



passed sections, provided the exam is administered prior to December 31, 1994 and the Board determines that the exam is equivalent in scope and subject matter to the written exam last given in California. Candidates who begin the exam process by taking CLARB's exam after January 1, 1995 must either take the PELA in its entirety in order to be licensed in California, or become fully licensed in another state and apply to qualify for California's licensure under section 2615 by taking the reciprocity section of the PELA only. [14:4 CRLR 60]

LEGISLATION

Future Legislation. At its November 18 meeting, BLA agreed to draft legislation which would authorize it to recover the costs of allowing candidates to review their PELA exams; according to BLA, approximately 25-30 candidates request to review and/or appeal their graded exams on a biannual basis. The Board noted that licensure candidates who take CLARB's national exam pay a fee separate from the exam fee to review their tests.

RECENT MEETINGS

At its November 18 meeting, BLA's Budget Committee reported that due to the current decrease in the number of applicants and lack of license reciprocity afforded by other states to California PELA candidates, the Board must continue to streamline its exam costs. [14:4 CRLR 60-61] BLA decided to offer the PELA exam only once per year and also agreed to recoup from candidates the actual costs of providing the exam handbook.

FUTURE MEETINGS

February 3 in Burbank.
May 12 in Sacramento.
August 5 in Irvine.
November 3 in Sacramento.

MEDICAL BOARD OF CALIFORNIA

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The Medical Board of California (MBC) is an administrative agency within the state Department of Consumer Affairs (DCA). The Board, which consists of twelve physicians and seven public members appointed to four-year terms, 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 13 district offices throughout California.

The purposes of MBC and its divisions are to protect the consumer from incompetent, grossly negligent, unlicensed, 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. Assisted by the Board's Committee on Affiliated Healing Arts Professions (CAHAP), DOL also oversees the regulation of dispensing opticians, lay midwives, research psychoanalysts, and medical assistants.

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 and criminal provisions of the Medical Practice Act. In this regard, DMQ 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 violators, and prosecutes the charges at an evidentiary hearing before an administrative law judge (ALJ). 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 also oversees 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.

On September 27, Governor Wilson announced his appointment of four new members to the Medical Board. William Foster Friedman, MD, the J.H. Nicholson Professor of Pediatrics (Cardiology) at UCLA School of Medicine, was appointed to the Division of Licensing. Also appointed to DOL was Raja Mohan Toke, MD, who practices medicine in Pittsburgh. Carole Hughes Hurvitz, MD, the director of the Pediatric Department of Hematology-Oncology and vice-chair of Pediatrics at Cedars-Sinai Medical Center in Los Angeles, was appointed to the Division of Medical Quality. Also joining DMQ is public member Phillip Pace, the president of Pace Development Company, a management consulting firm in Montebello.

Also on September 27, Governor Wilson reappointed Robert del Junco, MD, to another term on the Board; Dr. del Junco, who has already served a term on DOL and was elected MBC president at the Board's November meeting, was reappointed to DMQ. The Governor also reappointed public member Stewart Hsieh, a practicing attorney from Los Angeles, to another term on DOL.

MAJOR PROJECTS

MBC Recognizes "Near Crisis" in Hospital Peer Review Reporting. In the January 1995 issue of its *Action Report* newsletter, the Medical Board published an article highlighting several flaws in the so-called "peer review" process, a private system utilized by health care facility administrators, executives, and directors through which facilities grant admitting privileges to physicians, review complaints and reports of misconduct against staff physicians, and take disciplinary action against those privileges. Such disciplinary actions include denial, rejection, suspension, termination, and restriction of staff privileges or employment.

The hospital "peer review" process is unusual in that competitors are allowed to sit in judgment against one of their own in complete confidentiality and free from the antitrust laws which restrict anticompetitive conduct in almost every other trade



and profession. Viewed in isolation, the peer review process arguably constitutes an unlawful group boycott (colleagues conspiring to oust a competitor from a marketplace)—a *per se* federal antitrust violation in any other profession. However, Congress has immunized the process and its participants from antitrust liability under a special exemption in the Health Care Quality Improvement Act of 1986, 42 U.S.C. section 11101; under the statute, federal antitrust immunity is conferred so long as the hospital affords specified procedural due process protections to the accused physician in the peer review process, which California has ensured under Business and Professions Code 809.3. Organized medicine has also convinced lawmakers that, in order for the peer review process to function effectively and result in the removal of incompetent physicians from hospital practice, its participants (both institutional and individual) must be free to candidly discuss and take action on the privileges of such physicians without fear of increased civil liability. Thus, Evidence Code section 1157 makes hospital records of a peer review proceeding non-discoverable in a civil action against the accused physician.

The effect of the private peer review process, however, is limited in terms of public protection. Even if the process succeeds in removing a physician's admitting privileges, it serves only to bar a physician from practice at the particular facility which has taken action. Nothing in the peer review process prevents that same physician from obtaining or maintaining staff privileges at other hospitals or health facilities, or from continuing to practice medicine in non-hospital settings. Only the Medical Board's physician discipline system can fully protect the public from an incompetent physician by revoking his/her license to practice medicine entirely. But the Medical Board cannot act when it is deprived of information emanating from the peer review process.

Thus, Business and Professions Code section 805 requires hospital peer review committees to file a report with the Medical Board within 15 days of any of the following events: (1) the denial of an application for staff privileges for a medical disciplinary reason, (2) the termination or revocation of membership or staff privileges for a medical disciplinary reason, (3) the imposition or voluntary acceptance of restrictions on staff privileges for a total of 30 days during any twelve-month period, and (4) a physician's resignation or leave of absence from membership following notice of an impending investigation based on information indicating med-

ical disciplinary cause or reason. The reporting requirement is intended to enable the Medical Board to know of the otherwise confidential peer review action, investigate its basis, and determine whether action against the physician's license is warranted for the protection of the general public. Business and Professions Code section 805.5 requires hospitals, before granting or renewing staff privileges, to check with the Medical Board to determine whether any reports have been filed pursuant to section 805; section 805 makes these reports absolutely confidential and prohibits the Board from disclosing them to anyone except to authorized, inquiring health care facilities, and then only under certain circumstances.

Over the past few years, the legislature has enacted several bills to broaden section 805's reporting requirement and encourage the filing of "section 805 reports," as they are known: AB 2122 (Allen) (Chapter 1070, Statutes of 1989) added the requirement to report leaves of absence following notice of a disciplinary investigation, and SB 2375 (Presley) (Chapter 1597, Statutes of 1993) conferred absolute immunity from civil liability to those required to file section 805 reports, changed intentional failure to file a section 805 report from a misdemeanor to a "wobbler" (chargeable as either a felony or misdemeanor), and increased the maximum fine for intentional failure to report from \$1,200 to \$10,000.

However, in spite of the increased protections for mandated reporters, the enhanced range of reportable events, and increased penalties for failure to report, the number of section 805 reports filed with the Medical Board has dropped by 50% since 1987-88. Although consumer complaints against physicians have increased 10% per year for the past three years, the number of 805 reports filed with the Board has decreased from 249 in 1987-88 (when the Board was inactive in the enforcement area) to 124 in 1993-94.

In its January 1995 *Action Report*, MBC labeled cooperation between hospitals and the Board on section 805 reporting "a near crisis." In the article, DMQ President Karen McElliott and MBC Enforcement Chief John Lancara noted an increasing "deterioration" in the timeliness and accuracy of section 805 reports. They stated that "[a] hospital's failure to report in a timely and accurate fashion seriously jeopardizes present and future patient safety," and called on health care facilities to rise above "business considerations" which have already been addressed by the legislature and enable the Board to carry out its fundamental consumer protection role by complying with the statute.

Several pending court cases support the contentions of McElliott and Lancara. In *Arnett v. Dal Cielo*, currently pending in the First District Court of Appeal (*see* LITIGATION), the Board contends that Alameda Hospital failed to file section 805 reports on at least two reportable events regarding a staff anesthesiologist who was reported to have practiced medicine while under the influence of self-injected Fentanyl (a Schedule II narcotic). In *Arnett v. Pearce*, currently pending in the Sixth District Court of Appeal (*see* LITIGATION), MBC is arguing that Oak Creek Hospital failed to file accurate and timely section 805 reports on three occasions regarding a staff physician who is alleged to have committed sexual misconduct with a hospital employee and a patient.

In a related matter, the Board at its November meeting reaffirmed its 1993 decision to seek legislation authorizing it to disclose certain section 805 reports to inquiring members of the public. As noted above, section 805 currently prohibits the Board from disclosing adverse peer review actions to inquiring consumers. In May 1993, the Board agreed to seek legislation repealing this prohibition, and Senator Robert Presley agreed to include the amendment in his then-pending SB 916 (Presley). However, in June 1993, the Senate Business and Professions Committee struck the amendment at the insistence of the California Medical Association (CMA). [13:4 CRLR 56; 13:2&3 CRLR 78-81] At the Board's November meeting, MBC Executive Director Dixon Arnett revived the proposal in a scaled-back form, and sought Board approval of a bill authorizing MBC to disclose peer review actions in egregious cases and where the respondent physician has contested the charges brought by his/her peers and has been found to have violated the standards of the medical profession. Following spirited testimony by representatives from CMA, the Attorney General's Office, and the Center for Public Interest Law (CPIL), the full Board granted Arnett's request on a 12-4 vote; four physician members—Larry Dorr, Tom Joas, Anabel Anderson Imbert, and Clarence Avery—voted against the motion. At this writing, MBC is seeking a legislative author for the proposal.

Annual Report Indicates Slight Improvement in MBC Enforcement. In October, MBC published its 1993-94 annual report, including a variety of statistics which indicate a slight improvement in certain aspects of the Board's enforcement performance over 1992-93. [14:1 CRLR 50] For example, DMQ took a total of 224 disciplinary actions against licensed phy-



sicians in 1993-94, up from 149 in 1992-93. DMQ filed 407 accusations against physicians in 1993-94, an increase over 310 accusations in 1992-93.

However, other indicators are not so positive. The number of temporary restraining orders (TRO) and interim suspension orders (ISO) sought by DMQ decreased for the second year in a row—from 36 in 1991-92 to 25 in 1992-93 to only 21 in 1993-94. This decrease is disturbing because SB 916 (Presley) (Chapter 1267, Statutes of 1993) amended Government Code section 11529 to lessen the burden on HQES by providing that ISO hearings shall be based on affidavits rather than on oral testimony. [13:4 CRLR 55] Further, the average length of time which complaints spend in various Board stages prior to their disposition still exceeds the 180-day goal established in Business and Professions Code section 2319: According to the annual report, complaints spent an average of 93 days in DMQ's Central Complaint and Investigation Control Unit (CCICU) and an additional 97 days under investigation, for a total of 190 days prior to their dismissal or forwarding to HQES for the filing of an accusation. On top of 190 days at the Medical Board, the report indicates that a fully investigated case then sat at HQES for an average of 264 days prior to the filing of the accusation; this nine-month delay—during which time the completed investigation remains confidential under current law (see LITIGATION)—increased from an average of 253 days in 1992-93.

While DMQ's performance shows some improvement in certain areas, it still pales in comparison to external complaints and reports of physician incompetence and misconduct received by the Board. The number of consumer complaints lodged with the Board has increased by 10% per year for the last two years—from 7,892 in 1991-92, to 8,757 in 1992-93, to 9,686 in 1993-94. Further, in 1993-94, DMQ received more than 1,000 reports of medical malpractice judgments or settlements in excess of \$30,000, 17 reports from coroners indicating that the cause of death was physician gross negligence or incompetence, and 124 "section 805" reports of adverse peer review actions by health care facilities (see above). As noted above, this last number is one-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 10,000 physicians were the subject of consumer complaints and a total of 1,187 licensees were reported to DMQ for incompetence and/or misconduct to DMQ

in 1993-94, compared with only 224 administrative actions. These figures reflect a continuing performance problem in an area where incompetence, negligence, or misconduct can result in irreparable harm.

Board Holds Three-Day Educational Seminar. On October 6-8 in Oxnard, MBC held a retreat to review and educate new members on the Board's various programs and responsibilities, and to discuss significant issues now facing the Board. Among other things, Board members and staff reviewed the organizational structure of MBC's licensing and enforcement programs, the enforcement program's statistical performance since 1992, the licensing process and the types of applications which are considered "problem files" and are referred to DOL's Application Review Committee, the Board's data processing capabilities and goals, and preliminary implementation plans for AB 595 (Speier) (Chapter 1276, Statutes of 1994), which requires DOL to establish standards for outpatient surgical settings. [14:4 CRLR 69]

On October 7, Board President Bruce Hasenkamp delivered a "State of the Board" address in which he congratulated MBC for addressing the serious deficiencies revealed in CPIL's 1989 report entitled *Physician Discipline in California: A Code Blue Emergency* [9:2 CRLR 1], a 1992 "Sixty Minutes" segment which criticized the Board's then-existing public disclosure policy [12:4 CRLR 88-89], and the January 1993 audit of DMQ's enforcement program by the California Highway Patrol [13:2&3 CRLR 78-82; 13:1 CRLR 44-45]. In doing so, Hasenkamp stated that the Board "is today seen by medical licensing and discipline leaders in other states as one of the most, if not the most, progressive and enlightened board in the country."

In his prepared remarks, Hasenkamp also criticized CMA for filing suit to invalidate the Board's new public disclosure policy (see LITIGATION), and for agreeing with CPIL's longstanding proposal to eliminate DMQ's authority to review ALJ proposed decisions in discipline cases. Although CPIL first proposed the reform in its 1989 *Code Blue* report and CMA historically opposed it, CMA recently reversed course [14:4 CRLR 64]; Hasenkamp criticized CMA's new position and argued that neither CMA nor CPIL have "presented evidence or data to show that the newly constituted and rejuvenated Division of Medical Quality, which is just now developing the most exemplary record in its history, is not doing its job for the consumers of California." He urged MBC members to oppose CPIL's proposal, as it would

"destroy the DMQ, rendering it little more than an advisory committee." Hasenkamp concluded his remarks by noting that, although there is always room for improvement, "the state of this Board is good."

On the final morning of the retreat, MBC sponsored a panel discussion of emerging enforcement issues; the invited presenters discussed their individual perspectives on various aspects of DMQ's enforcement process. Specifically:

- DCA legal counsel Anita Scuri noted serious problems with DMQ's current practice of permitting oral argument after the Division has non-adopted a proposed ALJ decision. Scuri expressed deep concern that questions posed by DMQ members during oral argument which tend to elicit improper testimony by defense counsel, and counsel's increasing propensity to provide it, present serious due process problems, and urged DMQ to eliminate oral argument in favor of written argument only.

- Marie Kuffner, MD, Chair of CMA's Committee on the Medical Board, expressed CMA's opinion that "mistrust of the Medical Board among rank and file physicians has never been higher," and criticized MBC's recent decisions to (among other things) dismantle the Medical Quality Review Committee system [14:2&3 CRLR 65; 13:4 CRLR 55], eliminate the use of full-time district medical consultants to review medical evidence gathered by DMQ investigators [14:4 CRLR 61-63], and "gut" the Diversion Program (see below). She also cited two cases which illustrate CMA's opinion that both "punishment" and a desire to enhance numerical statistics are now playing a disproportionate role in DMQ's disciplinary decisionmaking.

- DMQ Enforcement Chief John Lancara expressed satisfaction about the partnership and communication between DMQ investigative staff and HQES prosecutors. However, he voiced his continuing concern about the length of time it takes to discipline a physician, and noted his need for approximately eight new investigator positions to keep pace with DMQ's increasing caseload. Lancara also rebutted Dr. Kuffner's contention that the Board is focused on enhancing its enforcement statistics by noting that DMQ withdrew 50 old accusations last year because they were not appropriate to pursue.

