods of measuring and evaluating the Program's actions and decisions. According to Dr. Shumacher, another overriding issue is "how in good conscience this Board can continue to support this program when we have inadequate resources to do our primary job." MBC (and physician licensing fees) subsidize the program to the tune of \$800,000-\$900,000 per year.

At this writing, the task force has scheduled a daylong public hearing on the Diversion Program for January 20 in San Diego.

### **DOL's Postgraduate Training Requirement**

At its November meeting, DOL discussed the failure of AB 1079 (Cardoza), the latest in a long line of proposals which would have required candidates for physician licensure to complete two years of approved postgraduate training (PGT) prior to licensure in California (see LEGISLATION). DOL has a longstanding interest in tougher PGT requirements, first proposing an increase in its one-year PGT requirement nearly a decade ago. [10:2&3 CRLR 99; 10:1 CRLR 75-76; 9:4 CRLR 62-63]

DOL was particularly upset at the failure of the 1998 Cardoza bill, however, because it had commissioned a study which it believed supported its position. During 1998, Dr. Doraiswamy Ramachandran, a statistician and mathematician at CSU Sacramento, conducted a study on the relationship between rates of disciplinary actions and number of years of postgraduate training. Specifically, Dr. Ramachandran analyzed 627 MBC discipline cases in which the respondent had at least one year of PGT prior to licensure, and found a reduction of 7.1% of severe disciplinary actions for those with two or more years of PGT; this reduction is not statistically significant. However, in focusing on a subset of 274 gross negligence and/or incompetence cases within the sample of 627 cases, there is a statistically significant reduction of 14.8% of severe action cases for those who had two or more years of PGT.

Dr. Ramachandran further analyzed data from the American Medical Association on the number of physicians in California, their number of years of PGT, and their rate of discipline. He found that among those with at least one year but less than two years of PGT, the number of disciplines per 1,000 physicians is 15.4, which is statistically significantly higher than the corresponding number of 7.3 disciplines per 1,000 among those with at least two years of training. According to MBC Deputy Director Doug Laue, "it's twice as likely that a physician will be disciplined if he has one versus two years of PGT." DOL members also noted that California is one of the few states in the nation which requires only one year of PGT for licensure, and that the Federation of State Medical Boards recommends a minimum of three years of PGT prior to full licensure.

While DOL was sure that its new evidence provided compelling support for its bill, CMA opposed it on behalf of its "young physician" membership, and Assemblymember Cardoza dropped the bill. DOL invited the leadership of CMA's "young physicians" to explain its opposition to the proposal at the Board's November meeting.

In November, three medical students complained that requiring them to wait an additional year for licensure is "(1) bad for families, and (2) limits access to health care." Specifically, they argued that postponing licensure would preclude them from "moonlighting" outside their residencies for the extra income needed to pay student loan debts and family expenses; moonlighting physicians sometimes provide services in low-income clinics and underserved communities. Also, female students would have to postpone childbearing plans, and physicians seeking further education would have to wait an additional year to pursue their career goals. The medical students also stated that the last two years of medical school are essentially "on-the-job training," such that an additional year of residency training is not needed prior to licensure.

Despite the objections voiced by the medical students, DOL expressed renewed interest in sponsoring similar legislation during 1999. DOL member Michael Sidley, JD, was particularly determined in asserting that concerns for public safety take precedence over medical students' inconvenience.

### DMQ Rulemaking

The following is a description of rulemaking proposals published and considered by DMQ during recent months.

◆ **Emergency Regulations to Implement New Statute of Limitations.** At its November 6 meeting, DMQ adopted section 1356.2, Title 16 of the CCR, on an emergency basis to implement AB 2719 (Gallegos) (Chapter 301, Statutes of 1998). AB 2719 requires MBC to file an accusation against a physician within three years after it "discovers" the alleged act or omission, or within seven years after the alleged act or omission, which is the basis for disciplinary action—which ever occurs first (see LEGISLATION). New section 1356.2 defines the term "discovers" to mean the date the Board receives a complaint or report describing the act or omission alleged as the grounds for disciplinary action, or the date the Board subsequently becomes aware of one or more acts or omissions, alleged as grounds for disciplinary action, that were not contained in the original complaint or report. "Complaint" means a written complaint from the public; "report" means any written report required to be filed with MBC under the Business and Professions Code. However, reports filed with MBC pursuant to Code of Civil Procedure section 364.1 do not suffice as a "report" which triggers the statute of limitations; section 364.1 requires a medical malpractice plaintiff to send the defendant and MBC a notice announcing that an action will be filed 90 days prior to the filing of the lawsuit. According to MBC, section 364.1 reports do not contain sufficient information about the acts complained of to serve as a

"report" and thus trigger the statute of limitations. DMQ forwarded new section 1356.2 to the Office of Administrative Law (OAL) on December 11; OAL approved it on December 21. Emergency regulations are valid for 120 days.

On December 19, DMQ published notice of its intent to permanently adopt section 1356.2, and scheduled a public hearing on the proposed regulation for its February 5 meeting in Santa Ana.

AB 2719 has caused major disruption within MBC's enforcement program. The bill passed as an urgency bill, and thus became effective on August 17, 1998, the day it was signed by the Governor. As the bill did not expressly state whether it applies solely to accusations filed after August 17 or whether it retroactively applies to all unresolved accusations pending on August 17, de-

fense attorneys for numerous respondents immediately filed motions to dismiss charges contained in then-pending accusations which were based on events outside the new limitations period. At this writing, MBC has successfully defended all of its pending charges. In the days and months following the new law's effective date, however, DMQ was required to halt numerous investigations and withdraw some accusations based on events occurring outside the limitations period. The new statute of limitations requirement has cost MBC's enforcement program significant time and money, and makes it even more important that MBC succeed in winning a fee increase (see above), so that additional investigators can enable it to meet the statute of limitations and ensure consumer protection.

