



to the Board for a vote in the most expeditious manner. Finally, Board members must—among other things—attend all Board and committee meetings regularly; have a thorough knowledge of all issues before voting; respond expeditiously to questions posed by officers of the Board; and prioritize consumer interest and protection prior to decisionmaking. Following discussion, BLA adopted the proposed position descriptions.

Also at its July 14 meeting, BLA elected public member Sandra Mandel to serve as vice-president. [15:2&3 CRLR 60]

■ FUTURE MEETINGS

February 2 in Ontario.

May 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 examina-

tions 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.

At this writing, the Board is functioning with four vacancies—each division lacks one physician member and one public member (*see* RECENT MEETINGS).

■ MAJOR PROJECTS

Arnett Resigns; MBC Hires New Executive Director. At the full Board's July 29 meeting, then-Executive Director Dixon Arnett announced his resignation effective August 30. Arnett left his post to take a cabinet-level position as Director of the Department of Aging offered by Governor Wilson.

Arnett inherited a sea of troubles when he began his tenure as MBC Executive Director on January 3, 1993. He replaced Ken Wagstaff, who resigned under pres-

sure in October 1992 during a six-month investigation by the California Highway Patrol of alleged improprieties within the Board's enforcement program. [13:1 CRLR 44-45] Only 17 days after Arnett began his job the CHP released its report, which revealed—among other things—that up to 300 complaints against physicians had been destroyed (instead of investigated) on the orders of top MBC officials.

Shortly after the report's release, Arnett and Department of Consumer Affairs (DCA) officials convened a "Medical Summit" of over 70 physicians, other health care practitioners, community and consumer group leaders, law enforcement representatives, and MBC members and staff to discuss proposed improvements to the Board's enforcement program. [13:2&3 CRLR 78-82] Many of the reforms proposed at the Summit—including the creation of mid-level sanctions (such as citations and fines and the public letter of reprimand) to supplement the Board's enforcement arsenal, improved public disclosure of physician information to inquiring consumers, a complete review and overhaul of the Board's use of medical experts and its own in-house medical consultants, enhanced investigative and prosecutorial staffing and resources, improvements to the Board's Diversion Program for substance-abusing physicians, and the development of a priority system for use in efficient complaint processing and investigation—have been implemented under Arnett's leadership. In a brief resignation speech, Arnett thanked Board and staff members for their support and assistance during his tenure; the Board appointed Deputy Director Doug Laue as Interim Executive Director.

On September 30, MBC hired Ron Joseph as its new Executive Director. Joseph has a 21-year career in public service. Most recently, he served four years as chief deputy director of the state Department of Health Services, where he was responsible for the management of program operations; together with the DHS Director, he established policy for the operation of the Medi-Cal program, primary care programs, public health services programs, and licensing and certification programs which oversee 5,000 facilities licensed to provide health care services.

Joseph began his new post on November 1, and attended his first Board meeting on November 3.

Board Finally Approves Concept of Fee Increase to Add Investigators, Decrease Case Processing Delay. At its July and November meetings, the full Board reconsidered staff's modified request for a fee increase, with the revenue dedicated



REGULATORY AGENCY ACTION

to replenishing MBC's contingency fund, increasing the number of DMQ investigative staff to meet a 23% increase in complaint volume over the past three years, and decreasing the time it takes the Board to process serious physician discipline cases. Because the Board's licensing fees are currently set at their statutory maximums (\$600 biennially, or \$300 per year), MBC must sponsor legislation to increase its fees.

MBC first considered staff's request at its May 1995 meeting, just prior to which the State Auditor had released a report stating that MBC is not maximizing its efforts to recover the costs of its enforcement and disciplinary system from disciplined licensees. Effective January 1, 1993, Business and Professions Code section 125.3 authorized MBC to request administrative law judges (ALJs) to direct physicians found to have violated the Medical Practice Act to reimburse the Board for its reasonable costs of investigation and enforcement of their respective cases up to dates of their hearings; in addition, MBC is not precluded from recovering costs incurred for investigation and enforcement of cases resolved through stipulated settlements. During fiscal year 1993-94, MBC spent more than \$25 million on enforcement and disciplinary efforts; of those costs, BSA opined that MBC could have attempted to recover more than \$6.3 million. However, MBC recovered only \$94,053 of its costs for that period. Following a review of this report, the Board rejected staff's request for a fee increase, instead instructing Enforcement Chief John Lancara to finance the needed positions with enhanced cost recovery. [15:2&3 CRLR 62-63]

Following the Board's May rejection of the fee increase concept, Lancara drafted a memo detailing all of the internal efficiency measures he has implemented to avoid a request for new staff, and more fully describing the 23% increase in complaint volume over the past three years with no commensurate increase in investigative staff. He noted that, while other agencies' investigators carry a caseload of 10 cases, MBC investigators carry an average of at least 32 cases. Because of the heavy caseload, MBC is experiencing difficulty retaining its experienced investigators and hiring new ones (who must be then trained and whose productivity is low during the training period). Despite the heavy caseload and the increased complexity of the cases being investigated and going to trial, DMQ's disciplinary output has increased: In 1992-93, 149 physicians were disciplined; in 1993-94, 227 physicians were disciplined; and in 1994-95, 353 physicians were disciplined (see

below). Lancara requested reconsideration of his proposal to increase fees to \$700 biennially (a \$50 annual increase) at the Board's July meeting.

At the July meeting, most members greeted the renewed request with hostility. Some physician members suggested that the legislature fund the Board's enforcement system through the general fund ("since the public is benefiting from the program, the public ought to pay for it") and that consumers be forced to pay for receiving MBC's information about physicians through a "900" number; others bemoaned the effect of the proposed \$50-per-year fee increase on the "shrinking income" of physicians. Dr. Lawrence Dorr and Dr. Clarence Avery questioned the efficiency of DMQ's investigators, suggesting that they simply aren't working hard and fast enough. Following discussion, the Board voted to delegate the issue to DOL to further investigate the matter and hold another hearing in November.

In August, Lancara outlined a modified fee increase proposal, accompanied by a detailed memo setting forth five issues for the Board to consider:

- MBC's contingency fund is dangerously low and not in compliance with Business and Professions Code section 2435(h), which requires that the Board maintain two months' worth of operating expenses in reserves. According to Lancara, by 1997-98, the operating fund will be depleted and show a \$558,000 deficit; to avoid the deficit, MBC needs to increase physician licensing fees by \$12 per licensee per biennial license renewal.

- To achieve full fund condition plus at least one month's worth of reserve funds (which is not in compliance with section 2435(h) but is MBC's historical level of reserves), MBC would need to increase fees by \$51 per licensee biennially.

- While most experts agree that investigator caseload should be at about 25 cases each, MBC's investigator caseload is at 32 cases each. This figure does not include an additional 11 cases per investigator which are pending at the Attorney General's (AG) Office and for which the investigator remains responsible, and at least 4 additional cases each to compensate for DMQ's 10% chronic investigator vacancy rate. These excessive caseload levels translate into an unacceptable investigation time delay of an average of 345 days in 1994-95 (see below). To reduce investigator caseload to 25 per investigator (not counting AG cases) and expedite the investigation of serious cases, DMQ needs 19 additional investigator positions, at a cost of \$23 per licensee biennially.

- To reduce investigator caseload to 25 per investigator including AG cases, DMQ needs 11 additional investigator positions, at a cost of \$13 per licensee biennially.

- To retain DMQ investigators in areas of the state where the Board is experiencing its highest turnover rate, Lancara proposed a pay differential for investigators in Los Angeles County and possibly elsewhere in southern California where personnel records demonstrative "intractable investigator retention conditions." The cost of this pay differential is \$200 monthly per investigator.

To raise this revenue, Lancara set forth several options: (1) an increase in the Board's current license fee, from \$600 to \$700 biennially (or \$50 per year); (2) a temporary fee increase which would act as a cash advance against enhanced cost recovery, coupled with vigorous efforts to obtain cost recovery; or (3) the strict implementation of the case prioritization system developed by Schubert & Associates, which will result in the Board's refusal to investigate certain types of "lower-priority" cases, such as aiding and abetting unlawful practice of medicine and unlicensed practice of medicine. Lancara expressed his desire to engage in vigorous cost recovery, but warned that the Department of Finance will not recognize enhanced cost recovery as a stable source of income until 1998-99, and that DMQ will not be successful in attaining the required amount of cost recovery without more investigators.