- HQES Chief AI Korobkin focused on the increased number of fully investigated cases referred to his prosecutors by the Medical Board (from 654 cases in 1992-93 to 821 cases in 1993-94), and his unit's efforts to handle that caseload: The total number of administrative filings by HQES against physicians rose from 476 in 1992-



93 to 590 in 1993-94, and the total number of administrative filings by HQES against physicians and allied health professionals increased from 583 in 1992-93 to 673 in 1993-94.

Korobkin expressed HQES' goal of filing accusations within 90 days of receipt, but warned that "several dangers on the horizon jeopardize accomplishment of this goal." Specifically, Korobkin noted that if (1) the Board's caseload continues to increase without a concomitant increase in HQES staffing, (2) DMQ insists on taking more cases to trial rather than settling, (3) more physicians decide to go to hearing rather than settling prior to hearing, and/or (4) more lawsuits are filed against the Board (which diverts HQES attorneys from prosecution to defense work), HQES will not be able to reduce the length of time which fully investigated cases languish prior to the filing of the accusation. Korobkin also noted that a major issue facing his unit is the need to improve the Board's ability to obtain medical records from physicians and hospitals without time-consuming and costly litigation.

• Karl Engeman, Director of the Office of Administrative Hearings (OAH), acknowledged that his ALJs are not producing proposed decisions within 30 days of the conclusion of the evidentiary hearing, as is required by Government Code section 11517. However, he noted "a change in the character" of many of the cases going to trial which is contributing to this problem: Because of more diligent "weeding-out" of marginal cases by DMQ investigators and HQES, "what's left are the tougher cases with complex factual issues. We've responded by trying to be more detailed in our decisions, but that takes longer." He also noted that the heavy trial schedule of the ALJs assigned to the Medical Quality Hearing Panel leaves them little time for decision-writing. Engeman noted that he is in the process of researching possible solutions to these problems, including greater use of *pro tem* judges to hear cases and paralegals to assist in decision-writing, and the development of an electronic system which will identify cases in which a proposed decision is long overdue.

• CPIL Supervising Attorney Julie D'Angelo complimented the Board for recent decisions which have improved various aspects of the discipline system, but stated that "the one thing you have never come to grips with is your steadily increasing caseload and your obligation to fashion and properly resource a system which is capable of dealing quickly, efficiently, and fairly with physicians who are injuring patients."

D'Angelo acknowledged that, through the averaging of case aging data of all complaints received, DMQ may be disguising of complaints within an average of 190 days, as stated in the Board's annual report (*see above*). However, she noted that 75% of those cases are not meritorious and do not present allegations of serious patient harm, and stated that she is far more concerned about the other 25% which accurately allege facts indicating gross incompetence or impairment. D'Angelo displayed statistics indicating that it still takes the Board an average of 1,217 days (or 3.3 years) from receipt of a complaint containing serious patient harm allegations to final DMQ decision (specifically, 170 days in CCICU, 285 days in investigations, 74 days with a medical expert in quality of care cases, at least 100 days at HQES prior to the filing of the accusation, 378 days at HQES after the filing of the accusation, 120 days with the OAH ALJ after submission, and 90 days for DMQ review of the ALJ's proposed decision); further, these figures do not include the time required for judicial review of DMQ's decision where the disciplined physician appeals. D'Angelo argued that these case aging statistics have not changed significantly from the Board's performance in 1989, and urged the Board to increase physician licensing fees to at least \$400 per year to properly resource its enforcement program.

Computer Data Reveals Flaws in Reporting Mechanisms. As required by the Sacramento County Superior Court in *San Jose Mercury News, et al. v. Medical Board of California*, No. 377991 (Sept. 14, 1994) (*see* LITIGATION), MBC prepared and delivered to three major California newspapers a computer tape containing all available "public information" on all licensed physicians in California on December 6. [14:4 CRLR 70-71] Specifically, the Board included on the tape all information which it considers "public" under its May 1993 public disclosure policy, including license status information, felony convictions, medical malpractice judgments in excess of \$30,000, and prior discipline in California or other jurisdictions.

The newspapers immediately began to analyze the data and found serious flaws in the statutory reporting mechanisms intended to provide the Board with information on physician misconduct. For example, the *Sacramento Bee* published a December 9 article revealing that court clerks are failing to report criminal charges and convictions and malpractice judgments against physicians to the Medical Board, as required by law. The *Bee's* analysis

identified at least three notorious malpractice judgments in excess of \$1 million which were not included in the Board's database. The *Los Angeles Times* published a January 8 article which contained the same findings; among other things, the article revealed that the largest medical malpractice judgment in Los Angeles County history (a \$2.3 million judgment in 1994) apparently never reached the Board and was not included in MBC's computer tape. The *Times* also criticized the Board for failing to include judgments prior to 1993, and identified several famous pre-1993 judgments which are not included in the database.

MBC was apparently aware of these flaws in the statutory reporting mechanisms before the publication of these articles. At its November meeting, DMQ approved several 1995 legislative proposals intended to enhance the required reporting of malpractice judgments and criminal charges and convictions by court clerks. The Board believes that one reason court clerks fail to comply with the reporting laws is because they are unaware that the defendant is in fact a physician; the legislative proposals attempt to ensure that court clerks are so informed through a variety of mechanisms (*see* LEGISLATION).

Also at its November meeting, the Board was asked to approve further staff research into more cost-effective ways to deal with future requests for large batches of information. MBC believes that provision of a one-shot computer tape provides only a "snapshot" of physician information which may become inaccurate or obsolete shortly after its release. According to MBC Deputy Director Doug Laue, "As long as the information is being made public, we want it to be up-to-date." Laue presented the Board with a list of seven alternatives which he believes would increase efficiency and lower costs associated with responding to the anticipated influx of requests for information about physicians; these alternatives include regular provision of the Board's information to a commercial data network such as CompuServe or to the Internet, the creation of a telephone voice response system which would provide information in response to a physician's name or license number (and which would be connected to a "900" number so the system would be self-supporting), expansion of the Board's existing online license verification system, Board participation in the state's planned automated "Info-California" kiosks, the provision of public information on physicians on CD-ROM, and development of an automated "fax-back" system



whereby public documents could be automatically faxed to a caller who inputs the license number and document(s) requested. The Board authorized staff to conduct further research into these alternatives, including a detailed cost-benefit analysis of each option.

Implementation of Medical Quality Task Force Report. Following extensive debate at its July 1994 meeting, the Medical Board adopted a proposal of its Task Force on Medical Quality Review which accomplishes two longtime goals of the Board: (1) It establishes minimum qualifications for physicians who review quality of care disciplinary cases and provide expert testimony at disciplinary hearings, and who will serve on volunteer "peer review panels" to assist DMQ in certain activities on the local level; and (2) it overhauls the Board's system of providing in-house medical review of disciplinary investigations by its employee district medical consultants (DMCs) and its employment of a single, full-time Chief Medical Consultant (CMC). The Board's vote was the culmination of nine public hearings of the Task Force since its creation soon after the March 1993 Medical Summit. [14:4 CRLR 61-63; 14:2&3 CRLR 65-66; 14:1 CRLR 52]

At the full Board's November 4 meeting, Task Force Chair Alan Shumacher, MD, reported on the steps that had been taken to implement the Board's decision since July:

• **Board Committee to Oversee Implementation.** Board President Bruce Hasenkamp appointed a Committee on Medical Quality to oversee MBC's implementation of the Task Force report. Chaired by Dr. Shumacher, the Committee also consists of Anabel Anderson Imbert, MD, Cathryne Bennett Warner, Ira Lubell, MD, and Karen McElliott. These Board members will be joined by representatives of HQES, the DMCs, and management of DMQ's Enforcement Unit.

• **Medical Expert/Peer Review Panel Selection.** MBC information systems staff are working to design a statewide computer database containing up-to-date information on all medical experts and peer review panel members to be used by DMQ; both experts and panel members will be chosen from the same pool and must meet the same requirements. This program will enable DMCs to locate appropriate experts and provide monitoring information on each expert used. The team is also looking at cross-referencing the database with an outside database containing American Board of Medical Specialties certifications for all physicians in California, providing quick "look-up" capability

as new experts are added to the system and as changes occur in the status of experts. Staff are also working with the DMCs, medical societies, specialty boards, and hospitals to assemble a list of names of potential expert medical witnesses and peer review panel members.

Also with regard to medical experts and peer review panel members, a group of Enforcement Unit investigators, DMCs, and HQES representatives is developing written performance standards. The standards will cover timeliness/productivity, and quality of work product, medical case analysis, and decisionmaking. A training program for medical experts/panel members is being developed by another team; the program will include a briefing on the Board's overall mission and goals, report writing, caseload management, reporting relationships, conflict resolution, confidentiality requirements, interviewing, and probation monitoring techniques.

• **District Medical Consultants.** Under the new program, the Board's DMCs will no longer be full-time employees; new DMCs will be hired on a "permanent intermittent" (no more than three-quarter time) basis, and—upon the advice of legal counsel from DCA and the Department of Personnel Administration—existing DMCs were given an option to accept the revised position, accept employment elsewhere within state service, or be subject to lay-off. All of the existing DMCs accepted the position on a permanent intermittent basis.

• **Medical Consultants to the Board.** In its July decision, MBC replaced its existing Chief Medical Consultant position with a more flexible position entitled "Medical Consultant to the Board" (of which there may be more than one, so as to provide the Board with a broad range of expertise and abilities); as with the DMCs, the Medical Consultants to the Board will be hired on a permanent intermittent basis. Richard Ikeda, MD, MBC's incumbent Chief Medical Consultant, was given the same options as were given to the DMCs; Dr. Ikeda ultimately accepted the revised position.

At the November 2 meeting of the Committee on Medical Quality, however, Dr. Ikeda expressed extreme displeasure about the Board's July decision. Ikeda protested that the elimination of his position is both inappropriate and illegal; he reiterated his argument that the combination of "permanent intermittent" status for DMCs and the CMC and the new lines of authority established in the Board's July decision (the DMCs report directly to the supervising investigator in their district office, and the new Medical Consultants to the Board will report directly to the

Board's Executive Director) will result in a "loss of independent umpires" in DMQ's enforcement process. Dr. Shumacher responded that Board's decision was carefully made. "If at some point we believe that the new system is not working, we would be amenable to changing it. But it's hard to say it's not working when we haven't done it yet. The change has been made; our job is not to second-guess the decision, but to move forward...and that's what we intend to do."

At the public comment period at the full Board's November 4 meeting, Dr. Ikeda again complained that MBC's July decision presents "a clear and present danger of politicizing the medical disciplinary system." He further accused Executive Director Dixon Arnett of seeking to "centralize all disciplinary authority in himself," and of manipulating the decision out of personal animosity toward Ikeda. Ikeda then announced that "last Tuesday, I took the painful step of going public" with what he believes is the true motivation for the Board's decision. He showed a videotape of a press conference in which he alleged that the decision to eliminate his position reflects racial discrimination; Ikeda is Asian American.

Diversion Program Issues. At the request of DMQ, the staff of MBC's Diversion Program for substance-abusing physicians repeated an educational presentation on the Program at the full Board's November 4 meeting; the seminar was originally presented in conjunction with the Board's July 1994 meeting, but only six of the nineteen Board members attended. Once again, Diversion Program staff and invited guests discussed the legislative history, rules, and requirements of the Program, and a "graduate" of the Program described his experience with substance abuse and recovery. [14:4 CRLR 64-66]

Created in 1980 in Business and Professions Code section 2340, the purpose of MBC's Diversion Program (DP) is to identify and confidentially rehabilitate physicians who are impaired due to substance abuse or mental illness. Self-abuse of drugs or alcohol is a violation of the Medical Practice Act and grounds for license discipline; according to the presenters, the purpose of the DP is to forgive—that is, afford disciplinary immunity for—that violation if the physician commits to rehabilitation and a permanent lifestyle which supports sobriety. Unlike other DCA agencies which contract with a private company to administer their diversion programs, MBC's DP is operated on an in-house basis largely by MBC employees. The bulk of the Diversion Pro-



gram is funded through physician licensing fees at a cost of \$750,000 per year; participants must bear the costs of twice-monthly urine tests and pay \$235 per month for biweekly group meetings.

By statute, the primary goal of the Diversion Program is protection of the public through the monitored rehabilitation of physicians. However, Board member Fredrick Milkie, MD, noted that for fifteen years, the average number of DP participants has hovered at 220-240. This number is far short of the 7,000-10,000 licensed California physicians predicted to have a drug or alcohol abuse problem. [9:2 CRLR 1] DP manager Chet Pelton admitted that the Program's traditional recruitment process, which consists of DP staff speaking to hospital well-being committees and medical societies, is a "hard sell," because physicians perceive MBC's in-house Diversion Program to be too closely connected with DMQ's Enforcement Unit. Public member Ray Mallel suggested that MBC's budget can accommodate a more aggressive public outreach program. Following discussion, staff agreed to develop both an internal and an external outreach program to boost participation in the Diversion Program; that program has already included an informative article about the DP in the January 1995 issue of the Board's *Action Report* newsletter.

On a related issue, DMQ staff and members of the CMA Liaison Committee to the Diversion Program continue to work on legislative language to resolve a problem created by the Fourth District Court of Appeal's decision in *Kees v. Board of Medical Quality Assurance*, 7 Cal. App. 4th 1801 (1992). [14:4 CRLR 65; 14:2&3 CRLR 67] In the process of ruling that DMQ could take disciplinary action against Dr. Phillip Kees because he had never been "formally admitted" into the Diversion Program, the *Kees* court stated that "once a physician enters the...[diversion] program..., the Board halts all action against the physician, whether it is investigatory or disciplinary." Although no law appears to confer both prosecutorial and investigatory immunity on an impaired physician upon formal admission into the Diversion Program, the court's broad language has prompted the Attorney General to advise Enforcement Chief John Lancara to complete a thorough investigation on each DP applicant prior to granting formal admission into the Program. Although impaired physicians are free to participate in the Program on an informal basis while DMQ completes the investigation, Lancara's policy has sparked protests by CMC Dr. Richard Ikeda and members of the CMA Liaison Committee, who complain

that DMQ investigations are unduly delaying the actual signing of the DP contract, which—according to CMA—has therapeutic and disciplinary value in and of itself.

Thus, since May 1994, the Medical Board has been working with CMA to develop legislative language to clarify the decision. DMQ wants to ensure its authority to continue to investigate and discipline any DP participant for violations of the Business and Professions Code which are not based solely on self-administration of drugs or alcohol as described in section 2239. CMA, however, would like disciplinary immunity for the illegal possession, prescription, or nonviolent procurement of drugs for self-administered use, so long as these actions do not involve actual harm to the public or the licensee's patients.

Although draft language was prepared by CMA and scheduled for consideration at DMQ's November 3 meeting, it was strongly opposed by DMQ staff and the Attorney General's Office. The language of the proposal would have required the Enforcement Chief to formally admit any licensee into the Diversion Program if the investigation "includes self-administration of drugs or alcohol under section 2239 or the illegal possession, prescription, or nonviolent procurement of drugs for self-administrative use and does not involve actual harm to the public or the licensee's patients." The language also suggested that once in the Program, a participant would be immune from disciplinary action so long as subsequent violations are based upon continued drug/alcohol abuse. HQES Chief Al Korobkin attacked CMA's language with the following example: "If a physician already in the Diversion Program shoots up in an operating room, but no actual harm comes to a patient, the Board could not take disciplinary action." He also stated the proposed wording would preclude DMQ from taking disciplinary action if a DP participant is convicted of drunk driving.