◆ **Procedures for Oral Argument.** At its July 31 meeting, DMQ adopted new section 1364.30, Title 16 of the CCR, which establishes procedural requirements for oral argument before DMQ on disciplinary decisions.

Under the Administrative Procedure Act, MBC must afford respondent physicians in disciplinary proceedings an evidentiary hearing before an administrative law judge from the Office of Administrative Hearings; following conclusion of the hearing, the ALJ submits a proposed decision to DMQ for review. One of the DMQ panels reviews the decision and determines whether to adopt it as its own, or to nonadopt it in order to change the decision in some way. If a DMQ panel nonadopts an ALJ decision in order to increase the recommended penalty (or if it decides to reconsider a prior decision), it must afford both sides an opportunity for oral argument before the panel; new section 1364.30 establishes procedures for that oral argument.

Section 1364.30 requires persons who wish to present oral argument to make a written request no later than twenty calendar days after the date of the notice of nonadoption or the order granting reconsideration. Section 1364.30(b) requires that an ALJ preside at the oral argument to ensure that argument is limited to the existing record and admitted evidence, and permits the ALJ to assist panel members with closed-session deliberations. The new regulation also sets forth the sequence of and time limits on oral argument.

**AB 2719 has caused major disruption within MBC's enforcement program.**

Following the public hearing, DMQ adopted the proposed regulation with a minor modification; DMQ published the modified text for a 15-day comment period ending on August 26. OAL approved new section 1364.30 on December 22.

♦ **DMQ Acceptance of Amicus Curiae Briefs in Disciplinary Matters.** In December, the Union of American Physicians and Dentists (UAPD) filed a petition for rulemaking requesting that DMQ adopt regulations permitting the filing of *amicus curiae* ("friend of the court") briefs in disciplinary matters.

UAPD's petition comes in the wake of Board staff's refusal to accept *amicus curiae* briefs from CPIL and CMA in a recent case. MBC Executive Director Ron Joseph rejected their *amicus* contributions, characterizing them as improper ex parte communications under Government Code section 11430.10 *et seq.* However, CPIL and CMA had served the briefs on all parties to the case, thus satisfying the requirements of section 11430.10 (a), which permits communications between interested persons and agency decisionmakers so long as there is "notice and opportunity for all parties to participate in the communication." Next, MBC argued that Government Code section 11440.50(f), concerning intervention by a non-party in an adjudicative proceeding of an agency, states that "nothing in this section precludes an agency from adopting a regulation that permits participation by a person short of intervention as a party...." MBC argued that, because it has not adopted such a regulation, it is prohibited from accepting *amicus* contributions.

CPIL and CMA argued that a judicial decisionmaker always has discretion to hear external contributions outside the framework of the parties' advocacy, regardless of whether it has adopted regulations which govern such contributions; and that, in any event, the decisionmaker (not the decisionmaker's staff, and certainly not the staff of one of the parties to the matter) should determine whether it needs external argument on the potential impact of its decision. UAPD argued that both the state and federal Administrative Procedure Acts permit the filing of *amicus* briefs, and that a number of state agencies have adopted regulations governing their admission. It pointed to the value of *amicus* briefs in addressing important policy implications of a case that parties to the proceeding may not have time or resources to present.

At this writing, DMQ has scheduled a public hearing on UAPD's petition for rulemaking at its February 5 meeting in Santa Ana.

## DOL Rulemaking

The following is a description of rulemaking proposals published and considered by DOL during recent months.

♦ **Physician Specialty Board Approval.** SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) added section 651 to the Business and Professions Code; this section

requires DOL to approve national specialty certification boards before their certificants may advertise that they are "board certified" in California, and authorizes DOL to charge a fee for reviewing each specialty board. [12:4 CRLR 90-91; 10:4 CRLR 85]

On July 31, DOL held a public hearing on its proposal to amend to section 1354, Title 16 of the CCR, to increase the specialty board application fee from \$830 to \$4,030 to reflect DOL's actual costs associated with the application process. Following the hearing, DOL voted to adopt the proposed changes. At this writing, the rulemaking file on this proposal is pending at OAL.

Also on July 31, DOL held a public hearing on proposed amendments to section 1363.5(c), Title 16 of the CCR, which currently states that DOL will inform a specialty board certification applicant of the status of its application (complete or deficient) within 30 days of receipt, and of its final decision within 120 days of the filing of a completed application; how-

ever, the section does not specify minimum, median, and maximum time periods for DOL's processing of specialty board certification applications, as required by the Permit Reform Act, Business and Professions Code section 15376 (Chapter 1087, Statutes of 1981). The amendments would add those

minimum (646 days), median (714 days), and maximum (918 days) time periods which are needed to review an application once it is considered "complete," and define "completed application form" to mean that a completed application form, together with all required information, documentation, and fees, has been filed by the applicant and the application has been reviewed by a medical consultant selected by the Division. Following the hearing, DOL adopted the proposed changes.

On December 30, OAL disapproved the proposed changes for failure to comply with the consistency and clarity requirements of Government Code section 11349.1. Specifically, OAL found proposed section 1363.5(c) unclear because it fails to indicate that review by an independent medical consultant, which is required before an application is considered complete, takes place outside the initial 30-day review period for completion. OAL also found that DOL's actual processing times from receipt of initial application to final decision (646 to 918 days) are inconsistent with its existing 30-day completion review and 120-day decision notification provisions. DOL has 120 days within which to correct the deficiencies noted by OAL; at this writing, DOL has prepared a response to OAL's disapproval which is under review by legal counsel before submission to OAL.