At DOL's November 2 meeting, members were greeted with a memo from the California Medical Association (CMA) announcing its opposition to any fee increase, whether characterized as permanent, temporary, or "cash advance." CMA stated that DMQ's increased disciplinary output has been the result of more work by (and more staffing for) the Attorney General's Office (not DMQ investigators), and that the Board is simply reducing the large "bubble" of cases which had backlogged over the past decade. Lancara and several Board members disputed the assertions in CMA's memo and accused CMA of distorting the issue; Board member Dr. Alan Shumacher reminded DOL members of the recent finding of the Federation of State Medical Boards that MBC has the largest number of complaints per licensee in the nation (122.5 complaints per 1,000 licensees, more than twice the average of other states). [15:2&3 CRLR 61-62]

Center for Public Interest Law representative Julianne D'Angelo Fellmeth testified in support of Lancara's request. She



noted that the Auditor General has spoken twice (1991 and 1995) on DMQ's excessive investigator caseload, yet the Board has failed to address this growing problem. She expressed discomfort about the "shrinking income" comments made by Board members at the July meeting, and reminded DOL members that their function as state officials is not to represent physicians' interests but to represent the public's interests. She noted that MBC's highest priority, as established by Business and Professions Code section 2229, is protection of the public; when that interest conflicts with some other interest, the other interest must take a back seat. She dismissed CMA's "bubble" theory, pointing to the 23% steady increase in complaint volume and noting that it takes DMQ an average of 44 months (or 3.8 years) to investigate a serious case involving a physician who has probably injured or killed at least one patient. She urged DOL to approve the full amount of the requested increase. Following discussion, the Division voted unanimously to recommend to the full Board that it sponsor legislation to increase the cap on physician licensing fees to \$700 biennially effective January 1, 1997; the actual biennial fee level will be set by rulemaking.

At the full Board's November 3 meeting, DOL President Dr. Tom Joas announced the Division's recommendation, noting that DOL had afforded a full opportunity for all interested persons to testify and that the discussion was "well-reasoned, unemotional, and thought-provoking." Without taking further testimony from audience members, the Board approved the Division's recommendation by a vote of 11-3. Board President Dr. Robert del Junco directed new Executive Director Ron Joseph to present a detailed justification for proposed actual fee increases at the February meeting.

Annual Report Reveals Unacceptable Delay in Case Investigation and Glaring Need for More Investigators. In October, MBC published its 1994-95 annual report, including a variety of statistics which indicate a slight improvement in certain aspects of the Board's enforcement performance over 1993-94. [14:1 CRLR 50] For example, DMQ took a total of 353 disciplinary actions against licensed physicians in 1994-95, up from 224 in 1993-94 and 149 in 1992-93. This jump in disciplinary actions is largely due to DMQ's adoption and use of two mid-level sanctions—DMQ issued 25 public letters of reprimand and 57 administrative citations in 1994-95.

The annual report indicates that DMQ filed 353 accusations against physicians in

1994-95, a decrease from 407 accusations in 1993-94. The number of temporary restraining orders (TRO) and interim suspension orders (ISO) sought by DMQ increased slightly to 24—from 21 in 1993-94 and 25 in 1992-93.

However, the glaring statistic in the Board's annual report concerns the average length of time which complaints spend in various Board stages prior to their disposition. Business and Professions Code section 2319 requires the Board to set a goal of disposing of disciplinary complaints within 180 days from receipt. According to the Board's 1993-94 annual report, DMQ's average was 190 days (93 days in DMQ's Central Complaint and Investigation Control Unit (CCICU) and an additional 97 days under investigation). According to the 1994-95 annual report, however, the Board's average soared to 436 days—91 days at CCICU and a whopping 345 days under investigation. Thus, the investigation time alone is almost double the legislative goal established in section 2319. This treble increase in investigative time came during a year in which investigator caseloads actually decreased slightly (from 33 active cases plus 23 AG cases in 1993-94 to 31 active cases plus 11 AG cases in 1994-95).

Further, the report indicates that DMQ's performance still pales in comparison to the number of external complaints and reports of physician incompetence and misconduct received by the Board. The number of consumer complaints about physicians lodged with the Board has increased by 10-15% per year for the last three years—from 6,050 in 1991-92, to 6,749 in 1992-93, to 7,902 in 1993-94, to 11,465 in 1994-95. Further, in 1994-95, DMQ received almost 1,000 reports of medical malpractice judgments or settlements in excess of \$30,000, six reports from coroners indicating that the cause of death was physician gross negligence or incompetence, and 114 "section 805" reports of adverse peer review actions by health care facilities. Thus, almost 11,500 physicians were the subject of consumer complaints and a total of 1,120 licensees were reported to DMQ for incompetence and/or misconduct in 1994-95, compared with only 353 administrative actions. These figures reflect a continuing performance problem in an area where incompetence, negligence, or misconduct can result in irreparable harm.

Board Amends Information Disclosure Regulation; CMA's Lawsuit Dismissed. At its July meeting, DMQ and the full Board both passed resolutions designating their intent to formally amend section 1354.5, Title 16 of the CCR, the reg-

ulation which codifies the Board's information disclosure policy. The Board originally adopted section 1354.5 at its February 1995 meeting, and submitted it to the Office of Administrative Law (OAL) on April 18; OAL approved the original version of the rule on October 26. While the original version was pending at OAL, however, MBC voted to amend the rule in an attempt to settle CMA's three-year-old pending litigation over the validity of the regulation. The language considered and approved by MBC at its July meeting—which was previewed by the Board at a closed session in May—was part of a draft settlement agreement worked out by CMA attorneys and the Attorney General's Office. [15:2&3 CRLR 60-61]

Under the revised version of section 1354.5, MBC will disclose to inquiring consumers the following information regarding any physician licensed in California:

(a) current status of the license, issuance and expiration date of the license, medical school of graduation, and date of graduation;

(b) "priority cases" which the Office of the Attorney General has "accepted" (see below);

(c) any public document filed against any physician and any disposition thereof, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, and public letters of reprimand. If the accusation has been withdrawn for any reason after public disclosure, MBC shall offer to the respondent physician the choice of (1) continued disclosure of both the accusation and the withdrawal, or (2) immediate termination of disclosure. An accusation which has been filed and later withdrawn shall be retained in MBC's files for a period of one year after the accusation was withdrawn;

(d) 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;

(e) discipline imposed by another state or the federal government reported to the Board on or after January 1, 1991, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer; and

(f) California felony convictions reported to the Board on or after January 1, 1991, including the nature of the conviction, the date of conviction, the sentence



(if known), the court of jurisdiction, and an appropriate disclaimer.

Subsection (b) above has been the stickler for MBC and CMA. Originally, MBC voted to disclose completed investigations which have been referred to the Attorney General at the time of referral. CMA challenged the constitutionality of this provision in its pending lawsuit. [13:2&3 CRLR 80-81] Following settlement negotiations, the two sides agreed to the language of subsection (b) above: "priority cases which the Office of the Attorney General has accepted." Under the revised rule, the term "priority case" means a case in which an accusation will be filed and which contains any of the following types of allegations: (1) sexual misconduct with two or more patients; (2) repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances; (3) fraud involving five or more patients being treated under the workers' compensation law; (4) drug or alcohol abuse by a physician and involving death or serious bodily injury to a patient; (5) an extreme departure from the standard of care which involves death or serious bodily injury to a patient, such that the physician presents a danger to the public; (6) gross negligence, involving death or serious bodily injury to two or more patients; (7) incompetence, involving death or serious bodily injury to a patient; or (8) cases in which the Attorney General's Office has decided to seek an interim suspension order or temporary restraining order to halt a physician's practice pending the conclusion of the disciplinary matter. The term "accepted" means that the Attorney General's Office has fully evaluated the case and has determined that all investigation necessary to file an accusation has been completed, that no referrals for non-prosecutory action (such as referral to the Diversion Program) are to be made, that an accusation will be filed, and the nature of the charges.

The draft settlement agreement included other terms and conditions sought by CMA, including an "enforcement rights" paragraph enabling CMA to enjoin any "material breach" of the settlement agreement. Under this provision, if in the future the Medical Board decides that it is in the public interest to amend its information disclosure regulation inconsistent with the language agreed to in the settlement agreement, the Board—by signing the draft settlement agreement—would be stipulating to an immediate preliminary injunction against the amended regulation. In other words, CMA would be given veto power over the Board's information disclosure regulation. The Board approved most of the proposed changes to its

information disclosure regulation but expressly rejected the "enforcement rights" provision and instructed staff to return to the negotiating table to finalize the settlement. CMA rejected the settlement without the "enforcement rights" provision, and filed a motion for summary judgment which was briefed throughout the summer.

On September 8, Sacramento County Superior Court Judge James Ford heard the parties' cross-motions for summary judgment. In a ruling from the bench, Judge Ford dismissed CMA's challenge to the old version of the regulation as moot, and dismissed any challenge to the new version of the regulation as not ripe for review (see LITIGATION).