DMQ member Robert del Junco, MD, reiterated his longtime concern with the Diversion Program—a concern which is not addressed by CMA's language. Although the Program's Diversion Evaluation Committees may require a serious abuser not to practice medicine in the formal DP contract, that agreement is not communicated to DMQ's Enforcement Unit, the physician has no official restrictions on his license, and the Diversion Program's monitoring function (attendance at two group meetings per week) does not necessarily ensure that the physician does not practice medicine. Thus, Enforcement

has no idea that a complained-of physician is in the Diversion Program and has agreed not to practice medicine. Dr. del Junco expressed discomfort at the thought of trusting a physician who is so impaired that he/she is deemed unfit to practice, without informing anyone or officially suspending his/her license. DMQ President Karen McElliott postponed consideration of the legislative language until the negotiating parties can address and reach agreement on these issues.

On December 28, another draft of the proposed legislation was distributed to DMQ for consideration at the February meeting. Under the new draft, DMQ's Enforcement Chief must admit a physician into the DP as long as investigations are "based primarily" on substance abuse. Additionally, the new language clarifies that failure to comply with the DP contract will result in termination from the Program and disciplinary action. The new language does not address the lack of any guarantee that a participant who has contractually agreed not to practice medicine actually discontinues practice. At this writing, DMQ is scheduled to resume discussion of this issue at its February meeting.

Implementation of Lay Midwife Licensure Program. DOL is still working on the implementation of SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires the Medical Board to establish a licensure program for lay midwives. [14:4 CRLR 66-67; 14:2&3 CRLR 68-69; 14:1 CRLR 56]

Under SB 350, there are two ways to obtain licensure as a lay midwife: (1) graduation from an accredited three-year midwifery program and successful completion of a comprehensive licensing examination, or (2) completion of an educational program in another state with equivalent standards, as determined by MBC, and licensure in that state. At its November 3 meeting, DOL declared that the standards for midwifery educational programs in Washington and Florida are equivalent to California's standards, such that midwives who have completed those programs (in Florida, after 1982 only) may become licensed in California by reciprocity.

Under the Killea bill, an applicant may be deemed to have "graduated" from an accredited program in two ways: (1) by actually completing a three-year program, or (2) through a "challenge" process whereby an approved midwifery program permits students to obtain credit by examination for previous midwifery education and clinical experience. Under Business and Professions Code section 2513, the challenge mechanism is tied to an approved



midwifery education program, and its proficiency and practical examinations must be approved by DOL. At its November 3 meeting, DOL approved the Seattle Midwifery School to provide the "challenge" mechanism for California lay midwives. Thus, instead of completing a three-year midwifery program (which currently does not exist in California), California lay midwives may "challenge" the graduation requirement through an examination provided by the Seattle Midwifery School. Other schools may still be considered, but at this time no California school has applied and the only out-of-state school approved to provide the challenge mechanism is the Seattle Midwifery School.

SB 350 requires DOL to adopt a series of regulations to implement the statute. The following is a status update on various DOL rulemaking proceedings related to the lay midwife licensure program:

- At its May 1994 meeting, DOL approved sections 1379.1, 1379.2, 1379.3, and 1379.5, Title 16 of the CCR; these rules set forth general provisions related to the lay midwife licensure program and establish license application (\$300), renewal (\$200), and delinquency (\$50) fees to support the program. [14:4 CRLR 67; 14:2&3 CRLR 69] At this writing, these rules still await approval by the Office of Administrative Law (OAL).

- At its July 1994 meeting, DOL held a public hearing on its proposal to adopt Article 3—Application for Licensure (sections 1379.10 and 1379.15) and Article 4—Standards of Practice (section 1379.20), Title 16 of the CCR. [14:4 CRLR 66-67] Following the July hearing, DOL adopted section 1379.10, which would require licensure applicants to file a prescribed application form with DOL, accompanied by evidence, statements, and documents required by the form and the application fee required by section 1379.50. DOL also approved a slightly modified version of section 1379.20, which implements Business and Professions Code section 2508 by requiring midwives who do not carry liability insurance for the practice of midwifery to disclose that fact to clients not later than the time when the client relationship is established. The disclosure, whether verbal or written, must be noted and dated by the midwife in each client's file. DOL released this modified language for a 15-day comment period ending September 2.

However, the Division modified the language of sections 1379.15, and released the modified language for a 15-day comment period ending on November 2. At its November 3 meeting, DOL approved the modified version, which would require the following minimum number of clinical

experiences to be verified: 20 new antepartum visits, 75 return antepartum visits, 20 labor management experiences, 20 deliveries, 40 postpartum visits within the first five days after birth, 20 newborn assessments, and 40 postpartum/family planning/gynecology visits. Section 1379.15 also requires persons who apply for license as a midwife on or before December 31, 1997 to have obtained all of the verified clinical experiences within ten years immediately preceding the date of the application; persons who apply for license as a midwife on or after January 1, 1998 must have obtained at least 50% of the verified clinical experiences within five years immediately preceding the date of the application.

At this writing, staff is preparing the rulemaking file on these changes for submission to DCA and OAL.

- Also at its November 3 meeting, DOL held a public hearing on proposed sections 1379.11 and 1379.21, Title 16 of the CCR. Section 1379.11, which would set forth the processing times for applications for licensure as a lay midwife, was adopted without change.

Section 1379.21 would establish guidelines for physician supervision of midwives. SB 350 "authorizes the holder under the supervision of a physician to attend cases of normal childbirth..." but expressly states that the physician need not be physically present in order to satisfy the supervision requirement. The precise nature of the supervision requirement must be established through DOL rulemaking. As proposed by DOL on September 16, section 1379.21 would require the supervising physician and midwife to have ongoing communication regarding the care of a pregnant woman or newborn, and to agree upon written practice guidelines which define the individual and shared responsibilities of the midwife and physician, including but not limited to a plan for communication, and emergency transfer and transport of a client who develops complications; appropriate communication between the midwife, the physician, and other health care providers; and periodic review and evaluation of cases and their outcomes.

During the public comment period on section 1379.21, DOL received testimony from District IX of the American College of Obstetricians and Gynecologists (ACOG); based on ACOG's comments, DOL modified section 1379.21 to provide that the supervising physician and the licensed midwife must (1) communicate regarding the care of pregnant women and newborns and in accordance with the guidelines described in (2) below; (2) review written practice guidelines which have been ap-

proved by the supervising physician (and which the midwife must "have at all times"), which (a) define the individual and shared responsibilities of the midwife and the physician, including but not limited to a plan for communication, emergency transfer and transport of a client who develops complications, and informed consent regarding the involvement of the physician, (b) provide for and define appropriate communication between the midwife, the physician, and other health care providers, and (c) require periodic review and evaluation of cases and their outcomes. The modified language also requires the supervising physician to retain in his/her files a copy of any practice guidelines which the physician has approved for a period of at least five years after termination of a supervisory relationship with a midwife.

On December 5, DOL released the modified version of section 1379.21 for a 15-day comment period; at this writing, sections 1379.11 and 1379.21 await OAL approval.

- Finally, DOL approved at its November meeting the draft language of section 1379.22, which would require physicians who supervise licensed lay midwives to have hospital privileges in obstetrics and to be "located in reasonable proximity, in geography or time, to the client whose care the physician will assume should complications arise." At this writing, DOL is scheduled to hold a public hearing on proposed section 1379.22 at its February 3 meeting.

Performance of Optometric Tasks by Medical Assistants. In *Engineers and Scientists of California (ESC), et al. v. Division of Allied Health Professions*, No. 532588 (April 25, 1994), the Sacramento County Superior Court ruled that parts of section 1366, Title 16 of the CCR, are invalid due to procedural irregularities in the rulemaking process. These subsections of MBC's regulations permitted unlicensed medical assistants (MAs) to perform "automated visual field testing, tonometry, or other simple or automated ophthalmic testing" under certain conditions. The regulations were challenged by ESC and the California Optometric Association (COA) on both procedural and substantive grounds, but the court did not reach ESC/COA's argument that the regulations impermissibly allows MAs to perform tasks reserved for licensed optometrists. As a result of the court's decision, DOL published an August 19 notice in the *California Regulatory Notice Register* declaring section 1366(b)(4) to be invalid. [14:4 CRLR 73; 14:2&3 CRLR 73; 13:4 CRLR 63, 79] On November 18, DOL officially repealed the subsection.



However, at the request of ophthalmological groups, DOL reopened discussion of the controversial regulations at a series of informational meetings prior to its November meeting. The meetings revealed at least one issue which will require legislation: The ophthalmologists want to authorize MAs to perform tonometry, but one type of tonometry requires the application of a local anesthetic to the eye so the operator can touch a probe to it, and Business and Professions Code section 2069(c) expressly prohibits MAs from administering local anesthetics. At its November meeting, DOL voted to pursue legislation to amend section 2069(c) to permit MAs to apply local anesthesia (*see* LEGISLATION).

In the meantime, DOL published draft regulatory language on December 16 which would permit MAs to "perform ophthalmic testing not requiring interpretation in order to obtain test results, including (for example) but not limited to, the operation of automated objective ophthalmic testing equipment, color vision and depth perception." As published, the language precludes MAs from performing "subjective refractions or any other procedure requiring the exercise of any judgment or interpretation of the data obtained on the part of the operator." At this writing, DOL is scheduled to hold a public hearing on this proposed regulatory change on February 3 in San Francisco.

Other MBC Rulemaking. The following is a status update on other rulemaking proceedings by MBC's divisions reported in detail in previous issues of the *Reporter*:

• **Public Letter of Reprimand.** On November 3, DMQ adopted the final language of new sections 1364.15-.17, Title 16 of the CCR, to implement its "public letter of reprimand" authority in Business and Professions Code section 2233. The proposed regulations authorize specified DMQ officials to issue, following an investigation, a public letter of reprimand in lieu of filing or prosecuting a formal accusation for minor unprofessional conduct violations. The letter must describe the nature and facts of the violation and be served upon the licensee by certified mail. Prior to formal service of the reprimand, DMQ must notify the physician of its intent to issue the letter; within 30 days, the licensee must indicate to DMQ in writing whether he/she will accept the letter. If the physician accepts, the letter will be served and its issuance shall be disclosed to members of the public who inquire about that physician's record. If the physician refuses to accept, DMQ is free to file and prosecute an accusation or evaluate the pro-

priety of other sanctions, such as a citation and fine. [14:4 CRLR 67; 14:2&3 CRLR 65] At this writing, the proposed regulatory changes await approval by DCA and OAL.

• **Public Disclosure Policy Regulations.** At its November 3 meeting, DMQ held a public hearing on proposed section 1354.5, Title 16 of the CCR, which would codify the Medical Board's new public disclosure policy in regulation. The Board adopted its new policy in May 1993, and it became effective on October 1, 1993. [14:1 CRLR 50; 13:4 CRLR 1, 56-57; 13:2&3 CRLR 79-81]

Under section 1354.5 as originally published, MBC will disclose the following information regarding any physician licensed in California: current status of the license, issuance and expiration date of the license, medical school of graduation, and date of graduation; whether a disciplinary case has been referred to the Attorney General's Office for the filing of an accusation, temporary restraining order, or interim suspension order and, if so, the nature of the allegation and an appropriate disclaimer; any public document filed against the physician, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, and public letters of reprimand; medical malpractice judgments in excess of \$30,000 reported to the Board on or after January 1, 1993, including the amount of the judgment, the court of jurisdiction, the case number, a brief summary of the circumstances as provided by the insurance company, and an appropriate disclaimer; discipline imposed by another state or the federal government reported to the Board on or after January 1, 1993, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer; California felony convictions reported to the Board on or after January 1, 1993, including the nature of the conviction, the date of conviction, the sentence (if known), the court of jurisdiction, and an appropriate disclaimer; and information regarding accusations filed and withdrawn.

In testimony supporting the proposed public disclosure regulations, CPIL Supervising Attorney Julie D'Angelo requested three amendments to enhance consumer protection. She suggested that DMQ (1) backload felony convictions, medical malpractice judgments, and prior discipline dating from January 1991 (instead of 1993); (2) disclose all criminal convictions (not just felonies); and (3) disclose medical malpractice settlements in excess of \$30,000 when a physician has settled more than two cases. On the last

issue, D'Angelo acknowledged that some malpractice settlements may be "business decisions by insurance carriers," as they are commonly characterized by MBC and CMA, and that physicians in some specialties are statistically subject to more lawsuits than others. However, she argued that her proposal leaves room for one or even two settlements of that nature; more than two, however, may reveal a pattern of problematical practice which may be relevant to the physician's competence and should be disclosed to an inquiring consumer. She noted that physicians are entitled to full legal representation in all lawsuits which end in settlement, that settlements require the use of the public judicial system whose results ought not to be concealed from the taxpayers who finance it, and that the fact of a court settlement is a matter of public record. Although it agreed to backload felony convictions and prior discipline from January 1991, DMQ took no action on D'Angelo's other proposals.

Following testimony, DMQ discussed and modified the language of the proposed regulation. The Division was confused by subsection (g) of the regulation, which required disclosure of "information regarding accusations made and withdrawn." Several Division members wanted to conceal this information, but DCA legal counsel Anita Scuri noted that once an accusation is filed, it is forever a public document even though it may subsequently be withdrawn. DMQ deleted subsection (g), but amended subsection (c) to require that inquiring consumers be provided with information on the disposition of all accusations filed, and to specify that accusations which have been filed and withdrawn must only be disclosed for a period of one year.

At this writing, DMQ has yet to release the modified language for a 15-day public comment period, and is scheduled to revisit section 1354.5 at its February meeting.

• **Contact Lens Notices.** At its July 1994 meeting, DOL unanimously approved the addition of section 1399.233, Title 16 of the CCR, which would require registered contact lens dispensers to ensure that a written statement is enclosed with each contact lens container which directs the person named in the contact lens prescription to return to the prescribing physician or optometrist for an evaluation. [14:2&3 CRLR 74; 14:1 CRLR 55-56] At this writing, the rulemaking package on this proposed regulatory change is still pending at OAL.

• **Medical Assistant Training.** On October 26, OAL approved the Board's amendment to section 1366.3, Title 16 of the CCR, which now includes the American Associ-



ation of Medical Technologists as a certifying body for qualified MAs who provide training to other MAs under the direction of a licensed physician. [14:4 CRLR 67; 14:2&3 CRLR 69-70]

• **Permit Reform Act Regulations.** At its November 3 meeting, DOL adopted new section 1319.4, Title 16 of the CCR, to implement the Permit Reform Act of 1981. The new regulation sets forth the following information regarding the processing of applications for physician and surgeon licensure: the maximum time for notifying an applicant that an application is complete or deficient; the maximum time after receipt of a completed application in which DOL must issue or deny a license; and the minimum, median, and maximum actual processing times for issuance of a license during the past two years. [14:4 CRLR 67] OAL has approved this regulation, which becomes effective on February 17.

• **Temporary Fee Decrease.** Also on November 3, DOL amended section 1352, Title 16 of the CCR, which fixes MBC's biennial license renewal fee; currently, that fee is \$600. However, SB 916 (Presley) required the Board to temporarily reduce its renewal fee if the California Medical Association succeeded in its lawsuit challenging the state's 1992-93 transfer of physician licensing fees to the general fund; CMA won its case in February 1994, and the state agreed to return \$2.6 million to the Medical Board (less \$75,000 for CMA's attorneys' fees). [14:2&3 CRLR 72-73] Accordingly, the amendment to section 1352 temporarily decreases the biennial renewal fee to \$575 for licenses expiring between January 1, 1995 through December 31, 1996. OAL approved this regulatory change on December 29.

LEGISLATION

Future Legislation. At their November 3 meetings, both divisions approved a range of legislative proposals for the 1995-96 session. Among others, DMQ agreed to pursue the following changes to the Business and Professions Code:

• Currently, section 801 requires malpractice insurers to file a report with DMQ when they settle a claim in excess of \$30,000; however, nothing requires the insurers to send or retain supporting documents, such as medical records or depositions obtained in the case. According to DMQ, insurers frequently destroy these records immediately after judgment or settlement, or otherwise stonewall DMQ's attempts to secure the records and investigate the underlying incident which led to the judgment or settlement. Proposed new section 804(d) would require malpractice

insurers who report settlements under section 801 to retain relevant medical records and depositions underlying the judgment or settlement for at least one year from the date of the report, and to produce them upon request by the Division. If the records have been sealed by court order (as frequently occurs in medical malpractice cases), the new provision would authorize DMQ to petition the court for a modification of the order to permit DMQ access to the records.