♦ **Special Faculty Permit Program.** At its May 1998 meeting, DOL held a public hearing on its proposed addition of sections 1315.01, 1315.02, and 1319.5, and amendments to sections 1351.5, 1352, 1352.2, and 1364.11, Title 16 of the CCR; these regulations implement AB 523 (Lempert) (Chapter 332, Statutes of 1997), which authorizes DOL to issue a

**In December, the Union of American Physicians and Dentists (UAPD) filed a petition for rulemaking requesting that DMQ adopt regulations permitting the filing of amicus curiae ("friend of the court") briefs in disciplinary matters.**

special faculty permit to practice medicine to an "academically eminent" physician who has a license to practice medicine in another state, country, or jurisdiction, and whose practice of medicine in California is part of his/her instructional responsibilities at a California medical school and certain affiliated institutions. The regulatory changes set forth definitions of relevant terms; specify the initial license, renewal, penalty, and delinquent fees for special faculty permit holders; and establish processing times for an application for a specialty faculty permit. DOL also amended section 1364.11 to include as a citable offense the practice of medicine outside the scope of a special faculty permit or practicing with an expired permit.

Following the hearing, DOL adopted the proposed regulatory changes; the Division submitted the rulemaking file to OAL in November, where it is pending at this writing.

♦ **Duplicate Fictitious Name Permit Request and Fee.** Also at its May 1998 meeting, DOL held a public hearing on its proposal to add sections 1350.1 and 1353 to Title 16 of the CCR. These sections implement AB 1555 (Committee on Health) (Chapter 654, Statutes of 1997), which authorizes MBC to charge a fee to replace a fictitious name permit that has been lost, stolen, or destroyed. New section 1350.1 specifies the information that must be contained in a request for a duplicate fictitious name permit, and section 1353 establishes the fee for such a permit at \$30. Following the hearing, DOL adopted the proposed regulatory changes; the Division submitted the rulemaking file to OAL in November, where it is pending at this writing.

♦ **Medical Assistant Certifying Bodies.** Business and Professions Code sections 2069–2071 require DOL to adopt regulations establishing standards for the technical supportive services which may be provided by unlicensed medical assistants (MAs), and standards for appropriate training in those services. MAs can receive training in a variety of ways; under existing section 1366.3, Title 16 of the CCR, one method is to become certified by the American Association of Medical Assistants or registered by the American Association of Medical Technologists. Since the time DOL adopted section 1366.3, other state and national associations have expressed interest in being identified in the provision as a certifying agency, including the California Certifying Board for Medical Assistants (which submitted a petition to this effect in 1997).

In March 1998, DOL published notice of its intent to amend section 1366.3's definition of medical assistants, delete the specific names of the certifying agencies, and specify requirements for certifying agencies which could then apply to DOL for approval. DOL also proposed to add sections 1366.31 and 1366.32 to Title 16 of the CCR, to establish criteria for DOL approval of an organization as an MA certifying agency, specify reporting requirements for certifying bodies, and require DOL to review each approved certifying body at least once every five years for compliance with the standards in section 1366.31. DOL held a public hearing on the proposed regulatory changes on May 8.

Following the public hearing, DOL adopted the proposed language with minor modifications, published the modified

text for a 15-day comment period ending on July 17, and submitted the rulemaking file to OAL for review. Thereafter, DOL modified the text again in response to concerns voiced by OAL, and published the modified text for another 15-day comment period ending on December 31. At this writing, DOL is preparing the rulemaking file for resubmission to OAL.

♦ **Continuing Medical Education.** On September 14, DOL's amendments to section 1337, Title 16 of the CCR, which lists programs approved by DOL for continuing medical education (CME) credit, became effective. Business and Professions Code section 2190 requires licensed physician to complete CME for license renewal. DOL recently added subsections 1337(e) and (f), which place into regulation the Board's longstanding policy of granting CME credit to a physician for receiving an American Medical Association Physician's Recognition Award, and for participating in an ACGME-approved postgraduate residency training program or clinical fellowship.

♦ **Midwifery Educational Programs.** SB 350 (Killea) (Chapter 1280, Statutes of 1993) added section 2505 *et seq.* to the Business and Professions Code, requiring DOL to establish a licensure program for lay midwives. [15:4 CRLR 89–90; 15:2&3 CRLR 64–65; 15:1 CRLR 64–65] Effective August 22, DOL added new sections 1379.30 and 1379.31, and amended section 1379.2, Title 16 of the CCR. New sections 1379.30–31 set forth the educational requirements for an approved midwifery program and require a licensure applicant to submit certain documentation proving that he/she has completed the necessary education. These sections require approved programs to prepare midwives to manage normal pregnancy, labor, delivery, and the postpartum period; administer intravenous fluids, analgesics, and specified local anesthetics; undertake episiotomies and repairs; and manage the normal newborn. The amendment to section 1379.2 defines the term "accrediting organization" for purposes of midwifery education program accreditation.

### The PACE Program

At DMQ's November meeting, Enforcement Chief John Lancara updated the Division on the Physician Assessment and Clinical Education (PACE) program which has been developed at the University of California at San Diego in order to provide assessments of physicians' clinical skill and remedial education and training as part of a probation order. In 1997, MBC's Enforcement Program and the UCSD Medical School collaborated in developing the program, which offers physicians subject to disciplinary action or remedial training requirements a broad-based, individualized clinical training program. Based on an extensive initial assessment and the probation order, ALJ proposed decision, or stipulation. PACE medical staff design a clinical training program for each physician participant. Physicians are evaluated on their knowledge, judgment, clinical skill, relationships with patients, care of actual patients, and ability to recognize medical expertise boundaries. Upon completion of the program, PACE medical staff may either extend the training period if needed, or prepare a final report detailing the specific training provided and

recommending specific areas to be emphasized for future CME enrollment and continuing training.

In the 1997-98 fiscal year, 54 physicians entered the PACE program; 50 completed successfully, one failed, and three were eliminated through the assessment program. Some physicians ordered into PACE did not enroll as required and are being assessed by Enforcement staff. In contrast, a similar Colorado program has processed and trained only 193 physicians since its inception in 1990.