In the meantime, MBC published notice of its intent to formally amend section 1354.5 on September 1; both DMQ and the full Board held public hearings at their November meetings and approved the revised version. At the November hearings, CMA indicated support for the revised version subject to one addition: CMA wants the Board to publish a quarterly report noting the number of cases referred by DMQ to the AG in each of the "priority case" categories; the number of cases accepted by the AG in each of the "priority case" categories; the date of disclosure of each priority case; and the date an accusation is filed for each priority case. DMQ agreed to provide the report.

Board Sponsors Telemedicine Symposium. On September 29 in Sacramento, MBC cosponsored (with the California Telehealth/Telemedicine Coordination Project) an educational symposium on telemedicine called "Toward the 21st Century." The symposium was organized by the Board's Committee on Telemedicine.

Telemedicine is the practice of medicine employing the technological revolutions in telecommunications; it involves the electronic transmission of medical images or the use of two-way video communications in patient care—and it frequently crosses state lines. The forecasted benefits of telemedicine are better access to health care for populations with limited access under current delivery systems, more rapid access to specialized care, lower patient care cost, better quality control, and continuing "hands on" medical training of remote primary care practitioners. However, telemedicine presents legal problems and carries risks as well—in addition to quality of care and initial cost concerns, telemedicine must somehow be reconciled with individual state licensing schemes, medical records confidentiality issues, medical malpractice and accountability questions, and the ever-present po-

tential for fraud which drives up health care costs. [15:2&3 CRLR 65-66]

At the symposium, one presenter played a videotape of telemedicine in which physicians from three different geographic locations contributed medical advice with respect to the diagnosis and treatment of an auto crash victim. Aside from its use to diagnose and treat patients, telemedicine may also be used to test applicants for licensure. Another presentation demonstrated a licensing exam which could not only test an applicant's knowledge of medicine but also present the examinee with an actual case study of a patient, in which the examinee could "see" the patient, "order" tests, "diagnose" the patient's condition, and treat the patient accordingly.

Following the daylong symposium, the Board's Committee on Telemedicine convened on September 30 and November 1 to discuss several legal issues presented in depth. Committee members noted that telemedicine can be divided into two types: teleconsulting and telepractice. Physicians have been "teleconsulting" for years—they do so every time they telephone one another to discuss a patient's condition and debate the best treatment approach. Telepractice, however, is a new concept. At present, it may involve a physician reading and diagnosing X-rays of another physician's patient; in the future, it may involve surgeons "operating on" patients miles away through the use of telecommunications technology and remote-controlled robotic arms. Committee members noted that telepractice is occurring now, and that legislation may be needed to ensure patient protection, proper physician licensure and accountability, and patient records confidentiality.

At its November meeting, the Committee reviewed staff's legal analysis of the Federation of State Medical Boards' (FSMB) "Model Act to Regulate the Practice of Telemedicine or Medicine By Other Means Across State Lines." According to FSMB, physicians who practice medicine across state lines without physically being located in the state where the patient encounter occurs are either required to have a full and unrestricted license in that state or are unregulated; "[i]t is unacceptable to allow this type of practice to be unregulated, thereby denying the protection of the state to its citizens." FSMB's model act proposes a limited licensure process for physicians who "regularly" engage in the practice of medicine across state lines; each state medical board would define what constitutes the "regular" practice of telemedicine, and the requirements for such limited licensure (which may simply be full and unrestricted licensure in the



physician's resident state). After noting that some states have enacted legislation which has the effect of stifling the practice of telemedicine, the Committee directed staff to develop language for a "registration" or "limited licensure" process whereby telemedicine could be practiced but patients would be protected and the Medical Board would have jurisdiction over the out-of-state physician who is practicing medicine on California residents. At this writing, staff's proposal is scheduled for discussion at the Committee's February meeting.

Quality of Care in a Managed Care Environment. The Board's Committee on the Quality of Care in a Managed Care Environment, chaired by DMQ member Dr. Carole Hurvitz, met on July 27, September 30, and November 1 to continue its identification and discussion of quality of care issues impacted by the managed care environment. [15:2&3 CRLR 65]

At its July meeting, the Committee reviewed existing laws regulating managed care organizations and the quality of care in the managed care environment; managed care organizations, or "health care service plans" (HCSPs) as they are called in California, are regulated by the Department of Corporations (DOC) under the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 *et seq.* Section 1367(d) requires managed care organizations to "furnish services in a manner providing continuity of care and ready referral of patients to other providers at such times as may be appropriate consistent with good professional practice." Section 1367(g) states that a plan must "be able to demonstrate to [DOC] that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management." For purposes of determining a course of treatment, the benchmark is "medical necessity" as that term is found in sections 1371.4 and 1375.1—a HCSP must provide care which is "medically necessary." However, existing law sets forth no standards or guidance to plans on the definition or determination of "medical necessity."

Also at the July meeting, a panel of experts on managed care addressed the Committee. The presenters were Wade M. Aubry, MD, Senior Vice President and Medical Director of Blue Shield of California; Marie G. Kuffner, MD, Chief of Medical Staff at UCLA and a representative of CMA; and Gary Mendoza, Commissioner of the Department of Corporations.

Dr. Aubry emphasized that a course of treatment afforded to plan enrollees is rec-

ommended by the patient's primary care physician (or referred specialist within the plan) and determined by the plan's "medical director," who is usually a physician employee of the plan; the precise medical services afforded are based directly on (1) the terms of the plan's contract, and (2) the plan's definition of "medical necessity." "Experimental services" may be defined and excluded by the plan's contractual language. Dr. Aubry opined that when a physician is acting as "medical director" and making decisions about treatment, he/she is not "practicing medicine" subject to the disciplinary jurisdiction of the Medical Board; instead, the quality of care delivered to plan enrollees is evaluated by DOC, and MBC should not duplicate the role of DOC.

Dr. Kuffner noted that quality of care in the managed care environment is an issue of growing concern to practicing physicians and to CMA; she stated there is "increasing pressure on us to recognize that we are not free to make any decision we might have in the past. We're very restricted—we have to follow the plan, but also advocate for the patient's needs." Dr. Kuffner stated that both CMA and the AMA have advocated strongly that the treating physician must participate in treatment decisions to ensure that care is not denied where needed. She argued that physicians are increasingly being "deselected" from plans because they advocate for their patients' needs; "insofar as physicians advocate appropriately for their patients, they should not be retaliated against." She appeared to disagree with Dr. Aubry in contending that a physician who functions as a medical director making treatment authorization decisions is practicing medicine, but suggested that MBC should not discipline such a physician solely because a plan denies coverage for care unless there is a pattern of treatment denial by the plan.

Commissioner Mendoza noted that DOC's regulation of health care is extremely significant—17 million Californians receive primary care through regulated health care service plans, and 23 million Californians receive specialty care through DOC's regulated specialty plans. He stated that DOC focuses on the system of the delivery of health care, not on the performance of individual physicians. He acknowledged that DOC does not have a strong history or track record as a consumer protection agency, but stated that several efforts are under way to assist consumers in dealing with HCSPs, including the establishment of a toll-free number to enable consumers to ask questions and lodge complaints about managed care; the

development of a database to enable DOC to track patterns of complaints within plans, providers (groups), and—ultimately—individual physicians; and the development of a grievance process to assist both physicians and patients in securing satisfactory treatment (*see* LEGISLATION).

By its November meeting, the Committee had prepared a lengthy discussion paper setting forth 26 issues identified through public hearings, research, and articles and news stories on the quality of care in the managed care environment and the participation of physicians in such care systems. The issues identified include the following: (1) State law contains no required qualifications for individuals who serve as "medical directors" and make treatment authorization decisions; (2) state law does not even require the medical director to hold a valid license from MBC; (3) state law contains no standards for determining "medical necessity"; (4) although Business and Professions Code section 2056 generally prohibits plans from discriminating against physicians who advocate for their patients, it fails to include sanctions which adequately deter plans from doing so; and (5) plans often shield physicians from discipline by the Board by refusing to name them in arbitration agreements, and failing to report them to the Board when required to do so under Business and Professions Code section 800 *et seq.* The Committee vowed to continue its discussion of these and other issues, and directed staff to draft a position statement regarding the quality of care in the managed care environment. The statement is to be based on a similar provision adopted by North Carolina, and will convey the message that the quality of health care provided should be the same regardless of the system used to deliver that care. The Committee also passed motions (1) directing staff to work closely with DOC in seeking an amendment to section 2056 to add penalties for its violation, and (2) recommending to the full Board that it sponsor legislation requiring that medical directors employed by HCSPs and who are responsible for medical decisionmaking have a current unrestricted California license.

Implementation of Lay Midwife Licensure Program. DOL is in the process of completing its implementation of SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires the Medical Board to establish a licensure program for lay midwives. [15:2&3 CRLR 64-65; 15:1 CRLR 64-65; 14:4 CRLR 66-67]

Under SB 350, which added section 2505 *et seq.* to the Business and Profes-



sions Code, 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.