• DMQ will also seek amendments to improve the reporting of criminal charges and convictions against physicians by court clerks; the Division has recently become aware that court clerks frequently fail to report these events to DMQ because they are unaware that a criminal defendant is a physician (*see* MAJOR PROJECTS). Specifically, the Division hopes to add new subsection 802(d) to require physicians to self-report to the Board whenever they are charged with a felony, convicted of a felony, and/or convicted of a misdemeanor committed in the course of the practice of medicine or in any manner such that a patient was the victim; add new subsection 802(e) to require any physician who is charged with a crime to notify both the prosecuting attorney and the court clerk that he/she is in fact a physician; and amend section 803.5(a) to require prosecuting attorneys to notify the court clerk of felony charges against a physician immediately upon obtaining information that the defendant is a licensee of the Board.

• DMQ will seek an amendment to section 805 to permit it to disclose certain adverse peer review actions to inquiring consumers (*see* MAJOR PROJECTS).

• Section 2317 would be amended to require the Board to provide legal representation to key lay witnesses, such as cooperating ex-office employees of an accused physician or patients complaining of sexual misconduct, who become defendants in retaliatory lawsuits filed by the accused physician and intended to intimidate the witness.

• Section 2225(a) currently specifies that a physician who refuses to produce a patient's medical records requested by DMQ, when such a request is accompanied by that patient's written authorization for release of the records to the Division, is subject to a \$1,000-per-day fine. DMQ proposes to expand section 2225(a) to also apply to health care facilities which refuse to produce such requested records.

• Section 125.9, which authorizes the Board to adopt regulations creating a citation and fine program for specified violations of the Medical Practice Act, limits the Board to a fine of \$2,500 for "each

investigation." Enforcement Chief John Lancara explained that many minor insurance fraud investigations involve several visits by a patient which add up to several thousand dollars; by limiting the permissible fine to \$2,500 per investigation, the fine ends up being far less than the ill-gotten gains. Thus, DMQ will seek an amendment to section 125.9(b)(3) to increase the maximum fine to \$2,500 for each violation or count, if the violation or count involves fraudulent billing submitted to an insurance company, Medi-Cal, or Medicare.

• Finally, DMQ approved a proposed amendment to section 801 which would include counties among those who are required to report medical malpractice settlements in excess of \$30,000 to the Medical Board.

DMQ also discussed but deferred for later action the following legislative proposals: (1) a controversial request by Executive Director Arnett for single- or double-signature interim suspension authority; (2) a proposed amendment to section 805.5 which would permit the Board to contract with a private entity to operate databases to service health care facilities and other authorized recipients of section 805 reports and other confidential information; (3) the addition of language which would more clearly specify DMQ's purpose and functions in statute; (4) Diversion Program language to address the Fourth District Court of Appeal's *dicta* in the *Kees* decision (*see* MAJOR PROJECTS); (5) a proposal which would establish a statute of limitations on MBC disciplinary actions; and (6) a proposal to ban the use of EDTA chelation therapy except in treating heavy metal poisoning (its only FDA-approved use) or as part of formal scientific testing on other possible uses.

At its November meeting, DOL agreed to pursue the following changes to the Business and Professions Code:

• Once again, DOL voted to seek an author to carry a bill increasing the Board's postgraduate training (PGT) requirement for full physician licensure of graduates of unapproved medical schools from one year to two years. DOL has been trying to make this change for at least five years. [12:1 CRLR 72; 10:2&3 CRLR 99; 10:1 CRLR 75]

Specifically, DOL will seek an amendment to section 2096 to require each applicant who completes his/her approved PGT after July 1, 1993 to demonstrate to DOL that he/she has satisfactorily completed at least two years of PGT in an approved PGT program, unless the applicant has completed at least two academic years (or 72 weeks of clinical instruction)



in a DOL-approved medical school. If the applicant satisfies the latter requirement, then only one year of approved PGT is required for full physician licensure.

In addition, DOL will seek the addition of section 2097, which will provide for the issuance of a provisional license to applicants who have completed at least one year of approved PGT; that provisional license, which will remain in effect until the full license is issued, will permit the holder to practice medicine to the extent required in the PGT program; it will not otherwise authorize the holder to engage in the practice of medicine.

- DOL will also seek an amendment to section 2435 to authorize it to charge a fee for the initial oral examination.

- Sections 2111 and 2113 will be amended to clarify and stiffen the licensure training exemptions for foreign physicians and medical graduates found therein.

- DOL also approved recommendations of the Committee on Affiliated Healing Arts Professions to (1) pursue legislation to amend section 2069(c) to allow medical assistants to apply local anesthesia (see MAJOR PROJECTS); (2) register and regulate "out-of-state replacement contact lens sellers" (see RECENT MEETINGS); and (3) amend numerous provisions of the enabling acts of the Medical Board's affiliated healing arts licensing programs to reflect the fact that there is no longer a Division of Allied Health Professions within MBC.

■ LITIGATION

At its October 6-8 retreat in Oxnard, MBC decided not to appeal Sacramento County Superior Court Judge Roger K. Warren's decision in *San Jose Mercury News, Inc., et al. v. Medical Board of California*, No. 377991 (Sept. 14, 1994). In that case, Judge Warren ordered the Board to reprogram its computer database to enable it to comply with Public Records Act requests for public information filed by three major California newspapers. [14:4 CRLR 70-71] In compliance with the court order, the Board reprogrammed its computer system and delivered the required computer tape by December 6 (see MAJOR PROJECTS).

The Board's legal struggle for access to hospital peer review records has expanded to two cases now pending in two different appellate courts. *Dixon Arnett v. William Dal Cielo*, No. A066269 (First District Court of Appeal), and *Dixon Arnett v. Kenneth W. Pearce*, No. H013143 (Sixth District Court of Appeal), both test whether Evidence Code section 1157, which protects hospital peer review records from "discovery," is applicable to administrative sub-

poenas of the Medical Board. In both cases, the Board contends that the hospitals (Alameda Hospital in *Dal Cielo*, and Oak Creek Hospital in *Pearce*) failed to notify MBC of reportable hospital peer review events under Business and Professions Code section 805 (see MAJOR PROJECTS), and that they are now impeding MBC's investigations of the accused physicians by failing to comply with administrative subpoenas for their peer review records. The hospitals assert that their records are privileged under Evidence Code section 1157, which protects peer review records from "discovery." The Medical Board, supported by the Center for Public Interest Law as *amicus curiae* in both cases, argues that the term "discovery" in section 1157 applies to civil malpractice litigation and not investigative subpoenas issued by the state agency responsible for protecting consumers from incompetent or impaired physicians. Both cases have been fully briefed and, at this writing, await oral argument.

MBC continues to litigate the validity of its new public disclosure policy in *California Medical Association v. Dixon Arnett, et al.*, No. 376275 (Sacramento County Superior Court). Under the new policy effective October 1, 1993, the Board began to disclose several new categories of information about physician conduct to inquiring consumers, including felony convictions, medical malpractice judgments in excess of \$30,000, prior discipline in California and in other states, and its own completed investigations once it has decided to pursue disciplinary action and referred the case to the Attorney General's Office. In November 1993, CMA filed suit to block implementation of the policy in its entirety, arguing primarily that the policy invades constitutionally protected privacy rights of physicians. On December 2, 1993, the court issued an order which leaves intact the bulk of the Board's new policy, temporarily enjoining only the disclosure of completed investigations at point of referral to the Attorney General's Office; under the court order, these cases may not be disclosed until the accusation is filed. [14:1 CRLR 50, 53-55; 13:4 CRLR 1, 56-57; 13:2&3 CRLR 79-81]

During 1994, the litigation was inactive as the parties were engaged in settlement negotiations. However, talks broke down toward the end of the year. At this writing, the parties are scheduled to file cross-motions for summary judgment on January 20. Responses are due on March 1, and replies must be filed by March 20. Judge Ronald Tochterman will preside over oral argument on March 31 in Sacramento County Superior Court.

Following DMQ's controversial August 1994 adoption of Administrative Law Judge Milford A. Maron's proposed decision regarding Dr. Leo Kenneally, the Attorney General's Office filed a motion for reconsideration. Whereas ALJ Maron recommended, and DMQ approved, a one-year suspension of Kenneally's license and ten years' probation, HQES filed a motion requesting revocation of the license. [14:4 CRLR 71-72] On September 7, DMQ granted HQES' motion for reconsideration; at this writing, all briefs on the issue are due on April 18 and DMQ will hold oral argument on May 11 in Sacramento.

■ RECENT MEETINGS

At their November 2-3 meetings, CAHAP and DOL once again addressed the issue of MBC's authority over out-of-state contact lens firms. The Board's former Division of Allied Health Professions (DAHP) first sought to regulate out-of-state contact lens dispensers through its existing Registered Dispensing Opticians (RDO) program in February 1994. However, DCA legal counsel advised DAHP that the RDO statutes do not authorize it to require out-of-state contact lens firms to adhere to any standards; thus, DAHP members instructed staff to seek both legislative and regulatory changes. [14:2&3 CRLR 74]

At CAHAP's November 2 meeting, DCA legal counsel Anita Scuri presented a draft legislative proposal which would add new Chapter 5.5 (section 2569 *et seq.*), the "Non-resident Replacement Contact Lens Seller Registration Act," to Division 2 of the Business and Professions Code. In its present form, the draft language would require out-of-state contact lens dispensers who sell replacement lenses to Californians to register with DOL. Registration and renewal registration would require a fee of \$100 and designation of an agent for service of process in California; in addition, applicants must demonstrate that they are either registered, in good standing, or otherwise authorized in the state in which the dispensing facility is located and from which the replacement contact lenses are dispensed. Registrants must maintain records of replacement contact lenses shipped, mailed, or delivered to patients in California for a period of at least three years, and provide a toll-free telephone service for responding to patient questions and complaints during regular hours of operation, but in no event less than six days per week and forty hours per week. The proposal also provides for the denial, suspension, and revocation of registration, and authorizes DOL to assess a fee on out-of-state lens dispensers for the recovery of investigative costs associated with a complaint filed against such a company.



Scuri noted that the proposed language would provide DOL with express jurisdiction over out-of-state dispensers, and would head off potential constitutional issues regarding the jurisdiction of the state of California over out-of-state entities selling products in the state. California Optometric Association representative Mark Andrews objected to the proposed language on grounds that several provisions are unclear and because COA believes the proposal does not go far enough; COA believes all contact lens dispensers should be required to have a California office. A representative of Lens Express, the largest mail-order contact lens firm in the United States, opposed COA's suggestion and argued that any undue burdens in the registration process may offend the Commerce Clause of the U.S. Constitution. Lens Express voiced support for the proposal as drafted, with the exception of the provision which permits DOL to assess out-of-state firms a fee to cover investigative costs.

Following discussion, CAHAP voted to recommend that DOL approve the legislative language as drafted; at its November 3 meeting, DOL ratified the recommendation and directed staff to find a legislative author for the proposal.

On November 4, the full Board elected its officers for 1995. Robert del Junco, MD, was elected Board president, replacing public member Bruce Hasenkamp. Alan Shumacher, MD, was chosen Board vice-president, and public member Stewart Hsieh was selected Board secretary. DOL elected public member Ray Mallel as Division president, Thomas Joas, MD, as vice-president, and Bruce Hasenkamp as secretary. DMQ elected Anabel Anderson Imbert, MD, as Division vice-president and, at this writing, plans to elect its other 1995 officers at its February meeting.

■ FUTURE MEETINGS

February 3-4 in San Francisco.
May 11-12 in Sacramento.
July 28-29 in Los Angeles.
November 2-3 in San Diego.

ACUPUNCTURE COMMITTEE

Interim Executive Officer:
Mary Howard
(916) 263-2680

The Acupuncture Committee (AC) was created by the legislature in 1982. Pursuant to the Acupuncture Licensure Act,

Business and Professions Code section 4925 *et seq.*, the Committee issues licenses to qualified practitioners, establishes standards for the approval of schools and colleges which offer education and training in the practice of acupuncture, establishes standards for the approval of tutorial programs (an alternative training method), receives and investigates complaints against licensees, and takes appropriate enforcement action against the licenses of practitioners who have committed disciplinary violations. The Committee is authorized to adopt regulations, which appear in Division 13.7, Title 16 of the California Code of Regulations (CCR), and submit them for approval to the Medical Board of California (MBC).

AC consists of five acupuncturists, two physicians who have experience in acupuncture, and four public members, all of whom serve three-year terms. The Governor appoints the five acupuncturists, the two physicians, and two of the public members. All of the Governor's appointments are subject to Senate confirmation; and the five acupuncturists must represent a cross-section of the cultural backgrounds of licensed members of the acupuncturist profession. The Assembly Speaker and the Senate Rules Committee each appoint one public member.

In late September, Governor Wilson appointed Jung Min Kim, L.Ac., of Gardena to AC. Kim owns the Gardena Health Center, which provides acupuncture, herbal, and chiropractic treatment.

On January 6, AC Executive Officer Sherry Mehl was chosen to become the new Executive Officer of the Board of Behavioral Science Examiners. AC subsequently named Administrative Coordinator Mary Howard as Interim Executive Officer pending its selection of a new EO.

■ MAJOR PROJECTS

AC to Adopt Citation and Fine Regulations. On December 9, AC published notice of its intent to adopt new sections 1399.463-468, Division 13.7, Title 16 of the CCR, to implement its citation and fine authority under Business and Professions Code sections 125.9 and 148.

AC will use the citation and fine system to address relatively minor violations by licensees of the Acupuncture Licensure Act or AC's regulations, and the unauthorized practice of acupuncture by unlicensed individuals. Currently, AC uses informal actions such as letters of warning, telephone calls, and office conferences to address minor or technical violations which may not warrant a full-blown, expensive disciplinary proceeding to revoke or suspend a license; however, such infor-

mal actions do not constitute discipline and are not disclosed to inquiring consumers. AC proposes to implement its citation and fine authority to provide it with a more effective enforcement tool to deter violations.

New section 1399.463 would authorize AC's Executive Officer to issue a citation for violations of the Act or AC's regulations; the citation may contain an order of abatement and/or an administrative fine. Each citation (which must be served on the individual personally or by certified mail) must be in writing and must describe the nature and facts of the violation, including a reference to the statute or regulation alleged to have been violated. New section 1399.464 would specify certain circumstances in which a citation is inappropriate. New section 1399.465 would establish the range of fines (from \$100 to \$2,500) which may be imposed by the EO, and set forth seven factors which the EO must consider on a case-by-case basis in determining the amount of the fine. New section 1399.466 would allow extensions of time for compliance with orders of abatement upon a showing of good cause, and describe the consequences for failure to comply with an order of abatement. New section 1399.467 would authorize AC's EO to issue citations to unlicensed individuals who are providing services for which a license is required under the Act. Finally, new section 1399.468 would permit the cited individual to contest the issuance of a citation by requesting an informal conference with the EO; if the EO affirms the issuance of the citation after the informal conference, the cited individual may request a hearing before an administrative law judge under the Administrative Procedure Act.

At this writing, AC is scheduled to hold a public hearing on its proposed citation and fine regulations at its January 24 meeting in Los Angeles.

Other AC Rulemaking. Following is a status update on several AC rulemaking packages discussed in detail in previous issues of the *Reporter*.