Lancara noted that PACE provides other advantages: (1) physicians should be taught the standard of care in California, not some other state; (2) the PACE program faculty tests the trainees at the end of the clinical training course to ensure the physician understood what he/she has learned and is capable of treating future patients safely and competently; and (3) the location (instate) is important so that physicians can make contacts and build relationships within their communities. Lancara noted that Enforcement Program staff will continue to review other training programs and will address features of other programs which Board members find desirable.

## **CME as a Term of Probation**

Over the past year, several DMQ members have expressed repeated concerns about imposing CME as a term of probation. Section 2190.1 of the Business and Professions Code identifies educational activities that meet DOL's CME standards as those activities which "serve to maintain, develop, or increase knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or improve the quality of care provided for patients..." Physicians subject to discipline by DMQ are often required to complete CME courses as a term of their probation. Public member Kip Skidmore and other members of DMQ are concerned that the probationary term is ineffective for the disciplined physician due to lack of required attendance or participation in actual coursework. If the probationary term is not serving any useful educational purpose, Skidmore believes DMQ should consider changing the requirements or mandating tighter control over CME requirements.

Attendance at CME courses is based on the honor system and, generally, no test or other method of evaluating whether a course attendee actually learned something or slept through the course is administered. Although it is unprofessional conduct for any physician to misrepresent his/her compliance with the CME requirements, the only way the Board ensures attendance is by conducting random compliance audits of roughly 800 physicians each year. In the rare case that a physician is caught for not fulfilling his/her CME hours, the Board allows the physician a certain time period in which to make up those hours. MBC does not require physicians to attend specific CME courses, but encourages coursework in a few important areas such as child abuse detection, nutrition, and elder abuse. DMQ's concern is that physicians on

probation are taking irrelevant courses in exotic places and not getting any educational benefit from their attendance.

On November 6, DMQ voted to place the issue of CME as a term of probation on the agenda of the full Board at its February 1999 meeting. The issue up for discussion by the Board is whether MBC should increase or tighten enforcement of CME courses when they are a term of probation. Some members of DMQ have suggested that disciplined physicians be required to attend specific CME courses relevant to the reason for discipline; others believe that the physician should be somehow evaluated or tested on his/her knowledge of the material presented at the course. Because DOL is responsible for adopting and administering standards for CME, DMQ would like to discuss these issues with DOL members present.

## **MBC on the Internet**

In May 1993, the Medical Board revised its public disclosure policy, and agreed to disclose many categories of information about physicians not previously disclosed to inquiring consumers. These categories include felony convictions, medical malpractice judgments in excess of \$30,000, and professional discipline in other states. [13:2&3 CRLR 78-81] While relatively modest, MBC's change led most other DCA occupational licensing boards to adopt similar policies, and opened the door for AB 103 (Figueroa) (Chapter 359, Statutes of 1997), which requires further disclosures (including all medical malpractice judgments and hospital peer review actions which result in the termination or revocation of a physician's privileges), and placement of the Board's public information about physicians on the Internet.

Consumers can now learn about the background of any California-licensed physician on MBC's website. By clicking

"Check on Doctor Online," a consumer can access the following information: license status, license number, city and state, original license date, license expiration date, medical school attended and year of graduation; medical malpractice judgment amount, if any, and court of jurisdiction and lawsuit number; arbitration awards, if any; description of Medical Board disciplinary action, if any; felony conviction(s) and sentence(s), if any; and revocation or termination of hospital privileges after January 1, 1995, if any. Consumers may order copies of legal documents relating to an MBC disciplinary action against a physician by following the instructions on the web page.

However, the Board will not disclose information about complaints against a physician unless an accusation has been filed by the Attorney General. Nor will MBC disclose personal information about a physician, such as social security number, test scores, or information about a physician's physical or mental health. The Board cannot tell consumers a physician's specialty, or refer a consumer to a doctor. However, consumers may determine whether a physician is board certified by any of the specialty boards within the American

**DMQ's concern is that physicians on probation are taking irrelevant courses in exotic places and not getting any educational benefit from their attendance.**

Board of Medical Specialties by accessing its website ([www.certifieddoctor.org/](http://www.certifieddoctor.org/)).

MBC's website contains other valuable pieces of information for consumers. If a consumer wishes to file a complaint against a Board licensee, he/she may click on "complaint about a licensee," print the complaint form, complete it, and either mail or fax it back to the Board. The website also contains instructions for completing the complaint form. Under the "finding a new doctor" link, MBC provides useful information on how to make a good choice when selecting a new physician.

MBC's site also includes a calendar of meetings, a brief biography of all Board members, the names of upper Board staff, links to other government agencies, HMOs, state and national physician trade associations, and a "consumer response form" which enables consumers to comment on the service provided by the Medical Board.

## Legislation

**SB 1981 (Greene)**, as amended August 24, extends MBC's sunset date until July 1, 2003 (see MAJOR PROJECTS). The bill also eliminates the Board's oral examination requirement for foreign medical graduates.

SB 1981 also amends Business and Professions Code section 2225.5 to provide that the failure or refusal of any physician or health care facility to comply with a court order issued in the enforcement of a Medical Board subpoena for medical records is a misdemeanor punishable by a fine payable to MBC not to exceed \$5,000; the fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. The failure or refusal of any physician to comply with a court order issued in the enforcement of a Medical Board subpoena for medical records is unprofessional conduct and grounds for professional discipline. Further, any statute of limitations applicable to the filing of an accusation by the Board is tolled during the period a licensee is out of compliance with a court order issued in the enforcement of a subpoena mandating the release of medical records to the Board. The Governor signed SB 1980 on September 21 (Chapter 736, Statutes of 1998).