Under section 2512.5, the "comprehensive licensing examination" required in option (1) above must be "equivalent, but not identical, to the examination given by the American College of Nurse-Midwives." At its July meeting, DOL reviewed an evaluation of the examination developed by the North American Registry of Nurse-Midwives (NARM); the evaluation was prepared by Dr. Norman Hertz of DCA's Office of Examination Resources (OER). According to Dr. Hertz, the content of the two exams is similar, but the NARM exam does not meet California's psychometric standards for licensing examinations. DOL agreed with OER's recommendation not to accept the NARM exam in its current version, but directed staff to assist NARM staff in revising the written exam to meet California standards. At DOL's November meeting, Program Manager Neil Fippin reported that Dr. Hertz has been working closely with the authors of the NARM exam to develop a valid exam, and hopes to present a final report and recommendation at DOL's February 1996 meeting.

SB 350 also 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:

- On June 30, OAL approved DOL's revised version of new section 1379.10 (Application for Licensure as a Midwife). [15:2&3 CRLR 64; 14:4 CRLR 67]

- On August 14, OAL rejected DOL's adoption of new section 1379.15, which would establish the minimum hours of verified clinical experience required for lay midwife licensure. [15:2&3 CRLR 64; 15:1 CRLR 65; 14:4 CRLR 67] Among other things, OAL found that DOL had not demonstrated necessity for the proposed action, and that the language of the regulation was more broad than the statute it purports to implement.

Following OAL's rejection, DOL staff prepared a modified version of section 1379.15. The modified language would require approved midwifery education programs to verify 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 post-

partum visits within the first five days after birth, 20 newborn assessments, and 40 postpartum/family planning/gynecology visits.

Section 1379.15 also notes that a person may obtain educational credit by examination for previous midwifery education and clinical experience, and states that an applicant for licensure on or before December 31, 1997 who relies on such education and experience as his/her sole qualifications for taking the licensing exam must have obtained all of the experiences described above within ten years immediately preceding the date of application. A person who applies for licensure on or after January 1, 1998 who is relying upon credit by examination for previous education and experience as his/her sole qualification for taking the exam must have obtained at least 50% of the experiences described above within five years immediately preceding the date of the application. [15:1 CRLR 65; 14:4 CRLR 67]

DOL released its modified language of section 1379.15 for a 15-day comment period on November 1; at this writing, the Division has not yet resubmitted the regulation to OAL.

- On August 15, OAL disapproved DOL's adoption of new section 1379.20, which would require 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." [15:2&3 CRLR 64; 15:1 CRLR 65] OAL rejected the proposed language for lack of clarity.

Following OAL's rejection, DOL staff prepared revised language which would require the disclosure to be made to the client "on the first visit or examination." DOL released the revised version for a 15-day comment period on November 1; at this writing, the Division has not yet resubmitted the regulation to OAL.

- On October 5, OAL approved DOL's adoption of section 1379.11, Title 16 of the CCR, which sets forth the processing times for applications for licensure as a lay midwife. [15:2&3 CRLR 64]

- On November 28, OAL disapproved DOL's adoption of new section 1379.21, Title 16 of the CCR, which would establish the respective duties of a supervising physician and a licensed lay midwife regarding communication, practice guidelines, case review, a plan for emergency transport and care when needed, and record retention. [15:2&3 CRLR 64] OAL found that the proposed language failed to meet the clarity and necessity standards of Government Code section 11349.1, and that DOL failed to adequately respond to several public comments. At this writing,

DOL is reviewing the language for possible modifications.

- On November 28, OAL approved DOL's adoption of new section 1379.22, which requires 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." [15:2&3 CRLR 64-65; 15:1 CRLR 65]

In November, MBC announced that two lay midwives have finally been licensed in California—two years after the enactment of SB 350; both candidates were licensed through reciprocity with the state of Washington.

Other MBC Rulemaking. The following is a status update on other rulemaking proceedings undertaken by MBC's divisions, some of which have been discussed in detail in previous issues of the Reporter:

- **Date of Filing Applications for Examination.** At its July meeting, DOL voted to amend section 1305, Title 16 of the CCR; the amendment would require licensure applicants to file completed applications at DOL's Sacramento office at least 100 days prior to the date of the written exam or oral exam, if required, desired to be taken. On August 29, DOL staff submitted the rulemaking file on this proposed change to OAL for review and approval; however, staff withdrew the file on October 12 due to problems with the language. The Division subsequently dropped this proposal.

- **Citations and Fines Against RDOs.** Also at its July meeting, DOL amended section 1399.276, Title 16 of the CCR, which lists the various provisions of the Business and Professions Code the violation of which justifies the issuance of a citation and fine against a registered dispensing optician (RDO) by the Program Manager of MBC's Registered Dispensing Optician Program. DOL amended section 1399.276 to add Business and Professions Code sections 2553, 2556.5, and 2559.2(e) as provisions whose violation may justify a citation and/or fine against a RDO. At this writing, the rulemaking file on the proposed amendments is pending review by the DCA Director, after which it will be submitted to OAL.

- **Amendments to Citation and Fine Regulations.** At its July meeting, DMQ considered staff's proposal to amend sections 1364.10-14, Title 16 of the CCR, the Division's citation and fine regulations. The regulations currently list 56 provisions of law the violation of which is a "citable offense." Staff proposed to add



19 new code sections to the list of citable offenses, and adopt new subsection 1364.15, which would provide that citation and fine information will be disclosed to the public for a period of five years from the date of issuance, after which it will be purged.

At the July meeting, CMA objected to the addition of most of the new code sections as citable offenses, and also objected to proposed subsection 1364.15. DMQ decided to add as new citable offenses only those code sections to which there was no objection, and approved the addition to section 1364.11 of Business and Professions Code sections 119 (license offenses), 730 (acting as qualified medical evaluator without certification), 2097 (failure to report financial interest in health-related facility upon license renewal), and 2238 (violation of federal or state drug laws); Penal Code section 11166 (failure to report child abuse); and Health and Safety Code section 11168 (failure to retain prescription records). DMQ declined to adopt new subsection 1364.15, and referred it and the remaining disputed code sections to a subcommittee.

On December 6, OAL approved DMQ's addition of the six new code provisions to section 1364.11.

• **Implementation of AB 595 (Speier): The Accreditation of Outpatient Surgery Settings.** At its May 1995 meeting, DOL adopted new Article 3.5 (sections 1313.2–1313.6), Title 16 of the CCR, to implement AB 595 (Speier) (Chapter 1276, Statutes of 1994). Commencing July 1, 1996, AB 595 prohibits physicians from performing surgery in an outpatient setting using specified anesthesia unless the setting is one of enumerated health care settings, including a setting accredited by an accreditation agency, unless that accreditation agency is approved by DOL; the bill requires DOL to adopt standards for the approval of accreditation agencies to perform accreditation of outpatient settings. [15:2&3 CRLR 63–64; 14:4 CRLR 69]

Currently, three agencies in California credit outpatient settings: the Accreditation Association for Ambulatory Health Care, the Joint Commission on Accreditation of Health Care Organizations, and the American Association for the Accreditation of Ambulatory Surgery Facilities. These agencies must now be approved by DOL under new Article 3.5. New section 1313.2 defines the terms "accredited" and "accreditation agency"; new section 1313.3 sets forth processing times for applications for DOL approval filed by accreditation agencies; new section 1313.4 requires accreditation agencies to meet the

standards set forth in Health and Safety Code sections 1248.4 and 1248.15, and requires agencies to forward to DOL a copy of any certificates of accreditation issued within fourteen calendar days of issuance; new section 1313.5 addresses renewal of DOL approval; and new section 1313.6 sets forth the fees which DOL will charge—\$2,000 for temporary approval as an accreditation agency, \$5,000 for approval as an accreditation agency, and a renewal fee calculated at \$100 per outpatient setting accredited or reaccredited during the three years immediately preceding the filing of the renewal application.

However, OAL rejected new Article 3.5 on August 28, primarily because it found that sections 1313.3 and 1313.4 are unclear. DOL clarified the language and released it for a 15-day comment period on October 23; on December 8, the Division resubmitted the regulatory package to OAL, where it is pending at this writing.

• **Performance of Ophthalmic Tasks by Medical Assistants.** At its May 1995 meeting, DOL adopted amendments to section 1366, Title 16 of the CCR, which defines the technical supportive services which may be performed by unlicensed medical assistants (MAs). The amendments would permit MAs to perform ophthalmic testing which does not require interpretation in order to obtain test results; delete existing subsection 1366(d) (which prohibits MAs from practicing optometry) as duplicative of existing law; and add a specific reference to Business and Professions Code section 2069 (which prohibits MAs from administering any local anesthetic agents). [15:2&3 CRLR 65; 15:1 CRLR 65–66] At this writing, the rulemaking file on DOL's amendments is pending review by the DCA Director, after which it will be submitted to OAL.