• **Continuing Education Regulations.** At this writing, AC's extensive overhaul of its continuing education (CE) regulations still awaits approval by the Director of the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL). The rulemaking package, which was adopted by AC at its June 1994 meeting, would repeal several of the Committee's existing CE regulations (sections 1399.480, 1399.481, 1399.483, and 1399.484) and replace them with new regulations which would clarify AC's CE requirements. [14:4 CRLR 74-75; 14:2&3 CRLR 74-75]



• **Fee Regulation.** On November 30, OAL approved AC's revisions to section 1399.460; among other things, the revisions reduce AC's annual license renewal fee from \$325 to \$200. [14:4 CRLR 75; 14:2&3 CRLR 75] These changes became effective on January 1.

• **Schools' Reports to AC.** On November 3, OAL finally approved AC's amendments to section 1399.439, which requires each approved acupuncture school to annually submit to AC a course catalog for that year, along with specified supplemental information. [14:4 CRLR 75]

• **Consumer Brochure on Acupuncture.** At its October 19 meeting, AC reviewed the latest draft of a brochure which is intended to educate consumers on acupuncture, the tasks and functions which may be performed by acupuncturists, AC's licensure requirement and the qualifications needed for licensure, and the role of AC. In the making for several years, the brochure is the culmination of a lengthy process of drafting and review by AC, acupuncture schools, and trade associations including the California Medical Association (CMA). [14:4 CRLR 76; 13:4 CRLR 64; 13:1 CRLR 50]

Once again, some of the language included in the brochure drew objections by CMA. Among other things, the draft reviewed by AC in October included a definition of the terms "oriental medicine" ("a complete system of healing, incorporating the use of acupuncture, natural herbs, oriental massage, nutrition, and exercise") and "acupuncture," stated that acupuncturists "typically treat illnesses or injuries using fine needles inserted into very specific points on the body," and stated that acupuncturists may "order x-rays, blood or urine tests, and other lab work" and "prescribe a herbal prescription as either raw herbs, herbal pills, or tinctures." CMA protested that inclusion of a discussion of "oriental medicine" is "misleading and inappropriate," as the term "oriental medicine" is not included or defined anywhere in the Acupuncture Licensure Act and acupuncturists may not lawfully practice "oriental medicine" in California; they may only practice "acupuncture" as narrowly defined by the legislature in Business and Professions Code section 4937. [14:1 CRLR 57] CMA also expressed concern that the brochure's language implies that acupuncturists are authorized to treat any illness or injury, whereas Business and Professions Code section 4927 limits the use of acupuncture to "prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunc-

tions...." CMA also complained about AC's use of the terms "prescribe" and "prescription" in the brochure, because substances which acupuncturists are authorized to "prescribe" (drugless substances and herbs) do not require a "prescription" as that term is normally understood by consumers, and may be "prescribed" by acupuncturists only "as dietary supplements to promote health" and not for treatment purposes. Finally, CMA argued that two Attorney General's Opinions narrowly construe the Acupuncture Licensure Act and opine that the ordering of "x-rays, blood or urine tests, and other lab work" is not within the definition of acupuncture.

While considering CMA's objections, several AC members did not want to misrepresent the practice of acupuncture by unduly limiting the scope of practice definition. Certain members emphasized that acupuncture is an independent system, perhaps complementary to western medicine but not dependent upon western medicine. [13:2&3 CRLR 87; 13:1 CRLR 50]

After a lengthy discussion, AC made several changes to the brochure. Specifically, AC deleted the word "complete" from its definition of "oriental medicine," expanded the brochure's description of the functions of an acupuncturist to state that "acupuncturists typically treat illnesses or injuries or pain using fine needles...." and amended the "prescription" language to state that acupuncturists may "prescribe a herbal formula such as raw herbs, herbal pills, or tinctures." AC decided not to delete the language regarding the ordering of x-rays, blood or urine tests, and other lab work. AC approved the brochure as amended; at this writing, the brochure is pending review and approval by the DCA Director.

• **1995-96 Budget Change Proposals.** At its October meeting, AC reviewed two budget change proposals (BCPs) for 1995-96 it had tentatively approved at its August meeting. The first BCP would double the Committee's examination budget to \$322,000, in order to allow it to administer its licensing examination twice per year instead of once per year; the second BCP would add \$141,000 to AC's budget to enable it to hire a contract consultant to perform an occupational analysis of the practice of acupuncture. [14:4 CRLR 74] In October, AC resolved to pursue the occupational analysis proposal, but voted to postpone the BCP to administer its exam two times per year. AC has scheduled a special exam administration in January 1995, and plans to pursue a BCP to permanently allow two exams per year during 1996-97.

LEGISLATION

• **Future Legislation.** At its October meeting, AC approved the language of several legislative proposals which it hopes to pursue during the 1995-96 session, including the following:

• AC will seek an amendment to Business and Professions Code section 4933 to delete the existing requirement that the Medical Board approve all AC regulatory changes. [14:4 CRLR 76] AC believes MBC approval is an unnecessary step, especially as all AC regulatory changes must be approved by DCA and OAL. According to AC, the extra step delays the rulemaking process and requires unnecessary expenditures because AC staff must travel to attend MBC meetings when AC regulatory proposals are on the MBC agenda. Although this proposal appears to be a step-back from AC's longtime goal of separating from MBC entirely, it may still generate opposition from CMA, which has historically opposed any separation of MBC from any of its allied health licensing programs.

• AC proposes the repeal of sections 4940.1, 4940.2, and 4940.3; these sections require AC to contract with a consultant to evaluate acupuncture tutorial programs. These studies have been completed, and AC seeks to repeal the obsolete provisions.

• AC seeks to amend section 4945. Currently, the section requires acupuncturists to renew their licenses and complete 15 hours of CE each year; on January 1, 1996, however, new language will take effect requiring 30 hours of CE every two years. In conjunction with proposed amendments to sections 4565 and 4970 to keep the annual license renewal period (see below), AC seeks to retain the annual CE requirement as well. Additionally, existing section 4945 permits acupuncturists to make up deficient hours of CE in the subsequent renewal period; AC proposes to delete this language, as it has no way of monitoring these make-up CE hours.

• AC also proposes substantial amendments to section 4955, which sets forth grounds for the denial, suspension, or revocation of an acupuncturist's license. AC believes that the existing language is vague and does not cover some of the actions which can lead to a charge of unprofessional conduct by a licensee; failure to specify these grounds in statute could prevent AC from taking disciplinary action in serious cases reported to the Committee.

• AC seeks to amend section 4965, which currently calls for AC licensees to revert to biennial license renewal in 1996;



AC would like to remain on an annual renewal schedule in order to better track the licensee population.

• AC also proposes to amend section 4970 to retain the annual license renewal requirement (*see above*), and to authorize it to charge a maximum of \$3,000 for the school application fee. The Committee has determined that its existing school review and approval process does not cost \$3,000, and would like legislative authority to lower that fee through the rulemaking process.

• Finally, the Committee will seek an amendment to section 4939, which currently requires AC to establish standards for its approval of schools and colleges offering education and training in the practice of acupuncture; under recent legislative changes, institutional accreditation of such a school is granted by the Council on Private Postsecondary Vocational Education (CPPVE), first on a "conditional" basis and then on a full basis. AC's proposed changes to section 4939 would require an institution to be fully accredited by CPPVE before applying to AC for Committee approval.

RECENT MEETINGS

At its October 19 meeting, AC adopted a new policy regarding requests for approval of CE courses; specifically, such requests must be received by the Committee at least 30 days before the first course is offered, as specified in section 1399.481, Title 16 of the CCR. Under AC's new policy, the 30-day period begins on the day of the postmark and stops on the first day of the course. Requests not received within that time period will be returned to the provider and under no circumstances will reconsideration be given.

FUTURE MEETINGS

January 24 in Los Angeles.
April 12 in Sacramento.
July 25 in San Francisco.
October 25 in Sacramento.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer:
M. Elizabeth Ware
(916) 263-2288

Pursuant to Business and Professions Code section 3300 *et seq.*, the Hearing Aid Dispensers Examining Committee (HADEC) prepares, approves, conducts,

and grades examinations of applicants for a hearing aid dispenser's license. The Committee also reviews qualifications of exam applicants and issues hearing aid dispenser licenses to qualified individuals. HADEC is authorized to take disciplinary action against its licensees for statutory and regulatory violations, and may issue citations and fines to licensees who have engaged in misconduct. HADEC functions under the jurisdiction of the Medical Board of California (MBC); it submits proposed regulatory changes to MBC for approval. HADEC's regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

The Committee consists of seven members, including four public members. One public member must be a licensed physician and surgeon specializing in treatment of disorders of the ear and certified by the American Board of Otolaryngology. Another public member must be a licensed audiologist. Three members must be licensed hearing aid dispensers.

At its November 18 meeting, HADEC welcomed new public member Gloria Schaefer de Cordova. She is president of Pacific Managed Health Care, a consulting company for physicians and hospital groups that want to develop preferred provider organizations.

MAJOR PROJECTS

Enhanced Educational Requirements for Dispenser Licensure. At its November 18 meeting, HADEC continued to discuss the proposal of its Examination and Educational Requirements Subcommittee which—if enacted by the legislature—would phase in considerably enhanced education and training requirements for licensure as a hearing aid dispenser. [14:4 CRLR 76; 14:2&3 CRLR 78; 14:1 CRLR 59]

Currently, there is no minimum educational requirement for licensure as a hearing aid dispenser. Under the first phase of the proposal, a high school diploma or its equivalent would be required as a prerequisite to licensure. Effective January 1, 1998, the proposal would require 60 units of experience and training beyond high school. This component of the proposal involves elimination of HADEC's existing trainee licensure program and replacement of the temporary trainee permit with a field placement permit; by January 1, 2000, licensure candidates will be placed in a hearing aid dispenser's office for practical training as part of the 60-unit requirement (or may demonstrate equivalent experience as a licensed practicing dispenser in another state or country). Additionally, specific course completion requirements

will be added by January 1, 2002; and requirements for the full 60-unit program will be specified by January 1, 2004.

Subcommittee members noted that, at the Subcommittee's October 18 meeting, Department of Consumer Affairs (DCA) legal counsel Anita Scuri advised that legislation is required to establish any degree as a prerequisite to licensure; however, requirements for a specified course of instruction could be accomplished through the rulemaking process based upon HADEC's existing statutory authority in Business and Professions Code section 3327.

At this writing, the Subcommittee intends to meet in February to continue fleshing out the proposal by specifying the coursework which must be taken as part of the post-high school 60-unit requirement. HADEC hopes to fully develop the proposal and introduce it during the 1995–96 legislative session.

HADEC to Enhance CE Requirements. At its November 18 meeting, HADEC voted to commence the rulemaking process to amend section 1399.140, Division 13.3, Title 16 of the CCR, to increase its continuing education (CE) requirement from six to nine hours per calendar year. Because the subject of many complaints received by HADEC is poor business practice rather than quality of care problems, the Committee agreed that the additional three hours should focus on proper business practices, including advertising, marketing, finance, and ethics. At this writing, HADEC is drafting the proposed regulatory changes.

In conjunction with its review of section 1399.140, HADEC also reviewed its "Continuing Education Course Provider Guidelines"; the guidelines interpret section 1399.141, Title 16 of the CCR, which sets forth the information which must be submitted to HADEC by those wishing to be approved as CE providers. Among other things, the guidelines clarify course content description requirements, and state that "course content shall consist of current practices related to the fitting of hearing aids for aiding or compensating for impaired human hearing." The guidelines also identify specific subject areas which are unacceptable as HADEC CE courses, and interpret the provisions of section 1399.141 relating to method of instruction, educational objectives, instructor qualifications, evaluation method, records maintenance, reporting to HADEC of changes in course content and/or instructor, and video course requirements. HADEC will also amend the guidelines to conform to its proposed regulatory changes.



Occupational Analysis to Affect Practical Exam. Several years ago, HADEC completed an "occupational analysis"—an empirical survey of the tasks and functions performed by hearing aid dispensers and the knowledge, skills, and abilities (KSAs) needed to perform those tasks and functions competently [11:4 CRLR 94; 11:3 CRLR 92; 11:2 CRLR 87]; HADEC then revised its written exam to ensure that it adequately tests those KSAs. At its November 18 meeting, the Committee discussed future changes to its practical exam to ensure its validity. Among other things, HADEC plans to change the format of the exam from the current use of a single examining room with two examiners present to a series of stations which each administers a different part of the test; HADEC also plans to use mannequins instead of live subjects as the patients. HADEC hopes to implement its revised practical exam by the fall of 1995.

Once the new practical exam is implemented, HADEC plans to change its examination appeals process. HADEC's current appeals process—which is not codified in its regulations—is very lenient, and permits applicants who have failed the practical exam to appear before the Committee to prove their knowledge and convince HADEC that they were failed unjustly; in other words, failed applicants essentially have the opportunity to retake the exam before the Committee without paying the usual fee to retake the exam. At its November meeting, HADEC noted that no law requires an appeals process, and envisions the abolition of its current appeals process once its practical exam is revised.

Enforcement Report. At the November 18 meeting, Committee member Deborah Kelly reported on HADEC's enforcement statistics thus far during fiscal year 1994-95 (from July 1 to November 14). HADEC has issued 22 citations without fines and 20 citations with fines. To date, HADEC has revoked three licenses, issued one conditional license, placed one license on probation, and accepted one voluntary surrender. A total of 207 enforcement cases are pending; 79 are being reviewed by a consumer services representative (CSR) at the Medical Board's intake unit; 61 are under formal investigation by an MBC investigator; two are being reviewed by an expert consultant; 41 investigations have been forwarded to HADEC's executive officer; ten fully investigated cases are pending at the Attorney General's Office awaiting the filing of an accusation; and the Attorney General has filed the accusation in 14 additional cases.

Kelly also presented a "case aging report" compiled by the Medical Board on the lengthy enforcement process. The report outlines the average total number of days HADEC cases spend in each of the six stages of enforcement. The November 11 report indicates that complaints against HADEC licensees sit at the MBC CSR stage for an average of 87 days, followed by a 264-day investigation period. Quality of care cases are usually submitted to an outside expert, which takes an average of 33 days. Completed investigations must be approved by HADEC's Executive Officer, which takes an average of 79 days. Once forwarded to the Attorney General's Office, cases sit for an average of 295 days before the formal accusation is filed, and then spend another 154 days at the AG's Office during the hearing and post-hearing decisionmaking process. Thus, it takes an average of 758 days—or 2.1 years—from the time a complaint is received until the filing of the accusation, and 2.5 years from receipt of complaint to final disciplinary decision.

Although the process is still quite lengthy, these case aging data indicate improvement in most areas over the previous case aging report presented at HADEC's July 1994 meeting, when it took an average of 3.3 years from complaint receipt to accusation filing and over four years from complaint receipt to final disciplinary action. [14:4 CRLR 76-77] Examination and Continuing Education Coordinator Dianne Tincher explained that much of the improvement is due to the fact that HADEC is now handling all of its own complaint processing and data entry. HADEC is also utilizing investigators from DCA's Division of Investigation rather than MBC investigators for many cases.

HADEC also noted that the Public Utilities Commission issued an October 12 resolution which implements recent legislation authorizing HADEC to request the cut-off of telephone service to unlicensed individuals who advertise hearing aid dispensing services.

Licensing Report. At HADEC's November 18 meeting, Licensing and Examination Coordinator Kathi Burns reported on the Committee's licensing statistics. Between July 20 and November 14, HADEC issued 38 temporary licenses, bringing the total number of temporary licenses to 79. During the same timeframe, 19 permanent licenses were issued. As of November 14, HADEC's cumulative license figures include 1,517 current licenses, 704 delinquent licenses, and 38 revoked licenses. Also during the same timeframe, 43 branch licenses were issued, bringing that cumulative total, as of November 14, to

241 current licenses and 532 delinquent licenses.

LEGISLATION

Future Legislation. At its November 18 meeting, HADEC noted that a new version of SB 2037 (McCorquodale) would probably be introduced in 1995. SB 2037, which would have merged HADEC with the Speech-Language Pathology and Audiology Examining Committee (SPAEC), was killed by the Senate in August 1994 for reasons unrelated to the HADEC/SPAEC merger [14:4 CRLR 76], and will most likely resurface in the 1995-96 session.