**SB 1930 (Polanco)**, as amended June 18, would have increased MBC's biennial licensure renewal fee for physicians from \$600 to \$690, primarily to finance additional investigators for the Board's enforcement system (see MAJOR PROJECTS). In response to CMA opposition registered on June 19, Senator Polanco dropped the provision from the bill.

**SB 2238 (Committee on Business and Professions)**, as amended August 26, requires MBC to initiate the rulemaking process by June 30, 1999 to adopt regulations requiring its licentiates to identify themselves to patients as licensed by the state of California. SB 2238 also requires MBC to report the method used for periodic evaluation of its licensing examinations to the DCA Director by December 31, 1999. This bill was signed by the Governor on September 26 (Chapter 879, Statutes of 1998).

**SB 2239 (Committee on Business and Professions)**, as amended August 24, makes several technical changes to

MBC's enabling act and related statutes. SB 2239's more important changes include the following:

- Amendments to Business and Professions Code section 2350 require physicians participating in DMQ's Diversion Program to sign an agreement that Diversion Program records may be used in disciplinary or criminal proceedings if the participant is terminated from the Program and one of the following conditions exists: (a) his/her participation in the Program is a condition of probation; (2) he/she has disciplinary action pending or was under investigation at the time of entering the Program; or (3) a Diversion Evaluation Committee determines that he/she presents a threat to the public health or safety. The agreement must also authorize the Diversion Program to exchange information about the participant's recovery with a hospital well-being committee or monitor and with MBC's licensing program, where appropriate, and to acknowledge, with the participant's approval, that he/she is participating in the Diversion Program.
- Amendments to Business and Professions Code section 2355 clarify that, if a Diversion Program participant successfully completes the Program, the Program will purge and destroy all treatment records pertaining to the physician's participation; however, the Program may retain any other information and records that it specifies by regulation.
- Amendments to Government Code section 11371 extend the existence of the Medical Quality Hearing Panel (MQHP) in the Office of Administrative Hearings. The MQHP is a special panel of ALJs who specialize in hearing medical discipline cases which was scheduled to sunset on January 1, 1999; SB 2239 extends the life of the panel until January 1, 2003. The bill also permits an ALJ to issue an interim order suspending a license, or imposing other license restrictions, if the affidavits in support of the petition show that a licensee is unable to practice safely due to a physical or mental condition.

SB 2239 was signed by the Governor on September 26 (Chapter 878, Statutes of 1998).

**AB 2719 (Gallegos)**, as amended July 9, requires MBC to file an accusation against a physician within three years after the Board discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first (see MAJOR PROJECTS). These statute of limitations does not apply to an accusation based on the procurement of a license by fraud or misrepresentation. AB 2719, which was opposed by the Board, took effect immediately as an urgency statute upon its approval by the Governor on August 17 (Chapter 301, Statutes of 1998).

**AB 1079 (Cardoza)**, as amended April 14, would have increased the amount of postgraduate training required of physicians prior to licensure in California from one year to two years. MBC sponsored this bill, arguing that a two-year postgraduate training requirement reflects current requirements in almost all other states. AB 1079 was dropped by its

author following opposition by the California Medical Association (see MAJOR PROJECTS).

**SB 324 (Rosenthal)**, as amended August 28, and **SB 557 (Leslie)**, as amended August 28, would have added section 2052.1 to the Business and Professions Code, to require a current California medical license for any person who makes decisions regarding the medical necessity or appropriateness of any diagnosis, treatment, operation, or prescription. SB 324 was sponsored by MBC; SB 557 was sponsored by CMA. The purpose of both bills was primarily to clarify that treatment decisions made by HMO personnel constitute the practice of medicine; and to ensure that medical directors of health plans, who make life-and-death decisions regarding medical care rendered to plan enrollees, are licensed to practice medicine in California such that the Medical Board has disciplinary jurisdiction over them. The managed care industry opposed both bills, arguing that they would preclude health plans from maintaining cost-effective claims processing procedures and would lead to conflicting and duplicative regulation by the Department of Corporations (which regulates managed care plans) and the Medical Board.

Governor Wilson vetoed both bills on September 29, on grounds that “[e]xtending Medical Board authority to medical necessity or appropriateness decisions will create new civil liability for those decisions without the protection of the Medical Injury Compensation Reform Act (MICRA).”

**AB 332 (Figueroa)**, as amended August 5, would also have required that decisions regarding the appropriateness or necessity of medical treatment be made only by a healing arts professional possessing a valid license authorizing the licentiate to perform such treatment. This bill would also have required health plans to disclose their utilization review procedure to any person or organization who requests it, and required that review criteria be determined by appropriately licensed health care professionals. Governor Wilson vetoed AB 332 on September 29, calling it “a transparent effort to eliminate the appropriate use of utilization review and a bald attempt to increase the number of lawsuits in the health care system.” In 1997, Wilson vetoed AB 794 (Figueroa), a nearly identical bill, despite broad support from consumer and medical groups, including both MBC and CMA. Opposition to AB 332 and AB 794 was comprised largely of insurance industry groups.

**AB 1181 (Escutia)**, as amended March 26, requires health care plans to establish procedures by which an enrollee can receive a standing referral to a specialist through the addition of section 1374.16 to the Health and Safety Code and section 14450.5 to the Welfare and Institutions Code. Existing law requires only that health plans provide continuity of care and referral to other providers (*i.e.*, specialists) as appropriate. Standing referrals will obviate the need for obtaining repeated referrals from a primary care physician when ongoing specialist care is required. Necessity of a standing referral will be determined by the primary care physician in consultation with the specialist and the plan’s medical director. However, a treatment plan limiting the number of visits or duration of specialist care may be required by the health plan. The plan

must make a determination on the referral within three business days of a request and, if approved, the referral must be made within four business days.

This bill also requires health care plans to implement procedures by which enrollees with life-threatening, degenerative, or disabling conditions who require specialized medical care over a prolonged period may receive care coordinated by a specialist or specialty care center with expertise in the enrollee’s condition. The specialist will be authorized to provide treatment in the same manner as a primary care physician, although a treatment plan can be required as described above.