• **Performance of Physical Therapy by Medical Assistants.** Also May 1995, DOL adopted another proposed change to its MA regulations—this time, the Division repealed subsection 1366(e), which states that "[n]othing in these regulations shall be construed to authorize a medical assistant to practice physical therapy." [15:2&3 CRLR 65] At this writing, the rulemaking file on DOL's repeal of this subsection is pending review by the DCA Director, after which it will be submitted to OAL.

■ LEGISLATION

SB 609 (Rosenthal) is DMQ's omnibus bill containing many desired legislative changes relating to the Medical Board's physician discipline system. [15:2&3 CRLR 66; 15:1 CRLR 67]

On July 28, DMQ considered three proposed amendments to the bill presented by the Center for Public Interest Law, which has long been concerned with the excessive number of steps in the physician discipline process and the absence of standards to guide DMQ in its decisionmaking process. [14:4 CRLR 1, 64; 9:2 CRLR 1] CPIL suggested that SB 609 be amended to (1) require DMQ to be bound by the ALJ's findings of fact in considering proposed decisions; (2) require four votes (instead of one) to "hold" a proposed decision for discussion at the next Panel meeting; and (3) require DMQ to adopt regulations governing the conduct of oral argument following the nonadoption of a proposed ALJ decision. DMQ rejected all three proposals, but two were enacted in part and the third (protocols for oral argument) was approved informally by DMQ later on at its July meeting (*see* RECENT MEETINGS).

As amended September 6, SB 609 makes (among others) the following changes:

- amends Business and Professions Code section 2335 to require DMQ, in reviewing a proposed ALJ decision in a disciplinary proceeding, to give "great weight" to the findings of fact made by the ALJ;

- amends Business and Professions Code section 2337 to provide that appellate court review of the decision of a superior court on a respondent physician's petition for writ of mandate challenging a DMQ disciplinary decision is by way of a petition for extraordinary writ (discretionary); prior to this change in the law, full appellate court review was mandatory if requested;

- requires DMQ to afford oral argument after it nonadopts an ALJ decision;

- requires DMQ members to attend oral argument and read the entire record before voting to increase the penalty recommended by the ALJ;

- requires the vote of two Panel members in order to "hold" a proposed ALJ decision for discussion at a future panel meeting; currently, only one vote can "hold" a decision;

- amends Business and Professions Code section 125.9 to increase the maximum fine which may be assessed by DMQ for fraudulent billing to \$2,500 per violation or count (instead of \$2,500 per inspection or investigation);

- adds new provisions requiring physicians to report to MBC the bringing of an indictment or information charging a felony against him/her or the conviction of any felony; and requiring prosecutors to notify court clerks that a defendant is a licensed physician;



REGULATORY AGENCY ACTION

- requires malpractice insurers to send a complete report to MBC regarding judgments against a physician in excess of \$30,000 within certain time limits, and requires insurers to provide copies of certain records and documents with the required report subject to reasonable costs to be paid by MBC;

- requires 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;

- authorizes civil penalties to be assessed against health care facilities for failure to provide requested medical records to MBC under certain circumstances;

- includes counties and other public entities within those employers of physicians which must report malpractice judgments and settlements or arbitration awards to MBC; and

- authorizes MBC to request that a physician whose license is put on probation be required to pay the costs of probation monitoring.

SB 609 was signed by the Governor on October 10 (Chapter 708, Statutes of 1995).

AB 1471 (Friedman) is DOL's omnibus bill containing many desired legislative changes relating to the Medical Board's licensing program. [15:2&3 CRLR 66; 15:1 CRLR 67] As amended June 19, AB 1471 makes (among others) the following changes:

- requires MBC to charge each applicant who is required to take the oral examination as a condition of licensure a fee equal to the amount necessary to recover the actual cost of that exam;

- authorizes DOL to prepare and mail to every licensee a questionnaire containing any questions necessary to establish that the physician has no physical, emotional, or behavioral disorder that would impair his/her ability to practice medicine;

- revises the requirements and procedures in section 2111 under which foreign physicians engaged in postgraduate training in an approved medical school may be granted permission to engage in the limited practice of medicine; and

- eliminates obsolete references to the Division of Allied Health Professions, which was abolished in SB 916 (Presley) (Chapter 1267, Statutes of 1993).

AB 1471 was signed by the Governor on August 2 (Chapter 279, Statutes of 1995).

SB 454 (Russell), as amended August 29, requires every health care service plan (HCSP) to include in its contracts with

providers a dispute resolution system for the submission of disputes to the plan by providers (*see* MAJOR PROJECTS); allows subscribers and enrollees, or their agents, to submit a grievance to the Department of Corporations (DOC) for review after compliance with certain procedures, and requires the HCSP to provide notice of this right to subscribers or enrollees in a prescribed manner; authorizes DOC to refer any grievance or complaints to other appropriate state and federal entities for investigation and resolution, and requires DOC to refer any grievance or complaint involving a Medi-Cal enrollee to the state Department of Health Services for investigation and resolution; and authorizes a provider to join with, or otherwise assist, a subscriber or enrollee submitting the grievance or complaint to DOC and to assist with DOC's grievance process.

The bill also requires DOC to review the documents submitted, authorizes DOC to request additional information and to hold meetings with the parties, and requires DOC to send a written notice of the final disposition of the grievance and the reasons therefor to the subscriber or enrollee, or their agent, and the plan within sixty calendar days. This bill requires that distribution of the written notice not be deemed a waiver of any exemption or privilege under existing law for any information disclosed in connection with the written notice, and prohibits any person employed or in any way retained by DOC from being required to testify regarding that information or notice.

This bill requires the DOC Commissioner, on or before January 1, 1997, to establish and maintain a system of aging of complaints that are pending and unresolved for 60 days or more; authorizes the subscriber or enrollee, or their agent, to request voluntary mediation with the plan prior to exercising their right to submit a complaint or grievance to DOC, and provides that choosing to use mediation services would not affect that right; requires, on or before January 1, 1997, a HCSP's grievance system to include a system of aging of complaints that are pending and unresolved for thirty days or more; and provides that the procedures authorized by the bill are in addition to other procedures that may be available, and that failure to pursue or exhaust the remedies or to engage in the procedures described shall not preclude the use of any other remedy provided by law.

This bill also authorizes the Commissioner to contract on a noncompetitive bid basis with necessary medical consultants to assist with DOC's health care program,

and exempts these contracts from certain provisions of the Public Contract Code. This bill was signed by the Governor on October 12 (Chapter 788, Statutes of 1995).

SB 779 (Lewis), as amended April 17, is an MBC-sponsored bill to legislatively repeal judicial language in *Kees v. Board of Medical Quality Assurance*, 7 Cal. App. 4th 1801 (1992). [15:1 CRLR 63-64] The *Kees* decision states that physicians formally admitted into MBC's Diversion Program for substance-abusing licensees are immune from any MBC prosecution or investigation. This bill clarifies that immunity will be granted only for violations of the Medical Practice Act which are based primarily on the self-administration of drugs or alcohol under Business and Professions Code section 2239, or the illegal possession, prescription, or non-violent procurement of drugs for self-administration, and which do not involve actual harm to the public or the physician's patients. This bill also establishes additional procedures relating to participation in the Diversion Program and the further investigation and discipline of a physician who is in the Program. This bill was signed by the Governor on August 1 (Chapter 252, Statutes of 1995).

SB 682 (Peace). Existing law requires MBC, the State Bar, and the Board of Chiropractic Examiners to each designate employees to investigate and report to the Department of Insurance's Bureau of Fraudulent Claims any possible fraudulent activities relating to motor vehicle or disability insurance by licensees of the boards or the Bar. As introduced February 22, this bill requires, in addition, that those entities investigate and report any possible fraudulent activities relating to workers' compensation. This bill was signed by the Governor on July 22 (Chapter 167, Statutes of 1995).

AB 1864 (Morrow). The Physician Ownership and Referral Act of 1993 prohibits a licensee (defined to include physicians) from referring a person for certain health care services if the licensee has a financial interest, as defined, with the person or entity that receives the referral. Existing law exempts from this prohibition a licensee or a payer to the extent the licensee or payer is subject to similar prohibitions on referrals for health care services paid pursuant to the provisions governing workers' compensation. As amended May 4, this bill makes a clarifying change by revising this exemption to instead exempt referrals that are subject to the similar prohibitions on referrals for services covered pursuant to the law governing workers' compensation.