LITIGATION

At HADEC's November 18 meeting, Executive Officer Elizabeth Ware noted that the Committee's effort to enforce California law against at least one out-of-state mail order corporation has succeeded. Several years ago, HADEC commenced an investigation of two out-of-state companies which were selling devices to California consumers which they claimed were not hearing aids but "amplification devices." These devices, which HADEC alleges are in fact hearing aids, were sold without any formal fitting and without a license from HADEC. The Committee issued letters to both companies advising them to comply with state law by November 1, 1994, and simultaneously issued press releases warning consumers that companies marketing "sound amplification devices" or "hearing enhancers" were in violation of state law and that at least one such company had been warned by the U.S. Food and Drug Administration. On November 1, out-of-state counsel for one of the companies, Home Health Products (which markets the "MaxiSound Duo"), notified HADEC that his client has ceased selling its product to California residents. The other corporation, Telebrands, Inc. (which sells the "Whisper XL"), has thus far refused to comply with HADEC's request to cease the sale of its product in California; at this writing, HADEC and the Attorney General's Office are planning an enforcement action.

Also on November 18, Executive Officer Ware discussed the tremendous fiscal impact on HADEC of the cost of defending *Hughes v. State of California, et al.*, No. BS029050 (Los Angeles County Superior Court, filed June 14, 1994), hearing aid dispenser Robert Hughes' second lawsuit against the Committee since 1990. His prior action was dismissed by the superior court [11:4 CRLR 94]; on appeal, the dismissal was upheld in September 1993. In his action, Hughes alleges that several HADEC licensing and examination poli-



cies and advertising guidelines are in fact "regulations" which must be adopted by the Committee through the formal rulemaking process and approved by the Office of Administrative Law, and that the Committee's advertising guidelines and specified disciplinary policies are unconstitutional as violative of the first and fourteenth amendments. Ware noted that the Committee was forced to spend over \$3,000 on the case in fiscal year 1993-94, and has spent an additional \$14,000 thus far in 1994-95. HADEC projected depletion of its 1994-95 funds for Attorney General services by the end of December, and noted that over half of those funds would be spent not for intended enforcement activities but for defense against Hughes' lawsuit.

RECENT MEETINGS

At HADEC's November 18 meeting, Committee staff reported that a total of 52 candidates took HADEC's practical exam on November 25 in Sacramento; of these candidates, 41 passed for a pass rate of 79%. Of eight applicants retaking the exam, four passed. The overall pass rate for this examination is 12% higher than the June 1994 practical examination, while the initial exam pass rate is 17% higher and the retake pass rate is 36% lower. Committee staff also reported that a total of 148 candidates took the computerized version of HADEC's written examination between April and October of 1994; of these candidates, 89 passed for a pass rate of 60%. The next scheduled practical exams will be administered on May 6 and November 4.

At its October 18 meeting in Sacramento, the Subcommittee on Examination and Educational Requirements discussed and resolved an issue that had developed with the administration of HADEC's written exam in electronic form. In September, HADEC received a letter from Assessment Systems, Inc. (ASI), the administrator of the written exam, informing HADEC that effective September 17, ASI would limit the administration of exams to only once per month at each of five ASI testing sites. The original contract between HADEC and ASI provided for testing at least once per week of each of the five sites, and specified that any change must be negotiated in advance and approved by both HADEC and ASI in writing. [14:4 CRLR 77]

HADEC held a meeting with ASI on October 4 and discussed all possible options to resolve the issue, ranging from enforcement of the original contract to termination of HADEC's relationship with ASI due to its unilateral decision to amend the contract. However, the Subcommittee chose an option representing a compro-

mise between HADEC and ASI; the plan was subsequently approved by ASI and implemented on December 1. The new agreement provides for exam appointments to be set 7 to 14 days in advance (previously 3 to 14 days), allowing ASI to close an inactive center a week in advance; tests will be administered twice per month (previously once per week), providing more options than available under ASI's altered schedule, with guaranteed testing within 14 days of the appointment call; and an implementation period of 120 days (December 1, 1994—March 3, 1995), with an opportunity at that time for reassessment of the schedule.

FUTURE MEETINGS

March 31 in Sacramento.

August 4 in Sacramento.

November 17 in Sacramento.

PHYSICAL THERAPY EXAMINING COMMITTEE

Executive Officer: Steven Hartzell (916) 263-2550

The Physical Therapy Examining Committee (PTEC) is a six-member board responsible for examining, licensing, and disciplining 16,749 physical therapists and 3,225 physical therapist assistants. The Committee is comprised of three public and three physical therapist members. PTEC is authorized under Business and Professions Code section 2600 *et seq.*; the Committee's regulations are codified in Division 13.2, Title 16 of the California Code of Regulations (CCR). The Committee currently functions under the general oversight of the Medical Board of California (MBC).

Committee licensees presently fall into one of three categories: physical therapists (PTs), physical therapist assistants (PTAs), and physical therapists certified to practice kinesiological electromyography or electroneuromyography.

PTEC also approves physical therapy schools. An exam applicant must have graduated from a Committee-approved school before being permitted to take the licensing exam. There is at least one school in each of the 50 states and Puerto Rico whose graduates are permitted to apply for licensure in California.

MAJOR PROJECTS

PTA Supervision Regulations Stalled Again. At its October 13 meeting, PTEC held a public hearing on the latest version

of section 1398.44, Division 13.2, Title 16 of the CCR, which is intended to define "adequate supervision" by a PT over a PTA.

Among other things, existing section 1398.44 requires a supervising physical therapist (SPT) to be "present in the same physical therapy facility with the assistant at least 50% of any work week or portion thereof the assistant is on duty unless this requirement has been waived by the Committee." Historically, PTEC's small staff has been inundated with requests for waivers of the so-called "50% requirement," such that it has sought to eliminate the waiver provision and more clearly define precise supervisorial requirements which will protect patients of PTs and PTAs.

PTEC's earlier drafts of the regulation set forth separate supervision requirements for the inpatient/outpatient facility setting and the home health care setting, and included a requirement that, in the inpatient/outpatient facility setting, the supervising physical therapist (SPT) must be present in the same facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty; the waiver provision would have been deleted. At that time, the California Chapter of the American Physical Therapy Association (CCAPTA) opposed the language on grounds that it was too strict and imposed requirements which were overly burdensome and unnecessary to patient protection; CCAPTA especially objected to elimination of the waiver provision. PTEC finally dropped the proposal in January 1994 [14:2&3 CRLR 80] and redrafted the entire regulation.

Among other things, the proposed amendments considered on October 13 would eliminate both the 50% actual presence requirement and the waiver procedure; further, they do not appear to differentiate between inpatient/outpatient facility setting and the home health care setting. Proposed section 1398.44 would require the licensed SPT to be readily available in person or via electronic means to the PTA at all times for advice, assistance, and instruction. The SPT must initially evaluate each patient prior to the provision of physical therapy treatment by the PTA, and document the evaluation and the date of the next scheduled reevaluation in the patient's record. Based on the evaluation and other information available to the PT, the SPT must formulate and record in each patient's record a treatment program, and determine which elements thereof may be delegated to the PTA; the SPT must sign the treatment program. The SPT must re-evaluate the patient as determined neces-



sary in the initial evaluation, modify the treatment program as necessary, and document and sign each reevaluation in the patient's record. [14:4 CRLR 77-78]

At the October 13 hearing, the proposed language once again came under fire from CCAPTA. However, the trade association now says the language is too vague and effectively destroys the supervision requirement; CCAPTA objected to the elimination of any requirement that a PT actually observe the work of a PTA, and again opposed deletion of the waiver process. Other groups and individual PTs, however, expressed support for the proposed amendments.

Following the hearing, PTEC deferred action on the proposal, and decided that new Chair Valerie Sinkus should convene a task force to reevaluate the supervision proposal, particularly the existing waiver process and problems associated with it. At this writing, the task force is attempting to draft new language for presentation to the Committee at its February 3 meeting.

Personnel Identification. Also on October 13, PTEC held a public hearing on its proposal to adopt new section 1398.11, Title 16 of the CCR, which would require PTs, PTAs, applicants for PT and PTA licenses, and aides who provide physical therapy services to wear an identification badge to indicate their title. [14:4 CRLR 78] At the hearing, PTEC received comments in support of ("patients will be able to more easily identify wrongdoers") and in opposition to ("this is unnecessary overregulation") the proposal; the Committee deferred action on this proposed regulation until its February meeting.

Exam Fee Increases Approved. Also on October 13, PTEC held a public hearing on proposed amendments to sections 1399.50 and 1399.52, Title 16 of the CCR. As proposed, the amendment to section 1399.50 would increase PT examination and re-examination fees from \$140 to \$225; the amendment to section 1399.52 would increase the PTA examination and re-examination fees from \$140 to \$225. [14:4 CRLR 78] At the hearing, staff presented an analysis which indicated that PTEC's actual cost to administer these exams is \$235.50 per candidate, such that the fees should be increased to at least \$235 per exam. PTEC decided to modify the language to increase the exam fees to \$235, and adopted the modified version of the regulatory changes pending a 15-day public comment period. The Office of Administrative Law (OAL) approved the increases on December 6.

Other PTEC Rulemaking. The following is a status update on other PTEC rulemaking proceedings reported in detail in previous issues of the *Reporter*:

• *Physical Therapy Aide Supervision.*

On October 21, OAL approved PTEC's amendments to section 1399 and adoption of section 1399.1, which stiffen the supervision requirements for physical therapy aides, unlicensed individuals who may be employed by PTs to perform both patient-related and non-patient-related tasks. The amendments to section 1399 require a mandatory evaluation of the patient by the SPT prior to the initiation of care by the aide, as well as a written treatment program in which specific patient-related tasks are assigned to the aide. New section 1399.1 restricts a PT to supervising not more than one aide who is performing a patient-related task at any one time. [14:4 CRLR 78; 14:2&3 CRLR 80]

• *PTA Training and Experience Requirements.*

Also on October 21, OAL approved PTEC's amendments to section 1398.47, which specify numerous combinations of training and experience which are equivalent to the Committee's education requirements for PTAs. The amendments also specify that, after June 30, 1996, applicants for PTA approval must have gained a significant portion of any qualifying work experience under the immediate supervision of a licensed PT in an acute care inpatient facility. [14:4 CRLR 78; 14:2&3 CRLR 80-81]

■ RECENT MEETINGS

At its October 13 meeting, PTEC reviewed and adopted a mission statement and several major long-range goals. [14:4 CRLR 79] PTEC's mission is "to protect the people of California by administering and enforcing the Physical Therapy Practice Act, and ensuring that physical therapy is provided by physical therapists and their supportive personnel who meet the requirements of the Practice Act." The Committee also adopted goals within the four categories of administration, enforcement, education, and licensing. In the area of administration, for example, PTEC's goals are to maintain and enhance its autonomy, update its policy and procedure manuals, ensure adequate staffing, and increase its knowledge of physical therapy education standards in foreign countries. In the area of enforcement, PTEC seeks to maintain control over its complaint investigation and discipline functions; complete investigation on 90% of complaints within 90 days of receipt, and complete the disciplinary process in 90% of cases within twelve months from receipt of a complaint. PTEC's educational goals include publication of a biannual newsletter to inform licensees and development of consumer education programs to educate the public about PTEC's function, en-

forcement process, professional responsibilities, and patient rights. The Committee's priorities in licensing include participation in the national practitioners' data bank of the Federation of State Boards of Physical Therapy, ensuring that all examinations are consistent with contemporary education and practice standards, and advocating development of computer-based national PT and PTA examinations.

Also on October 13, Jon Thayer of Occupational Health Services, Inc. (OHS), the outside contractor which administers PTEC's diversion program for substance-abusing licensees, made a presentation on the program. [12:2&3 CRLR 113] The purpose of the diversion program is to identify and rehabilitate PTs and PTAs with drug and/or alcohol problems. For individuals who voluntarily seek admission, participation in the program is confidential, meaning that information about participation is not subject to discovery and is not accessible for disciplinary purposes. PTEC will be notified, however, of the unsuccessful completion of the program by individuals who are required to participate by the Committee as part of or in lieu of discipline.

Finally, PTEC elected 1995 officers at its October meeting. The Committee selected PT Valerie Sinkus as Committee Chair and PT Dick Matthews as Vice-Chair.

■ FUTURE MEETINGS

February 3 in Los Angeles.
May 12 in Sacramento.
August 4 in San Francisco.
October 26 in San Diego.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale
(916) 263-2670

The legislature established the Physician Assistant Examining Committee (PAEC) in Business and Professions Code section 3500 *et seq.*, in order to "establish a framework for development of a new category of health manpower—the physician assistant." Citing public concern over the continuing shortage of primary health care providers and the "geographic maldistribution of health care service," the legislature created the physician assistant (PA) license category to "encourage the more effective utilization of the skills of physicians by enabling physicians to delegate health care tasks...." PAEC func-



tions under the jurisdiction of the Medical Board of California (MBC); the Committee's regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

PAEC licenses individuals as PAs, allowing them to perform certain medical procedures under a physician's supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC also establishes standards for and approves education and training programs for PAs, and makes recommendations to MBC concerning guidelines for physicians who apply to supervise PAs and the approval of such applications. PAEC keeps two registers—one consisting of approved supervising physicians (SPs) and one consisting of licensed PAs. PAEC's objective is to assure the public that the incidence and impact of "unqualified, incompetent, fraudulent, negligent and deceptive licensees of the Committee or others who hold themselves out as PAs [are] reduced."

PAEC's nine members include one MBC member, a physician representative of a California medical school, an educator participating in an approved program for the training of PAs, one physician who is an approved supervising physician of PAs and who is not an MBC member, three PAs, and two public members. Committee members may serve a maximum of two four-year terms.

MAJOR PROJECTS

PAEC Continues to Work Toward Adoption of Citation and Fine Regulations. PAEC will soon commence the rule-making process to implement its citation and fine authority as a means of more efficiently and effectively disciplining minor violations of its enabling act and regulations. [14:4 CRLR 80] PAEC's draft regulations are modeled after similar rules recently adopted by MBC [14:2&3 CRLR 69; 14:1 CRLR 63], and would allow PAEC's Executive Officer to levy citations and/or fines between \$100 to \$2,500 per infraction against licensed PAs, PAs who have practiced with a delinquent license, or applicants for PA licensure who practice beyond the scope of their approval as an interim PA. At this writing, PAEC's Citation and Fine Regulations Ad Hoc Subcommittee is scheduled to hold an informational session to hear comments on its proposed draft of the regulations on January 19, in conjunction with PAEC's January 20 meeting in San Diego; the full Committee tentatively plans to hold a formal public hearing on the proposed regulatory changes at its April meeting.

PAEC Develops Vision Statement and Strategic Plan. At its October meeting, PAEC reviewed its mission statement and developed, under the direction of Michael Dues, Ph.D., as facilitator, draft versions of its vision statement and strategic plan. The Committee articulated as its vision the goal "to assure that health care needs for all persons are met in a compassionate, efficient and culturally sensitive manner," noting that PAs can better fulfill this goal if their utilization is expanded. The Committee defined its primary functions as the following: to license PAs and promote their training; enforce laws and regulations regarding PA practice; educate consumers, licensees, and other medical personnel about PA practice; monitor conditions, such as federal and state legislation and trends in health care provision, that may affect PA practice; provide a diversion program for PAs who abuse drugs and/or alcohol, and monitor participants for compliance with the program; and advocate legislative and regulatory changes affecting PAs in order to improve the quality of health care offered to consumers. In drawing up its strategic plan for 1995-2000, the Committee listed as its first priority the promotion of utilization of PAs through reduction of permit fees for supervising physicians and an increase in the ratio of PAs to SPs. PAEC listed the following, in order of declining priority, as further objectives: the timely preparation of documents to meet the requirements of the "sunset" bill, SB 2036 (McCorquodale) [14:4 CRLR 80, 221]; promotion of increased communication between PAs, nurses, and physicians; assurance of internal and external compliance with SB 1642 (Craven), which clarified PAs' authority to transmit prescriptions [14:4 CRLR 80]; acquisition of true prescriptive privileges for PAs; establishment of a database of information about PA practices and factors influencing PAs; and increased communication between various health care boards with the goal of eliminating misconceptions about the scope of PA practice. At this writing, the Committee plans to present the mission statement, vision statement, and strategic plan for discussion and adoption at its January meeting.