**AB 1181**, which was widely supported by both medical professionals and patient advocates, applies to Medi-Cal programs as well as private health plans, but excepts specialized health care service plans. AB 1181 was signed by Governor Wilson on April 30 (Chapter 31, Statutes of 1998).

**AB 2305 (Runner)**. Existing law prohibits clearly excessive prescribing or administering of drugs by health care providers and provides both disciplinary and criminal penalties for violations. As amended August 26, this bill amends sections 725, 1367.5 and 2024 of the Business and Professions Code to comply with the California Intractable Pain Treatment Act, ensuring that no physician will be subject to disciplinary action by the Medical Board for prescribing or administering medication for the treatment of a person for intractable pain. This bill also adds section 1367.215 to the Health and Safety Code, requiring that health plan prescription drug benefits cover medically necessary pain medications for terminally ill enrollees. Authorization requests must be approved or denied by the plan within 72 hours or shall be deemed authorized. Furthermore, denials must be explained to providers within one working day. AB 2305 was approved by Governor Wilson on September 29 (Chapter 984, Statutes of 1998).

**AB 2693 (Migden)**. Existing law requires each prescription for a Schedule II controlled substance to be prepared in triplicate, with one copy forwarded to the Department of Justice. As amended August 18, this bill exempts Schedule II prescriptions for use by a patient who has a terminal illness from the triplicate requirement. Instead, AB 2693 requires prescribers of a Schedule II substance for terminally ill patients to provide basic information regarding themselves, the quantity and name of the substance, directions for use, and the name and other basic information of the person for whom it is prescribed. The bill relaxes the standards for prescribing controlled substances to treat pain associated with terminal illness, such as cancer. AB 2693 was signed by the Governor on September 23 (Chapter 789, Statutes of 1998).

**AB 2387 (Baugh)**, as amended August 25, adds section 14124.12 to the Welfare and Institutions Code, and prohibits—until July 1, 2003—the Department of Health Services from reimbursing a disciplined health care provider who is on probation for any Medi-Cal claim for the type of service or procedure that gave rise to the probation. This bill also requires MBC and other health care licensing agencies to work in conjunction with DHS to provide all information that is necessary to implement this provision. This bill was signed by the Governor on September 27 (Chapter 892, Statutes of 1998).



**AB 745 (B. Thompson)**, as amended June 24, makes several changes in the statutes of the Board of Dental Examiners (BDE) which establish BDE's permit program for the administration of general anesthesia and/or conscious sedation (GA/CS) to patients in a dental office, and prohibit dentists from administering or supervising the administration of GA/CS to patients on an outpatient basis unless the dentist has a permit issued by BDE.

AB 745 permits a licensed physician to administer general anesthesia to dental patients in the office of a licensed dentist, whether or not the dentist has a GA/CS permit, if the physician holds a valid GA/CS permit issued by BDE; authorizes BDE to conduct onsite inspections and evaluations of the dental office, and requires automatic suspension of the physician's permit if he/she fails the inspection; requires MBC to verify with BDE that a permit applicant is a licensed physician who has successfully completed an ACGME-approved training program; provides that a physician's violation of these provisions may constitute unprofessional conduct under the Medical Practice Act, and may be grounds for suspension or revocation of the GA/CS permit issued by BDE; and requires BDE to refer physician misconduct to MBC for further disciplinary action. This bill was signed by the Governor on September 15 (Chapter 505, Statutes of 1998).

**AB 1439 (Granlund)**, as amended August 28, requires health care practitioners to wear a name tag indicating their license status; exempted from this requirement are health care practitioners who work in an office or practice and whose licenses are prominently displayed, and those who work in a psychiatric setting or in a setting that is not licensed by the state. This bill was signed by the Governor on September 29 (Chapter 1013, Statutes of 1998).

**AB 2721 (Miller)**, as amended August 10, establishes a four-year term of office, expiring on June 1, for members of the Medical Board and other DCA agencies. This bill also provides that individuals regulated by DCA agencies who engage in, or aid and abet, prostitution-related offenses in the workplace are guilty of unprofessional conduct and subject to disciplinary action and fines up to \$5,000. This bill was approved by the Governor on September 29 (Chapter 971, Statutes of 1998).

**SB 379 (Rosenthal)**. Existing law prohibits disclosure of patient medical information without authorization from the patient or various other official entities. As amended June 24, this bill would have expressed the intent of the legislature to provide additional protections to patients from unauthorized disclosures. This bill failed on July 30 when the Senate refused to concur in Assembly amendments deleting specific prohibitions to and penalties for unauthorized disclosure of medical information, which were detailed in the Senate version. SB 1382 (Leslie), a nearly identical legislative intent bill, was also defeated when the Senate failed to concur in Assembly amendments removing specific protections.

## Litigation

Pending before the California Supreme Court are two cases which will decide the constitutionality of Business and Professions Code section 2337, which was recently amended to require a physician to appeal a superior court decision affirming DMQ's discipline of a medical license by way of a petition for an extraordinary writ. In *Leone v. Medical Board of California*, 57 Cal. App. 4th 1240 (1997), the Second District Court of Appeal held that section 2337 violates a physician's right to appellate review, which is guaranteed by the California constitution. However, the First District Court of Appeal in *Landau v. Superior Court (Medical Board of California)*, 60 Cal. App. 4th 940 (1998), upheld the validity of the same statute, finding that review by way of an extraordinary writ satisfies the constitutional guarantee.