Existing law also exempts from this referral prohibition referrals where there is no alternative provider, or referrals when the person referring has certain ownership interests in the entity to which the referral is being made. This bill revises, clarifies, and broadens these exemptions and provides that the referral prohibition does not apply in certain instances involving pathological examination services, diagnostic radiology services, and radiation therapy. This bill was signed by the Governor on July 31 (Chapter 221, Statutes of 1995).

AB 281 (Kuehl), as amended April 25, would change the composition of MBC by requiring that it consist in majority of public members. It would prohibit any public member appointed to the Board from having any financial interest in the medical profession, and would require at least two of the nonpublic board members to be persons who serve a substantial number of low-income patients in their practice of medicine. This bill was rejected on July 10 by the Senate Business and Professions Committee, where it is being held. [S. B&P]

AB 1107 (Campbell), as amended August 28, authorizes a pharmacist to dispense replacement contact lenses in accordance with certain requirements; these requirements will be applicable to nonresident pharmacists.

Existing law requires nonresident pharmacies, as defined, to register with the Board of Pharmacy and to disclose certain information to the Board and provides for the denial, revocation, and suspension of nonresident pharmacy registration for failure to comply with certain requirements. This bill adds the requirements for dispensing replacement contact lenses to the requirements for which nonresident pharmacy registration may be denied, revoked, or suspended. The bill requires that nonresident pharmacies comply with certain requirements, maintain certain records, and disclose certain information to the Pharmacy Board. This bill also adds the requirement that those pharmacies maintain records of all replacement contact lenses shipped, mailed, or delivered to California residents. The bill requires that these records be available for inspection upon request by the Pharmacy Board or MBC's Division of Licensing.

This bill also requires any pharmacy, including nonresident pharmacies, dispensing replacement contact lenses to comply with certain laws governing advertising of contact lenses, and to register with MBC at the time of initial licensure or registration or upon renewal of the license or registration. This bill was signed

by the Governor on October 9 (Chapter 719, Statutes of 1995).

SB 640 (Craven), as amended August 29, prohibits, commencing January 1, 1997, any person located outside of California from shipping, mailing, or delivering contact lenses to residents of California unless registered with DOL, and provides that only replacement lenses may be shipped, mailed, or delivered to a patient; requires nonresident contact lens sellers to complete an application, pay prescribed licensure and renewal fees, and satisfy various conditions in order to obtain and maintain registration; provides that contact lenses may be sold only within one year of the date on the written prescription, and if the written prescription is unavailable to the seller, it requires the seller to directly communicate with the prescriber or his/her authorized agent to confirm the prescription; sets forth circumstances under which registration may be denied, suspended, or revoked, and establishes procedures for renewal of registration; and authorizes DOL to adopt regulations necessary to administer these provisions. This bill was signed by the Governor on October 12 (Chapter 853, Statutes of 1995).

AB 1974 (Friedman). Business and Professions Code section 805 requires the chief of the medical staff or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic to file a report to the appropriate licensing authority in certain situations, including but not limited to when specified healing arts practitioners have been denied staff privileges or membership, or had their membership, staff privileges, or employment terminated, revoked, or restricted for a medical disciplinary cause or reason. As amended July 19, this bill would require DMQ to investigate the underlying circumstances of any report received pursuant to those provisions within 30 days.

Existing law provides for DMQ's establishment of Diversion Evaluation Committees, and specifies the duties of those committees. Existing law also authorizes a licensing agency to order a licensee to be examined by one or more physicians or psychologists whenever it appears the licensee may be unable to practice his/her profession safely because of mental or physical illness. This bill would require peer review bodies that review physicians to report certain information regarding investigations of physicians who may be suffering from a disabling mental or physical condition,

within fifteen days of initiating an investigation, to MBC's Diversion Program. This bill would require the Diversion Program administrator to monitor the peer review body's investigation and to notify DMQ's chief of enforcement of the investigation in certain cases. This bill would also require MBC to adopt regulations regarding the implementation of these provisions on or before January 1, 1997. [S. B&P]

SB 1119 (Watson), as amended June 13, would provide that if a licensed psychiatrist or psychologist is appointed as an expert witness by a court in a matter relating to child custody, no court-directed activity by that person within the scope of that appointment may be the subject of any disciplinary investigation or action by his/her licensing body, except for acts of unprofessional conduct constituting gross negligence. [S. Jud]

SB 497 (Maddy). AB 595 (Speier) (Chapter 1276, Statutes of 1994) prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting, as defined, unless the setting is one of certain enumerated settings including an outpatient setting that is accredited by an accreditation agency, as defined, that has been approved by DOL (*see* MAJOR PROJECTS). Under AB 595, DOL is required to ensure that accreditation agencies include prescribed standards for outpatient settings in their certification programs. Existing law authorizes outpatient settings that have multiple service locations to have all service sites surveyed or a sample of sites surveyed for purposes of accreditation. As amended July 5, this bill would clarify those provisions governing accreditation of outpatient settings with multiple service locations.

This bill would, as an alternative to the certification of an outpatient setting by an accreditation agency, establish procedures for the registration of outpatient settings operated by integrated health care delivery systems and make such outpatient settings exempt from AB 595's prohibition against operating, managing, conducting, or maintaining an outpatient setting which is not accredited by an accreditation agency approved by DOL. [A. Health]

AB 1147 (Friedman). Existing law prohibits the for-profit referral of a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition; the presumption of a for-profit referral is created when the person or organization making the referral imposes a fee or charge for the referral. As introduced February 23, this bill would



specifically prohibit the for-profit referral of a person for diagnostic imaging services, as defined, and create the presumption of a for-profit referral when the person or organization making the referral imposes a fee or charge for the referral, including the making of any additional or mark-up charges to charges made by licensed health care professionals. [A. Appr]

SB 890 (Leslie). Existing law authorizes DMQ to investigate the circumstances of practice of any physician where there have been any judgments, settlements, or arbitration awards requiring the physician or his/her liability insurer to pay damages of \$30,000 or more. As introduced February 23, this bill would also authorize MBC to investigate the practice of any physician where his/her employer was required to pay those damages. [A. Health]

AB 1310 (Mazzoni) and AB 1080 (Martinez). Existing law authorizes an individual of sound mind and eighteen or more years of age to execute a declaration governing the withholding or withdrawal of life-sustaining treatment; existing law also authorizes an individual to appoint an attorney in fact to make health care decisions for that individual in the event of his/her incapacity pursuant to a durable power of attorney for health care. As introduced February 23, these bills would enact the Death with Dignity Act, which would authorize an adult who meets certain qualifications, and who has been determined by his/her attending physician to be suffering from a terminal disease, to make a request for medication for the purpose of ending his/her life in a humane and dignified manner. The bills would establish procedures for making these requests, and would further provide that no provision in a contract, will, or other agreement shall be valid to the extent it would affect whether a person may make or rescind a request for medication for the purpose of ending his/her life in a humane and dignified manner; prohibit the sale, procurement, or issuance of any life, health, or accident insurance or annuity policy, or the rate charged for any policy, from being conditioned upon or affected by the request; require that nothing in them be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and provide that action taken in accordance with the Act shall not constitute suicide or homicide; provide immunity from civil or criminal liability or professional disciplinary action for participating in good faith compliance with the Act; and provide that willful alteration or forgery of a request with certain intent, and coercion or exertion of undue influ-

ence on a patient to make a request, are felonies. [A. Jud; A. Jud]

AB 596 (Knight). Existing law exempts a physician from civil damages as a result of certain acts or omissions of the physician who in good faith renders emergency care at the scene of an emergency, emergency obstetrical services, emergency medical care at the request of another physician, or gives emergency instructions to paramedics. As introduced February 17, this bill would, in addition, exempt a physician, who in good faith and without compensation or consideration renders voluntary medical services at a privately operated shelter, as defined, from liability for any injury or death caused by an act or omission of the physician in rendering the medical services, as defined, when that act or omission does not constitute gross negligence, recklessness, or willful misconduct, and if certain conditions are met. [A. Jud]

AB 869 (Katz). The Medical Practice Act requires all applicants for a physician's certificate to take an examination, and requires DOL to keep the examination records on file for a period of at least two years. As introduced February 22, this bill would instead require DOL to keep the examination records on file for a period of at least three years. [A. Health]

AB 1727 (Bustamante). Existing law requires MBC to maintain a central file that includes information about each of its licensees regarding any conviction of a crime that constitutes unprofessional conduct, any judgment or settlement of a claim that injury or death was proximately caused by the licensee's negligence, error, or omission, public complaints, and disciplinary information. As introduced February 24, this bill would require MBC to annually prepare and issue a report to inform the public of all awards of \$50,000 or more based on judgments against a licensee for acts of medical malpractice. [A. Health]

SB 1166 (Mountjoy). The Therapeutic Abortion Act requires the Department of Health Services (DHS) to, by regulation, establish and maintain a system for the reporting of therapeutic abortions, as prescribed, and requires DHS to report to the legislature each even-numbered year its findings related to therapeutic abortions and their effects. As introduced February 24, this bill would repeal the above-described provisions, and instead would require a report of each abortion performed to be made to DHS on forms prescribed by it. The report, in the case of an abortion performed in a licensed facility, would be required to be completed by the general acute care hospital, clinic, or other li-

ensed facility, signed by the physician who performed the abortion, and transmitted to DHS. The report would be required to be completed and signed by the physician in the case of an abortion not performed in a licensed facility. The bill also would require a representative sample of tissue removed at the time of abortion to be submitted to a board eligible or certified pathologist, who would be required to file a copy of the tissue report with DHS and provide a copy to the facility where the abortion was performed or induced. The bill would require DHS to prescribe a form on which pathologists would be required to report to DHS and to the physician any absence of pregnancy, live birth, or viability.