In addition to long-range planning, PAEC is examining its internal practices, policies, and procedures. At the October meeting, Executive Officer Ray Dale announced that the same facilitator who assisted PAEC in the development of its vision statement and strategic plan will meet with the Committee's six-member staff to discuss morale, efficiency, and productivity. Also at the October meeting, the Committee requested a report at the

January meeting from its Policy Subcommittee regarding the formalization of internal PAEC procedures. For example, the Committee agreed that a policy should be drafted stating that newly-elected Committee officers take their positions on January 1. Although PAEC follows this practice, it has no written policy prescribing its procedure for electing and installing officers.

LEGISLATION

Future Legislation. At its October meeting, PAEC discussed four potential legislative proposals for the 1995-96 session: (1) a change in the Committee's name to either "Physician Assistant Examining Board" or "Physician Assistant Committee"; (2) an increase in the number of PAs which an SP may supervise (from two to three); (3) establishment of group or facility fees to be imposed on institutions which hire PAs; and (4) an increase in PA application fees. However, the Committee rejected all four proposals and voted to seek no legislative changes in calendar year 1995.

In rejecting the proposals to impose group or facility fees and to raise PA fees, Committee members noted that one of PAEC's goals during the past year has been to reduce fees imposed on SPs. [14:4 CRLR 79; 14:2&3 CRLR 82; 14:1 CRLR 63] In addition, the Committee felt that imposing group or facility fees would be difficult to implement, as PAEC currently has no system to track where PAs are working. Raising PA fees was considered inadvisable because it might discourage rather than encourage PAs from practicing in California; Committee member Steven Johnson reported that nearly 50% of PAs licensed in California leave the state to practice. Nevertheless, PAEC directed its Executive and Budget Subcommittee to study this proposal.

Although PAEC decided not to sponsor any 1995 legislation at its October meeting, the 1994 passage of SB 1642 (Craven), the prescription transmittal bill which authorizes SPs to delegate to a PA the authority to transmit a prescription from the SP to a person lawfully able to furnish medication to the patient [14:4 CRLR 80], may trigger further legislation and/or rulemaking. For example, there has already been considerable confusion over the bill's use of the terms "formulary" and "protocol." At its December 12 meeting, PAEC's Executive and Budget Subcommittee interpreted these terms as synonymous, provided that the written protocol adopted by the SP lists the medications whose prescription the SP may authorize the PA to transmit. On this issue of pre-



scription transmission, PAEC supports the Board of Pharmacy's proposed regulation allowing prescribers to use electronic transmission as a means of requesting prescriptions from pharmacies (see agency report on BOARD OF PHARMACY for related discussion).

Legislation and/or rulemaking may also be necessary to clarify SB 1642's impact on the tension between the scope of practice of a PA and that of a registered nurse and/or nurse practitioner. While PAs operate under the supervision of a physician, RNs and NPs have an independent scope of practice. PAEC interprets SB 1642 as authorizing a PA to transmit a supervising physician's prescriptive order to an RN, while some RN groups have traditionally resisted the notion that an RN must take orders from a PA. [12:2&3 CRLR 117, 141; 12:1 CRLR 80]

The Department of Consumer Affairs is currently considering proposed legislation that would allow DCA agencies to grant temporary probationary licenses to applicants; such a license would be issued to applicants who have a questionable history but are deemed capable of practicing safely. PAEC considers this an additional, effective enforcement tool which would allow it to protect the consumer by closely monitoring a practitioner through a less cumbersome process than the current one, which requires that PAEC deny the application for a license to practice, draft a "statement of issues" detailing the reasons for denial, afford the applicant a full hearing, and then grant the license subject to a probationary period. If proposed, PAEC would likely support such legislation.

RECENT MEETINGS

At the Committee's October meeting, PAEC Analyst and Enforcement Coordinator Glenn Mitchell reviewed the Committee's enforcement statistics for the fiscal year which began on July 1, 1994. As of September 27, 11 complaints against PAs were being processed by the Medical Board's Central Complaint and Investigation Control Unit, 53 complaints were under active investigation, and 15 cases were pending at the Attorney General's Office, 11 of which were at early stages of the adjudication process. Thus far in fiscal year 1994-95, PAEC has disciplined one licensee by revoking his license.

Staff member Jennifer Barnhart reported that two PAs have joined the Committee's diversion program, bringing the total number of PA participants to four. Executive Officer Ray Dale informed the Committee that it is required by law to anonymously review files of participants in the diversion program, and urged the Committee to

plan how it will perform such a review. The Committee decided to discuss this issue at its January meeting.

Dissatisfied with its licensee newsletter [14:4 CRLR 80], the Committee discussed the possibility of discontinuing its publication and instead asking MBC to mail its *Action Report* newsletter to California PAs. Several Committee members said that MBC's newsletter is helpful to their practice as PAs, and that it is advantageous for PAs to be able to obtain information at the same time it becomes available to their supervising physicians. The Committee agreed to consider this proposal at its January meeting.

Also in October, the Committee again postponed action on its proposal to modify its supervising physician application in order to request more information about the applicant SP's past offenses and history of mental illness [14:4 CRLR 80]; the issue of whether the modified application would be in compliance with the Americans with Disabilities Act is still being researched by DCA legal counsel. At this writing, the Committee plans to discuss this matter at its January meeting in conjunction with a proposal to revise the PA application.

Finally, PAEC elected its 1995 officers in October. The Committee chose PA Robert Sachs as Chair and PA Steve Morey as Vice-Chair.

FUTURE MEETINGS

January 20 in San Diego.
April 7 in San Francisco.

BOARD OF PODIATRIC MEDICINE

Executive Officer:
James Rathlesberger
(916) 263-2647

The Board of Podiatric Medicine (BPM) of the Medical Board of California (MBC) regulates the practice of podiatry in California pursuant to Business and Professions Code section 2460 *et seq.* BPM's regulations appear in Division 13.9, Title 16 of the California Code of Regulations (CCR).

The Board licenses doctors of podiatric medicine (DPMs), administers two licensing examinations per year, approves colleges of podiatric medicine, and enforces professional standards by initiating investigations and disciplining its licentiates, as well as administering its own diversion program for DPMs. The Board consists of four licensed podiatrists and two public members.

In November, Assembly Speaker Willie Brown appointed new public member Iva P. Greene to BPM. Greene is a small business owner from Pacific Palisades; she holds bachelor's degrees in business administration and psychology, and a master's degree in psychology. Greene replaces Theresa D. Taylor, whose term expired. At this writing, BPM is functioning with only five members; the public member position appointed by the Senate Rules Committee is still vacant. [14:4 CRLR 81]

MAJOR PROJECTS

Public Disclosure Regulations. On November 4, BPM held a public hearing to consider proposed new section 1399.700, Title 16 of the CCR, which would establish BPM's public disclosure policy in regulation. [14:4 CRLR 81; 13:2&3 CRLR 92]

Under proposed section 1399.700, BPM will disclose the following information regarding any DPM licensed in California: current status of the license, issuance and expiration date of the license, podiatric medical school of graduation, and date of graduation; whether a disciplinary case has been referred to the Attorney General's Office for the filing of an accusation, temporary restraining order, or interim suspension order and, if so, the nature of the allegation and an appropriate disclaimer; any public document filed against the podiatrist, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, and public letters of reprimand; medical malpractice judgments in excess of \$30,000 reported to the Board on or after January 1, 1993, including the amount of the judgment, the court of jurisdiction, the case number, a brief summary of the circumstances as provided by the insurance company, and an appropriate disclaimer; discipline imposed by another state or the federal government reported to the Board on or after January 1, 1993, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer; California felony convictions reported to the Board on or after January 1, 1993, including the nature of the conviction, the date of conviction, the sentence (if known), the court of jurisdiction, and an appropriate disclaimer; and information regarding accusations filed and withdrawn. The language of proposed section 1399.700 mirrors that of proposed section 1354.5, Division 13, Title 16 of the CCR, the Medical Board's proposed public disclosure regulations which was considered by MBC's Division of Medical Quality on November 3.

Following the hearing, BPM adopted the proposed language but authorized Ex-



ecutive Officer Jim Rathlesberger and Board President Joanne Watson, DPM, to incorporate into BPM's rule any modifications made by MBC to its rule on November 3 (see agency report on MBC for related discussion). At this writing, BPM's section 1399.700 has yet to be approved by MBC, the Department of Consumer Affairs (DCA), and the Office of Administrative Law (OAL).

Citation and Fine Amendments Approved. On January 6, OAL approved BPM's amendments to section 1399.698, Division 13.9, Title 16 of the CCR, its citation and fine regulations. The existing regulations permitted BPM's Executive Officer to issue citations for specified violations of the Business and Professions Code, the Health and Safety Code, and the California Code of Regulations, and set forth two ranges of fines (from \$100 to \$1,000, and from \$1,100 to \$2,500) which may be assessed for the violation of specified sections. BPM's amendments add specific sections of law currently excluded from the regulations, provide greater latitude in determining the exact amount of the fine to be imposed, extend BPM's cite and fine authority to all appropriate sections of law, and conform to the citation and fine program recently adopted by MBC. [14:4 CRLR 81; 14:2&3 CRLR 84; 14:1 CRLR 51]

Future BPM Rulemaking. At its November meeting, the Board agreed to initiate the rulemaking process to amend several other existing regulations:

- Existing section 1399.662 requires all applicants for a podiatric medical license to complete a medical curriculum at a school or college of podiatric medicine approved by the Board, and requires BPM to approve all colleges of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. BPM will seek to amend section 1399.662 to permit it to approve a CPME-accredited college, thus preserving its discretion to reject CPME-accredited curricula which provide insufficient podiatric medical education and training.

- Existing section 1399.666 requires that "equivalent training" for purposes of Business and Professions Code section 2483 be undertaken through those educational programs approved by the CPME; the Board proposes to amend section 1399.666 to further specify that such training must meet all requirements of the Business and Professions Code.

- Section 1399.667 currently specifies that hospitals approved to provide post-graduate training to podiatric medical residents must meet minimum requirements set

by the CPME; BPM proposes to further specify that hospitals must have designated a Director of Medical Education, provide emergency medial training through emergency room rotations and exposure to medical research, measure and evaluate the progress of participants and program effectiveness, and reasonably conform with general requirements of the AMA's Accreditation Council for Graduate Medical Education.

- Section 1399.670 currently provides for approval of some continuing medical education (CME) courses by BPM based upon prior approval by various organizations, including medical associations and educational institutions. BPM's proposed amendments to section 1399.670 would expressly state that all CME courses accepted by the Board in fulfillment of license renewal requirements must be scientific courses relating directly to patient care. All other types of courses, although they have previously qualified for CME credit, would no longer satisfy license renewal requirements.

At this writing, BPM is scheduled to hold a public hearing on these proposed regulatory changes at its January 24 meeting in Sacramento.

LEGISLATION

Future Legislation. At its November 4 meeting, BPM approved a proposal to seek 1995 legislation updating the required course curriculum at colleges of podiatric medicine. Specifically, BPM will seek amendments to Business and Professions Code section 2483 to delete psychology and add behavioral science, pediatrics, and women's health as areas of required instruction; this proposal implements a suggestion made in the so-called "Nelson-Medio report" on podiatric medical training recently commissioned by MBC and BPM. [14:1 CRLR 64] BPM hopes to receive Wilson administration approval to sponsor the legislation during 1995.

At its January 24 meeting, BPM is scheduled to vote on another piece of proposed legislation which would permit MDs and DPMs to enter into partnerships; at this writing, the same issue is currently on the Medical Board's February 3-4 agenda. If approved by both boards, it will be included in MBC's 1995 legislative package.

RECENT MEETINGS

At its November 4 meeting, BPM was introduced to new staff Enforcement Coordinator Michelle Mason. Ms. Mason previously served as Enforcement Coordinator at the Board of Examiners in Veterinary Medicine.

FUTURE MEETINGS

January 24 in Sacramento.
May 5 in San Francisco.

BOARD OF PSYCHOLOGY

Executive Officer:
Thomas O'Connor
(916) 263-2699

The Board of Psychology (BOP) is the state regulatory agency for psychologists under Business and Professions Code section 2900 *et seq.* Under the general oversight of the Medical Board of California (MBC), BOP sets standards for education and experience required for licensing, administers licensing examinations, issues licenses, promulgates rules of professional conduct, regulates the use of psychological assistants, investigates consumer complaints, and takes disciplinary action against licensees by suspension or revocation. BOP's regulations are located in Division 13.1, Title 16 of the California Code of Regulations (CCR).

BOP is composed of eight members—five psychologists and three public members. Each member of the Board is appointed for a term of four years, and no member may serve for more than two consecutive terms.

Assembly Speaker Willie Brown recently appointed new public member Mary McMillan to BOP. McMillan, who holds a bachelor of arts degree from the University of California at Berkeley, replaces former Board member Linda Lucks, whose term expired.

MAJOR PROJECTS

Continuing Education Regulations Approved. At its March 1994 meeting, BOP adopted new Article 10 (commencing with section 1397.60), Division 13.1, Title 16 of the CCR, to implement SB 774 (Boatwright) (Chapter 260, Statutes of 1992). SB 744 added section 2915 to the Business and Professions Code, which requires psychologists, effective January 1, 1996, to satisfy continuing education (CE) requirements prior to license renewal. [14:4 CRLR 82; 14:2&3 CRLR 86; 14:1 CRLR 65-66]

In October, the Office of Administrative Law (OAL) disapproved BOP's CE regulations because they contained unclear provisions and because the rulemaking record did not contain substantial evidence of necessity for the fees set forth in sections 1397.68 and 1397.69. BOP staff corrected these deficiencies, released modified regula-



tory language for a 15-day public comment period on October 27, and resubmitted the proposed regulations to OAL, which approved them on December 29.

Citation and Fine Regulations. At BOP's August 1994 meeting, staff presented draft regulatory language implementing the Board's "citation and fine" authority under Business and Professions Code sections 125.9 and 148. The citation and fine system is intended to provide occupational licensing agencies with intermediate sanctions for violations which do not warrant a full-blown disciplinary proceeding but should not be ignored. [14:4 CRLR 82] As directed by the Board, staff presented a more polished version of the proposed language at BOP's November meeting. However, additional changes were recommended. The next draft will include language implementing Business and Professions Code section 149, which permits DCA agencies to order unlicensed individuals who are offering services for which a license is required to disconnect telephone service furnished to the telephone number contained in the unlawful advertising. At this writing, BOP staff hopes to publish the citation and fine regulations for public hearing by August 1995.

Examination Regulations Proposal. At BOP's November meeting, staff proposed changes to sections 1388, 1388.5, 1389, and 1390, Division 13.1, Title 16 of the CCR, which would alter the Board's examination structure. Among other things, the proposed modifications would allow all candidates an opportunity for performance feedback on their oral examinations, but would also limit a candidate's ability to request reconsideration of oral examination results to petitions based solely on procedural error. Following discussion, the Board asked staff to draft regulatory language reflecting the proposals. At this writing, the Board hopes to hold a public hearing on these proposed regulatory changes at its March meeting.