When the Medical Board asserts that a physician is guilty of gross negligence or other misconduct warranting discipline, the law provides up to five decisionmaking steps for that physician. After a full investigation and the filing of formal written charges (the accusation), the physician is afforded an evidentiary hearing before an ALJ specially trained in medical legal issues; following submission of the case, the ALJ submits a written proposed decision to DMQ. Thereafter, a DMQ panel reviews the ALJ's proposed decision, and may adopt it or nonadopt it and change it in any way it desires; DMQ's decision is the final agency

decision, and is subject to judicial review. The physician may challenge that decision by filing a petition for writ of mandate in superior court under Code of Civil Procedure section 1094.5. The trial court reviews the record of the administrative proceeding, and engages in independent judgment of the facts and application of the law to those facts. Prior to the amendment to section 2337, physicians then had the right to a full appellate court review of the superior court's decision, including full briefing, oral argument, and a written opinion. Following appellate court review, the physician has one last avenue of relief—a discretionary petition for review to the California Supreme Court.

Amended section 2337 permits the appellate court to "shortcut" its review of superior court rulings on DMQ disciplinary decisions. Instead of guaranteeing a physician full appellate review, section 2337 now requires a physician to seek review by filing a petition for an extraordinary writ. Under this procedure, both the physician and MBC engage in full briefing on the merits of the appeal. After full briefing, the court may choose to engage in full appellate review, or it may summarily dispose of the case by denying the petition for a writ; in the latter case, the court need not hold oral argument, and it need not issue a full written decision.

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 a typical physician discipline case can take six to eight years—during which time

**Pending before the California Supreme Court are two cases which will decide the constitutionality of Business and Professions Code section 2337.**

most respondent physicians continue to practice with an unrestricted license. [9:2 CRLR 1] The administrative costs and resources devoted to each case are enormous, thus limiting the number of disciplinary cases the Board can bring. SB 916 (Presley) (Chapter 1267, Statutes of 1993) initially amended section 2337 to eliminate superior court review entirely; judicial review of a DMQ disciplinary decision could be triggered by a petition for writ of mandate to a court of appeal, which would exercise its independent judgment in reviewing the agency proceedings. [13:4 CRLR 55] However, the effective date of that provision was delayed in order to give the Judicial Council time to review the issue. In 1995, SB 609 (Rosenthal) (Chapter 708, Statutes of 1995) repealed SB 916's amendments to section 2337 (which had never taken effect); SB 609 instead amended section 2337 to preserve superior court independent judgment review but require a physician to seek appellate review of a superior court by way of a petition for extraordinary writ—thus allowing the appellate court to “shortcut” its review in unmeritorious cases.

In *Leone*, the Second District noted that Article VI, section 10 of the California Constitution provides that superior courts have original jurisdiction in “proceedings for the extraordinary relief in the nature of mandamus, certiorari, and prohibition,” and Article VI, section 11 vests courts of appeal with “appellate jurisdiction” in cases where superior courts have original jurisdiction. Relying on a 110-year-old California Supreme Court decision which held that the legislature may not abridge the jurisdiction vested in courts by the Constitution, nor may it “take from parties the right of appeal, by the easy device of a change of procedure,” the Second District found that the amendment to section 2337 “effectively destroys a physician’s right to appeal by relegating him or her to filing a petition for an extraordinary writ in this court.” Absent issuance of the writ, the court need not hear oral argument or issue a written decision—both of which are important rights.

In *Landau*, the First District Court of Appeal relied on another California Supreme Court decision, *Powers v. City of Richmond*, 10 Cal. 4th 85 (1995), which analyzed the constitutionality of a provision in the California Public Records Act (PRA) stating that a superior court decision in an action under the PRA is not appealable but is “immediately reviewable by petition to the appellate court for the issuance of an extraordinary writ.” A plurality of the Supreme Court upheld the PRA provision at issue in *Powers*, finding that writ review is but one of several ways to satisfy a litigant’s right to “appellate jurisdiction” under the California Constitution. The First District engaged in a detailed examination of the extensive legislative history underlying the amendments to section 2337, finding that the amendments were “a response to one aspect of a perceived crisis in physician discipline procedures—that of lengthy delays in the final imposition of discipline....The Legislature could reasonably determine that the public interest was better protected by expediting resolution of physician discipline cases than by requiring oral argument and a written opinion in every instance of appellate review of the superior court’s judgment reviewing the discipline decision of the Medical Board.”

In *American Academy of Pain Management v. Joseph*, No. CV-96-02108-LKK (U.S.D.C., E.D. Cal.), the American Academy of Pain Management (AAPM) has challenged DOL’s 1997 denial of its application for approval as a specialty board under Business and Professions Code section 651. DOL’s denial prevents AAPM members from advertising themselves as “board certified” in California (see above). AAPM argues that section 651 and the Division’s regulations implementing it are unconstitutional, in that they impermissibly infringe on AAPM’s commercial speech rights under the first amendment.

In addition to challenging the statute on its merits, AAPM sought a preliminary injunction against DOL. The U.S. District Court for the Eastern District of California found “serious questions regarding whether plaintiffs’ speech is protected by the First Amendment,” and denied the motion in May 1997; the Ninth Circuit upheld the district court’s ruling in September 1998. On December 28, AAPM filed a petition for *certiorari* with the U.S. Supreme Court, seeking review of the Ninth Circuit’s decision. Meanwhile, the case is expected to go to trial on the merits during the spring of 1999.

In *Joel v. Valley Surgical Center*, 68 Cal. App. 4th (Dec. 4, 1998), the First District Court of Appeal rejected a physician’s tort claims against a health care facility for its reporting of adverse peer review action against him to MBC and the National Practitioner Data Bank (NPDB). ValleyCare suspended Dr. Joel’s hospital privileges for attempting to provide services without proper authorization. As required by law, the hospital reported its action to MBC and NPDB. Dr. Joel sued the hospital, alleging defamation and other tort causes of action. ValleyCare demurred to Dr. Joel’s claim for defamation, claiming its reporting is privileged under Business and Professions Code section 805(f) and Civil Code section 47. The First District sustained the demurrer, finding that “protecting such communications against defamation actions is necessary to accomplish the strong policy goal of maintaining a high quality of professional medical care. Therefore, even if Dr. Joel was able to prove ValleyCare’s report to MBC was improperly motivated, the communication is still entitled to absolute immunity.”