The bill would require DHS to prepare an annual statistical report for the legislature based on the data gathered pursuant to the above-described provisions and based upon required reports of maternal deaths, and would provide that any person who willfully discloses any information obtained from the reports, except as otherwise authorized by law, is guilty of a misdemeanor.

This bill would require every facility in which an abortion is performed during any quarter year to file with DHS a report regarding the total number of abortions performed. The bill would require DHS, by regulation, to require that all reports of maternal deaths occurring within the state arising from pregnancy, childbirth, or intentional abortion state the cause of death and other information related to the woman's pregnancy, as prescribed.

The bill would require every physician who provides medical care or treatment to a woman who is in need of medical care because of a complication or complications resulting, in the good faith judgment of the physician, from having undergone an abortion or attempted abortion to prepare and file a report with DHS.

The bill would provide that any physician required to file a report, to keep any record, or supply any information, who willfully fails to do so is guilty of unprofessional conduct and his/her license to practice medicine and surgery is subject to suspension or revocation in accordance with procedures provided under the Medical Practice Act. The bill also would provide that any person who willfully delivers or discloses to DHS any report, record, or information known by him/her to be false is guilty of a misdemeanor. The bill would further provide for the suspension or revocation of a license of any person, organization, or facility who willfully violates any provision of the bill, as prescribed. [S. H&HS]



AB 235 (Burton), as introduced February 1, would provide that any licensed physician who knowingly files a false peer review action report with MBC pursuant to Business and Professions Code section 805 against another physician, and who is motivated from a desire to harm that physician in order to benefit economically, is guilty of unprofessional conduct. The bill would require, upon the receipt of a complaint by a physician that a report was filed under these circumstances, DMQ to request all records and documents relating to the peer review action from the health facility or clinic where the peer review action took place. It would require the health facility or clinic to provide the records and documents upon DMQ's request. [A. Health]

LITIGATION

In *Dixon Arnett v. William Dal Cielo*, 40 Cal. App. 4th 1807 (July 7, 1995), the First District Court of Appeal held that Evidence Code section 1157, which protects hospital peer review records from "discovery," is not applicable to administrative subpoenas of the Medical Board. [15:2&3 CRLR 69; 15:1 CRLR 59-60, 68; 14:4 CRLR 71] Relying on *People v. Superior Court (Memorial Medical Center)*, 234 Cal. App. 3d 363 (1991), in which the Second District held that section 1157 does not protect peer review records from criminal search warrants issued by law enforcement, the First District agreed with MBC that the term "discovery," as used in section 1157, applies to pretrial discovery in an adversarial civil malpractice suit. Both courts found that section 1157 was enacted by the legislature in immediate response to an appellate court decision in *Kenney v. Superior Court*, 255 Cal. App. 2d 106 (1967), wherein a hospital was ordered to disclose peer review records to a civil malpractice plaintiff, and found no convincing evidence that the legislature intended section 1157's ban to go further than that. The First District acknowledged the hospital's argument that its ruling may have a "chilling effect" on physicians' willingness to participate in peer review activities, but stated that the legislature should address that concern.

Two other recent decisions have addressed similar issues. The Sixth District Court of Appeal, confronted with the exact challenge presented in *Dal Cielo*, agreed with the First District in *Dixon Arnett v. Kenneth W. Pearce*, 38 Cal. App. 4th 1467 (Oct. 2, 1995). However, the Fourth District Court of Appeal, presented with a *Memorial Medical Center*-like challenge to the applicability of section 1157 in criminal proceedings in *Scripps Memo-*

rial Hospital v. Superior Court of San Diego County, 37 Cal. App. 4th 1720 (Aug. 31, 1995), disagreed with the reasoning in *Memorial Medical Center* (upon which the *Dal Cielo* ruling relied) and found that section 1157 provided "broad protection for the confidentiality of records of health providers who were covered before the [1982] adopt of Proposition 8...." Perhaps for this reason, the California Supreme Court has decided to review both *Dal Cielo* (Oct. 5, 1995) and *Pearce* (Dec. 21, 1995); because of the similarity of issues presented, only *Dal Cielo* is currently being briefed.

On September 8, Judge James T. Ford dismissed *California Medical Association v. Dixon Arnett, et al.*, No. 376275 (Sacramento County Superior Court), CMA's challenge to the Medical Board's original information disclosure policy adopted in 1993, as moot. CMA primarily objected to the Board's proposal to disclose its own completed investigations once it has decided to pursue disciplinary action and referred the case to the Attorney General's Office. [14:1 CRLR 50, 53-55; 13:4 CRLR 1, 56-57; 13:2&3 CRLR 79-81] On July 29, MBC decided to modify that provision; under the revised policy, it will disclose "priority cases" which have been referred to and "accepted" by the Attorney General's Office (see MAJOR PROJECTS). Because the Board has abandoned the policy at issue in CMA's lawsuit, and because the court found that MBC is acting in good faith in revising the policy and does not intend to revert to the original policy, Judge Ford dismissed CMA's challenge as moot. CMA does not challenge the amended policy in this action.

On May 24, DMQ issued a decision revoking the license of Dr. Leo Kenneally after hearing oral argument on a motion for reconsideration by the Attorney General's Office. In August 1994, DMQ originally adopted Administrative Law Judge Milford A. Maron's controversial proposed decision recommending a one-year suspension of Kenneally's license and ten years' probation; thereafter, the Attorney General filed a motion for reconsideration requesting revocation of Kenneally's license. [15:2&3 CRLR 69; 15:1 CRLR 68; 14:4 CRLR 71-72] At oral argument, the Attorney General argued for revocation due to two deaths and serious injuries to five other women resulting from abortions performed by Kenneally. Kenneally has vowed to appeal the revocation.

On May 17, MBC issued a first-ever citation and \$10,000 fine against a hospital administrator for failure to comply with Business and Professions Code section 805. That provision requires hospitals to submit a report to MBC when they take

adverse peer review action against a physician's admitting privileges; MBC's notice of violation alleges that Bryan Ballard, former chief executive officer of South Valley Hospital (SVH) in Gilroy, failed to file reports of internal hospital discipline taken by SVH against anesthesiologists Larry Weiss and James E. Pearson. The Board seeks a fine of \$5,000 per violation. Ballard has requested a hearing on the citation and fine; at this writing, the hearing is scheduled for July 29, 1996.

In issuing the citation and fine, MBC again demonstrated its concern about the dwindling number of "section 805 reports" filed with the Board by hospitals; in spite of recent legislation expanding the types of events which trigger the reporting requirement, the number of reports filed has tumbled from 249 in 1987-88 to only 114 in 1994-95 (see above). Compliance with section 805 is the only way MBC will know about the results of the otherwise-confidential peer review process in individual hospitals. A peer review action serves only to bar a physician from practicing at a particular hospital; the "section 805 report" is designed to inform the Medical Board of the action and enable it to investigate the events leading to the action and take warranted disciplinary action for the good of the general public. The Board cannot act, however, when it is deprived of information about the peer review process. In a recent issue of its *Action Report* newsletter, MBC characterized hospitals' failure to comply with section 805 as a "near crisis." [15:1 CRLR 59-60]

The Second District Court of Appeal's decision in *Baughman v. Department of Justice*, 40 Cal. App. 4th 398 (Oct. 23, 1995), demonstrates the importance to MBC licensees of maintaining a current mailing address on file with the Board. MBC served an accusation on Baughman by certified mail to his mailing address on file with the Board. The envelope was returned "unclaimed," with an indication that the post office sent three notices. Baughman failed to submit a timely notice of defense, and the Board revoked his license by default. Baughman later attacked the revocation on grounds he never received the accusation. Finding that MBC fully complied with the method of service authorized by Government Code section 11505(c), the court upheld the revocation, noting that "due process of law does not require actual notice, but only a method reasonably certain to accomplish that end."