Fee Increase Proposal. Also in November, staff reported that the Department of Finance approved BOP's budget change proposals for permanent augmentation of its enforcement budget, an additional clerical position, and increased operating expenses. To pay for the additional enforcement costs, the Board approved staff's recommendation to increase biennial renewal fees and initial licensure fees to \$475 effective July 1995. BOP hopes to hold a public hearing on these proposed regulatory changes at its March meeting.

LEGISLATION

Future Legislation. At this writing, the Board of Psychology does not intend

to sponsor any legislation during 1995. The California Psychological Association (CPA) still plans to sponsor 1995 legislation to authorize psychologists to prescribe some medications in California. [14:4 CRLR 82] CPA's Prescriptive Privilege Task Force is continuing its study and is in the process of securing an author for its legislation.

RECENT MEETINGS

At the Board's November 5 meeting in Sacramento, Emil Rodolfa, Ph.D., of the Organization of Counseling Center Directors in Higher Education spoke to the Board regarding section 1387(b), Division 13.1, Title 16 of the CCR. Effective July 1, 1995, this regulation requires qualified supervisors (*i.e.*, licensed psychologists who are supervising the professional experience of candidates for psychologist licensure) to have at least three years of professional post-licensure experience. [13:2&3 CRLR 94-95; 12:4 CRLR 107-08] Dr. Rodolfa argued that there is no empirical evidence supporting the notion that supervisors with three years of post-licensure experience provide more effective supervision than licensed psychologists with less experience. Dr. Rodolfa cited research which indicates that the length of time since licensure has little effect on supervisory practices, and suggested that the most effective way to ensure the safety of the public is to train supervisors before permitting them to supervise a psychological assistant. He argued that a training program would ensure higher-quality supervised experience than a rigid three-year time requirement. Dr. Rodolfa stated that he was not petitioning to amend the regulations, but merely requesting further consideration of this issue. The Board responded by creating an ad hoc committee to further analyze this issue with Dr. Rodolfa.

Also at its November meeting, BOP discussed a memorandum from the Department of Consumer Affairs' (DCA) Legal Office regarding telephone counseling. Recently, corporations have begun to offer counseling services via a "900" telephone information service line. The memo indicates that no law appears to prohibit a California-licensed psychologist from providing counseling over the telephone to a California resident, but unlicensed individuals and/or individuals licensed in another state probably cannot legally provide telephone counseling services to California residents. The Board expressed concern that these services charge over \$200 per hour without the consumer's informed consent. The Board designated certain members to an ad hoc committee

to further study the telephonic counseling issue.

Also in November, the Board revised its policy statement on psychologist-patient sexual contact/misconduct to reflect SB 2039 (McCorquodale) (Chapter 1274, Statutes of 1994). This legislation requires BOP to revoke the license of any licensee who is found to have engaged in inappropriate sexual contact with a patient, or a former patient under certain circumstances. [14:4 CRLR 46, 83; 14:1 CRLR 35, 66] BOP revised its policy statement to define the term "former patient" only to cover the situation where the psychologist has terminated the psychologist-patient relationship for the purpose of engaging in sexual contact with the patient.

At BOP's January 6 meeting, DCA Supervising Counsel Dan Buntjer discussed the Board's response to the California Medical Association's (CMA) petition to the Department of Health Services to amend sections 73627, 77103, and 76867, Title 22 of the CCR. These amendments would remove a clinical psychologist's authority to order seclusion or apply restraints in the treatment of patients in specified health care facilities. [14:4 CRLR 83] Mr. Buntjer has responded to CMA's petition on behalf of BOP and other interested DCA agencies by pointing out that the use of seclusion and restraint has always been within the scope of practice of licensed psychologists and that, if CMA is successful, the amendments would result in grave consequences in hospitals.

Also on January 6, the Board reviewed its enforcement statistics for the first quarter of the 1994-95 fiscal year. From July 1 to October 1, 1994, the Board received 165 complaints, opened 45 investigations, and forwarded 10 cases to the Attorney General's Office for disciplinary action and/or to a district attorney's office for criminal action. During that same time period, the Board filed nine accusations and made a total of 12 disciplinary decisions (including the revocation of four licenses). Of the 12 disciplinary decisions, five were for sexual misconduct and two were for criminal conviction.

Also in January, BOP released its first newsletter to all psychologists licensed in California. The newsletter was completed in November but could not be released until the continuing education regulations were approved (*see above*) because the new requirements are explained in the newsletter. The Board hopes to publish another newsletter in 1995.

FUTURE MEETINGS

March 17-18 in San Francisco.
May 19-20 in Los Angeles.
August 18-19 in San Diego.



SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards
(916) 263-2666

The Speech-Language Pathology and Audiology Examining Committee (SPAEC) consists of nine members: three speech-language pathologists, three audiologists and three public members (one of whom is a physician). SPAEC currently functions under the jurisdiction and supervision of the Medical Board of California (MBC).

The Committee administers examinations to and licenses speech-language pathologists and audiologists, and registers speech-language pathology and audiology aides. SPAEC hears disciplinary matters assigned to it by the Medical Board, including but not limited to any contested case or any petition for reinstatement, restoration, or modification of probation. Decisions of the Committee are forwarded to MBC for final adoption.

SPAEC is authorized by the Speech-Language Pathologists and Audiologists Licensure Act, Business and Professions Code section 2530 *et seq.*; its regulations are contained in Division 13.4, Title 16 of the California Code of Regulations (CCR).

Recently, SPAEC member Jacquelyn Graham, a speech-language pathologist, resigned from the Committee. At this writing, Governor Wilson has yet to name her replacement.

MAJOR PROJECTS

Mission and Vision Statements. In 1989, SPAEC adopted formal mission and vision statements and goals to guide its decisionmaking. The 1989 mission statement notes that SPAEC's mission is to "protect the consumer by requiring adherence to statutes and regulations designed to ensure the qualifications and competency of providers of speech-language pathology services." SPAEC's stated goals were to continuously review and improve its licensing, educational, and enforcement standards, improve communication and cooperation with all internal and external sources, and improve office procedures affecting licensees and consumers.

In light of the 1994 passage of SB 2036 (McCorquodale), the "sunset" bill [14:4 CRLR 85], SPAEC Executive Officer Carol Richards noted at the Committee's October 28 meeting that a review of these statements is in order to address changes in

health care demands, the need for continuing education of licensees, and other transformations within the professions regulated by SPAEC. Committee members agreed that a review is necessary, and specifically addressed the possibility of including a statement to the effect that all consumer complaints against licensees will be aggressively pursued by SPAEC. The Committee decided to circulate a draft of a revised mission statement, vision statement, and goals, and to revisit this issue at its January meeting.

Occupational Analyses on Hold Until January. Also on October 28, SPAEC discussed the upcoming occupational analyses of the speech-language pathologist and audiologist professions which will be conducted by the Department of Consumer Affairs' (DCA) Office of Examination Resources (OER). [14:4 CRLR 84-85] SPAEC Chair Robert Hall noted that he and Executive Officer Richards had met with OER Manager Dr. Norman Hertz to develop a preliminary list of settings in which speech-language pathologists and audiologists practice. Committee members were invited to supplement the list, and added several settings including pediatric hospitals and early intervention speech-language programs. Executive Officer Richards noted that, due to time and budgetary constraints, it may not be possible to survey every possible setting in the occupational analyses.

Although an OER representative was scheduled to attend SPAEC's October 28 meeting to unveil a specific plan of action, prior commitments necessitated postponement of the presentation until SPAEC's January meeting.

Extended Practice Issues. On October 28, SPAEC continued its ongoing discussion of several invasive procedures which are not presently covered by statutes establishing the scope of practice of SPAEC licensees—specifically, endoscopy (both nasal and oral) by speech-language pathologists, and cerumen management (ear wax removal) by audiologists. [14:2&3 CRLR 88; 14:1 CRLR 68; 13:4 CRLR 74] Staff distributed a draft position paper prepared by the California Speech-Language Hearing Association (CSHA) regarding cerumen management to SPAEC members, but CSHA requested that the paper be kept confidential and that responses or comments be made by SPAEC members in their personal capacities rather than their official capacities. Committee members also received and briefly discussed a draft position paper on endoscopic procedures prepared by speech-language pathologist Christie Ludlow, Ph.D., and Peek Wu, M.D. The Committee took no

action on either position paper, but decided to initiate a dialogue with the Medical Board to determine its position on the issue of whether these invasive procedures are limited to physicians by the Medical Practice Act. At this writing, the Committee is expected to discuss this issue further at its January meeting.

Future Rulemaking. At its October 28 meeting, SPAEC debated whether to commence the rulemaking process to revise several of its regulations in Division 13.4, Title 16 of the CCR. Following discussion, SPAEC directed staff to initiate rulemaking proceedings to revise section 1399.158 to increase the number of hours of supervised clinical practice required in order to be licensed by SPAEC to 300 hours, the current statutory maximum under Business and Professions Code section 2532.2(c) (see LEGISLATION); and to update sections 1399.198-.199, the Committee's citation and fine regulations. SPAEC was one of the first DCA agencies to implement its citation and fine authority, and its regulations are fairly minimal. SPAEC plans to update its regulations to specify particular sections of its statute and regulations which, if violated, should be sanctioned with a citation and/or fine, and to tailor the range of fines so that the fine better fits a particular violation.

LEGISLATION

Future Legislation. At its July 1994 meeting, SPAEC discussed a possible 1995 legislative proposal to amend Business and Professions Code section 2532.2(c), which currently establishes a maximum requirement of 300 hours of supervised clinical practice in order to be licensed by SPAEC. The American Speech-Language Hearing Association (ASHA), the national accrediting body for training programs, has recently increased its minimum number of supervised clinical practice hours to 400. To bring California into conformity with ASHA's national accreditation standards, SPAEC hopes to sponsor a legislative amendment to section 2532.2(c) to increase the number of required clinical practice hours to 400. [14:4 CRLR 85] At SPAEC's October 28 meeting, however, staff noted that the Department of Consumer Affairs has declined to include the proposed amendment in its 1995 omnibus bill. While the proposal could theoretically be included in another bill, DCA noted that SPAEC's regulations require only 275 hours of supervised clinical practice, and suggested that—in the meantime—SPAEC revise its regulations through the rulemaking process to raise the number of hours to the current statutory maximum (see MAJOR PROJECTS).



RECENT MEETINGS

At its October 28 meeting, SPAEC discussed the increasing problem of speech and language "therapy" being offered by paraprofessionals and/or unlicensed individuals who have designed programs which do not conform to established speech-language standards. Many of these programs are offered by individuals with training in the behavioral sciences and directed at autistic and developmentally disabled children. According to SPAEC, these individuals are not licensed to practice speech-language pathology, and may pose a danger to those patients who genuinely need the assistance of a trained speech-language pathologist and present unfair competition for licensed speech-language pathologists. Because many of the people offering these programs have backgrounds in psychology, Executive Officer Richards agreed to ask the Board of Psychology and the Board of Behavioral Science Examiners whether their enabling acts permit licensees to provide speech-language services. SPAEC will address this issue in greater depth at a future meeting.

The Committee also discussed a request by a private audiology firm to allow audiology aides to perform public service "hearing screenings" at health fairs in the absence of licensed audiologists. Although the request was limited to preliminary evaluations rather than comprehensive testing, SPAEC denied the request because of the potential inability of the aides to detect "false normalcies" during the screening procedure.

FUTURE MEETINGS

January 20 in southern California.
April 7-8 in northern California.
July 21 in southern California.
October 27 in northern California.

BOARD OF NURSING HOME ADMINISTRATORS

Executive Officer:
Pamela Ramsey
(916) 263-2685

Pursuant to Business and Professions Code section 3901 *et seq.*, the Board of Nursing Home Administrators (BNHA), formerly the Board of Examiners of Nursing Home Administrators, develops, imposes, and enforces standards for individuals desiring to receive and maintain a license as a nursing home administrator (NHA). The Board may revoke or suspend

a license after an administrative hearing on findings of gross negligence, incompetence relevant to performance in the trade, fraud or deception in applying for a license, treating any mental or physical condition without a license, or violation of any rules adopted by the Board. BNHA's regulations are codified in Division 31, Title 16 of the California Code of Regulations (CCR). Board committees include the Administrative, Disciplinary, and Education, Training and Examination committees.

The Board consists of nine members. Four of the Board members must be actively engaged in the administration of nursing homes at the time of their appointment. Of these, two licensee members must be from proprietary nursing homes; two others must come from nonprofit, charitable nursing homes. Five BNHA members must represent the general public. One of the five public members is required to be actively engaged in the practice of medicine; a second public member must be an educator in health care administration. Seven of the nine members of the Board are appointed by the Governor. The Speaker of the Assembly and the Senate Rules Committee each appoint one member. A member may serve for no more than two consecutive terms.

On December 7, BNHA welcomed new member Diana Fortune, who was appointed by the Governor to fill the NHA position left vacant by Martha Lang; Fortune is the administrator of Las Flores Convalescent Hospital and owner of Marina Care Center. Also at the December meeting, public member Gloria Sutton-Clark announced her recent marriage and name change to Gloria Johnson.

MAJOR PROJECTS

BNHA Reviews Disciplinary Guidelines. As part of its ongoing effort to improve its disciplinary process, BNHA is developing an expert witness program (*see below*), drafting a memorandum of understanding with the Department of Health Services (DHS) for coordinated investigations (*see RECENT MEETINGS*), and preparing to adopt a set of disciplinary guidelines. [14:4 CRLR 85-86] Executive Officer Pamela Ramsey recently prepared the first draft of BNHA's proposed disciplinary guidelines, using similar guidelines developed by the Board of Psychology as a model. The document is intended to serve two purposes: It lets the public and the profession know the Board's policies and intent regarding disciplinary matters, and provides a tool to be used by investigators, the Attorney General's Office, and administrative law judges in adjudicatory proceedings.

BNHA's Disciplinary Committee reviewed the first draft of the proposed disciplinary guidelines at its October 21 meeting; the Committee made minor changes to the document, and presented the revised draft to the full Board for review at its December 7 meeting. However, BNHA Chair Dr. Orrin Cook explained that the draft had not yet been reviewed by all appropriate legal counsel, and thus was not ready for Board approval.

The draft disciplinary guidelines include, among other things, BNHA's policies for remedial disciplinary action in response to its receipt of citations issued against nursing home facilities by DHS; penalty guidelines (including recommended maximum penalties for specified violations of the Business and Professions Code); a section on reinstatement/penalty relief hearings; BNHA's complaint disclosure policy [14:2&3 CRLR 90]; and the guidelines for terms and conditions of probation it previously approved in March 1994. [14:4 CRLR 86; 14:2&3 CRLR 90] The California Association of Health Facilities (CAHF), a professional organization representing California licensed long-term health care facilities, previously objected to the Board's disciplinary guidelines and its guidelines for terms and conditions of probation on the basis that they constitute underground rulemaking in violation of the Administrative Procedure Act (APA). [14:4 CRLR 86] In an August 4 response to CAHF's protest, Department of Consumer Affairs (DCA) legal counsel Christopher Grossgart maintained that BNHA has not engaged in underground rulemaking; Grossgart stated that these guidelines do not constitute "regulations" as defined by the APA "because the Board does not apply them rigidly in every disciplinary action." Further, Grossgart opined that "the Board has no authority to adopt disciplinary regulations which purport to bind administrative law judges....Therefore, it is appropriate to view the guidelines as 'administrative suggestions' from the Board regarding appropriate penalty provisions and probationary terms." If CAHF wants to pursue the matter further, it has the option of filing a request for a regulatory determination with the Office of Administrative Law (OAL).

While reviewing the disciplinary guidelines at its December 7 meeting, BNHA made a number of revisions to the proposed language. For example, the first draft included a section which directed staff to send a warning letter to NHAs when Level A requirements for Medicare/Medi-Cal participation are not met; at its October meeting, the Disciplinary Committee had expressed concern as to whether such a letter