In *Goodstein v. Cedars-Sinai Medical Center*, 66 Cal. App. 4th 1257 (Sept. 29, 1998), the Second District Court of Appeal held that a hospital did not violate a physician’s due process rights by refusing to disclose the source of information that triggered an investigation of substance abuse charges against him. The court stated “a physician’s right to practice in a hospital is not absolute. It must be balanced against other competing interests: the interests of members of the public in receiving quality medical care, and the duty of the hospital to its patients to provide competent staff physicians.” The court noted that “because the actions of a private institution are not necessarily those of the state, the controlling concept in such cases is fair procedure and not due process.” Further, the hospital proceeding is not criminal in nature, and Goodstein was not entitled to criminal protections. The court found that the hospital’s nondisclosure policy comports with the concept of fair procedure, and is supported by valid policy concerns.

In two recent cases, courts affirmed a physician's right to procedural due process when being terminated by managed care providers and physician groups. In *Potvin v. Metropolitan Life Insurance Co.*, 54 Cal. App. 4th 936 (1997), the issue was whether an independent contractor physician is entitled to notice and opportunity to be heard before his membership in a mutual insurer provider network may be terminated notwithstanding an at-will provision in the agreement. In April 1997, the Second District Court of Appeal held that a physician who was a participating member of a managed health care network provided by an insurance company had a common law right to fair procedure before the insurance company could terminate his membership. The court stated that membership in an association (including a hospital staff), once attained, is a valuable interest which cannot be arbitrarily withdrawn. Procedural fairness in the form of adequate notice of the charges brought against the individual and an opportunity to respond is an indispensable prerequisite for one's expulsion from membership, and "overrides a provision in the agreement between the two [parties] allowing termination without cause." The court based its decision on the premise that health plans control a physician's economic well-being by acting as gatekeepers between doctors and their patients. Metropolitan controlled substantial economic interests, as demonstrated by the number of physicians in its networks as well as the adverse effect on Potvin's practice following his "deselection." On July 30, 1997, the California Supreme Court accepted this case for review.

In *Self v. Children's Associated Medical Group*, No. 695870 (San Diego County Superior Court) (Apr. 6, 1998), after almost 10 days in deliberations, a San Diego jury awarded \$1.75 million in damages to Dr. Thomas Self in an employment termination case. Self, a 58-year-old double board-certified pediatric gastroenterologist, claimed that defendant medical group and its president fired him when he refused to compromise his quality of care in favor of profits to the health care group, which was becoming increasingly reliant on managed care contracts. Self claimed he repeatedly resisted pressure from defendants to spend less time on patient visits and curtail tests and other treatment, and alleged that he was terminated in violation of Business and Professions Code section 2056, which prohibits retaliation against a physician for protesting "cost containment" or advocating appropriate medical care for patients. Defendants alleged that Self's termination had nothing to do with managed care, and was in fact based on plaintiff's shortcomings which plaintiff refused to discuss with them. The jury determined that the defendants acted with malice or oppression in firing Self and that defendants violated section 2056. Self's attorneys claim that he is one of the first physicians to successfully invoke the law; such anti-retaliation laws are in place in about two dozen states, but are relatively new and untested.

In *Gamage v. Medical Board of California*, 60 Cal. App. 4th 936 (Jan. 12, 1998), the Second District Court of Appeal held that under Government Code section 11523, an administrative agency whose decision is challenged by mandamus must provide a hearing transcript to petitioner upon payment

of the court reporter's fees at the rate specified in Government Code section 69950. However, if the agency prevails on judicial review of its decision, it is entitled to the remaining balance of all fees actually incurred by the agency for the preparation of the transcript.

## Recent Meetings

DOL is in the process of reexamining the standards it uses to review foreign medical schools. Because graduates of Philippine medical schools represent one of the largest groups of California license applicants from any foreign country, the Division plans to conduct site inspections of medical schools in Manila. The Division will visit the University of Santo Tomas, the University of the East, Far Eastern University, and the University of the Philippines during its January 1999 trip. This proposed inspection has been well-received by the deans at these schools. DOL plans to report on its findings at its February 1999 meeting.

At DMQ's November 6 meeting, CPIL Administrative Director Julie D'Angelo Fellmeth reminded the Division that it has not yet complied with Government Code section 11371(c), which was added by SB 916 (Presley) (Chapter 1267, Statutes of 1993). [13:4 CRLR 54-55] Section 11371(c) requires MBC to fund and publish a "Medical Discipline Report" containing "the decisions of the administrative law judges of the [Medical Quality Hearing Panel within the Office of Administrative Hearings] together with any court decisions reviewing those decisions...." Fellmeth noted that the "Medical Discipline Report" provision was modeled after a similar publication issued by the State Bar. According to Fellmeth, one of DMQ's goals should be to "treat similarly situated persons similarly." In light of the two-panel structure of DMQ, the constantly-changing membership of DMQ and its panels, and their lack of access to the decisions of their predecessors in cases similar to pending cases, this goal is difficult for DMQ to achieve. The "Medical Discipline Report" provision was intended to help DMQ members as judges, the DAGs who represent DMQ, MBC's licensees, and their counsel to know what to expect; at the Bar, the publication of such decisions has resulted in an enhanced number of settlements of disciplinary matters—which cuts enforcement program costs. Fellmeth sympathized with MBC's fiscal predicament, but reminded members that section 11371(c) has been on the books for five years.

## Future Meetings

- February 4-6, 1999 in Santa Ana.
- May 6-8, 1999 in Sacramento.
- July 30-August 1, 1999 in San Francisco.
- November 4-6, 1999 in San Diego.