RECENT MEETINGS

At the full Board's July 29 meeting, MBC said farewell to members DOL mem-



bers Dr. Fredrick Milkie and Ray Mallel, and DMQ members Dr. Clarence Avery and Gayle Nathanson, whose terms have expired. At this writing, these Board positions remain vacant.

At its July meeting, DOL unanimously disapproved the University of Health Sciences, Antigua (UHSA). This means that DOL will not accept coursework taken at UHSA on or after the date of the order of disapproval and that it will not license any person who graduates from UHSA after the order of disapproval. The disapproval order follows DOL's May 11 issuance of an "order to show cause" requiring the medical school to show cause why its curriculum should not be disapproved under Business and Professions Code sections 2101 and 2102. [15:2&3 CRLR 70] Following the issuance of the order to show cause, UHSA requested an extension of time in which to respond; because DOL has been corresponding with UHSA for almost three years and requesting information on its curriculum, members felt that the school has had ample time to respond and agreed to disapprove its curriculum. DOL also decided to visit two other medical schools in the Dominican Republic which have provided information to DOL and whose curricula are under consideration—Instituto Tecnológico de Santo Domingo (INTEC) and Universidad Eugenio Maria de Hostos (UNIREMHOS). These schools must pay the expenses of DOL members to perform the site visit.

At its July meeting, DMQ established new protocols for oral arguments following a Division panel's nonadoption of a proposed ALJ decision in disciplinary proceedings. The major changes include the sequence of argument and time limits. Under the new protocols, the respondent's attorney must argue first for a maximum of 15 minutes; then the Deputy Attorney General may argue for 15 minutes; respondent's attorney may have a 5-minute rebuttal; and the DAG may have a 5-minute rebuttal. The protocols also note that DMQ has requested the presence of an ALJ at all oral arguments following the nonadoption of a proposed decision and when it is reconsidering a decision; the ALJ is expected to preside over the proceeding and to provide legal and practical assistance to DMQ members. Oral argument must be based on evidence in the existing record; no new evidence will be heard. Panel members may ask questions of the parties, but may not ask questions which will elicit new evidence; the ALJ is expected to tell a panel member when a question is out of order and should not be asked, and to stop an attorney or party if the line of argument

is beyond the record or otherwise out of order.

Also at its July meeting, DMQ considered a recommendation by the Liaison Committee to Diversion on the qualifications of persons appointed to DMQ's Diversion Evaluation Committees (DECs), regional groups of physicians and non-physicians experienced in chemical dependency and recovery which determine admission into the Board's Diversion Program for substance-abusing licensees. The Liaison Committee recommended that candidates for appointment should meet three criteria: (1) they should either be (a) a licensed health care provider with demonstrated clinical experience in the treatment of chemical dependency, or (b) if not a licensed health care provider, must have acquired and demonstrated clinical experience and expertise in the treatment of health care professionals with impairment due to chemical dependence, or (c) a physician who has experience with chemical dependence through his/her own personal recovery; (2) if the candidate works in the treatment of chemical dependence, he/she must have a minimum of two years' experience as a treater; and (3) if the candidate is recovering, he/she must have a minimum of five years of uninterrupted recovery.

Following consideration of this proposal, DMQ members expressed several concerns. They suggested that all non-physician members of DECs be required to be licensed health care professionals (e.g., psychologists, licensed clinical social workers, marriage/family/child counselors, certified drug counselors). DMQ members also expressed concern about being presented with the resume of only one nominee for each vacant DEC position; they stated that they wanted the resumes of at least three nominees for each vacancy, so they could have a meaningful choice. After discussing these issues, DMQ referred these suggestions back to the Liaison Committee for further consideration.

The Board and its divisions held 1996 officer elections in November. The full Board elected Dr. Alan Shumacher as president, Stewart Hsieh as vice-president, and Dr. Thomas Joas as secretary. DOL elected Dr. Tom Joas as president, Dr. Raja Toke as vice-president, and Bruce Hasenkamp as secretary. DMQ elected Dr. Anabel Anderson Imbert as president and Dr. Ira Lubell as vice-president.

■ FUTURE MEETINGS

February 2-3 in Los Angeles.
May 10-11 in Sacramento.
July 26-27 in San Francisco.
November 1-2 in San Diego.

ACUPUNCTURE COMMITTEE

Executive Officer:
Marilyn Nielsen
(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 Division of Licensing (DOL) of 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.

Jeff Wallack resigned from his position as AC Executive Officer on October 31. Marilyn Nielsen, an Assistant Deputy Director at the Department of Consumer Affairs (DCA) who served as Interim Executive Officer, was appointed as AC's Executive Officer at the Committee's December 13 meeting.

At this writing, AC is functioning with two physician member vacancies and two public member vacancies.

■ MAJOR PROJECTS

AC Adopts "Housekeeping" Amendments to its Regulations. At its October 11 meeting, AC held a hearing on numerous proposed "housekeeping" changes to its regulations in Division 13.7, Title 16 of the CCR. Following the hearing, AC adopted the following changes:

- AC repealed section 1399.401, which states the address of AC's principal office;



as AC is no longer at the address indicated, the Committee repealed the section.

- AC's amendment to section 1399.403 deletes a reference to MBC's Division of Allied Health Profession, which no longer exists.

- Existing section 1399.405 states that, in the absence of its executive officer, AC must delegate authority to the Executive Director of the Medical Board; AC amended the section to permit it to delegate authority to a designee of its choice.

- AC amended section 1399.406 to require licensees to notify AC, in writing, within 30 days of any address change.

- AC amended section 1399.413 to establish timeframes within which licensure applicants must submit supporting documents necessary for determining examination eligibility. The current regulation requires AC to accept supporting documentation up to the date of the exam; the amended version requires applicants to submit such documentation 30 days prior to the examination. The amendments also establish a deadline for applications to be received by individuals applying to retake the Committee's examination.

- AC also amended section 1399.415 to specify that applicants for the examination must meet the minimum educational or tutorial requirements by the date of the examination for which the application has been made.

- AC made technical amendments to section 1399.416 to conform it to other regulatory sections.

- AC also approved an amendment to section 1399.436, which sets forth criteria for approval of acupuncture training programs; currently, the section establishes separate requirements for students who matriculated prior to September 1, 1985 and for those who matriculated after that date, and provides that up to 50% transfer credit may be awarded for courses completed successfully. AC's amendments would delete the training requirements for students who matriculated prior to September 1, 1985; and clarify the transfer credit requirement by stating that credits will be awarded by a school approved by AC for courses completed successfully at a school not approved by AC, provided that at least 50% of the course hours in these subject areas are completed successfully at a school approved by AC.

Finally, the amendments to section 1399.436 also state that, in order to be considered for AC approval, acupuncture schools must first be approved by the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine (NACSCAOM), a national body which conducts onsite inspec-

tions of schools seeking official accreditation and prepares detailed reports and recommendations evaluating compliance with "fourteen essential requirements." These requirements relate to purpose, legal organization, governance, administration, records, admissions, evaluation, program of study, faculty, student services and activities, library and learning resources, physical facilities and equipment, financial resources, and publications and advertising. Following his review of AC's current application form and procedures for approving schools, then-Executive Officer Jeff Wallack found them to be inadequate and recommended that AC require at least candidate status approval by NACSCAOM prior to considering a school for AC approval.

- AC amended section 1399.441 to rename its application form to "Application for Examination/Licensure" in order to more accurately reflect the form's purpose.

- AC's amendments to section 1399.443 more clearly specify that its "examination" consists of both a written and a practical exam, and delete existing language specifying the contents of the examination.

- AC also amended section 1399.444 to conform the regulation to state law specifying that a delinquent license may not be renewed after it has been delinquent for three years.

- Finally, AC amended section 1399.460 to establish a biennial license renewal fee of \$325, to conform to legislative changes to Business and Professions Code section 4970.

At its December meeting, AC decided to reconsider two of the above changes. Department of Consumer Affairs (DCA) legal counsel Don Chang noted that MBC's Division of Licensing had reviewed the proposed amendments at its November meeting, and expressed concern about two provisions. Due to DOL's comments, AC approved a modified version of section 1399.405 permitting it to delegate authority to a state employee. AC also decided to withdraw section 1399.436 from the package, and tabled further discussion of that section and the controversial issue of NACSCAOM approval of schools prior to AC approval of schools until its March 1996 meeting.

At this writing, AC staff is preparing the rulemaking file on the proposed "house-keeping" changes for submission to the Office of Administrative Law (OAL).

Citation and Fine Regulations Approved. On June 14, OAL approved AC's adoption of 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. The new provisions authorize AC's Executive Officer to issue a citation to AC licensees for violations of the Act or AC's regulations, and to non-licensees for engaging in acts for which a license is required; the citation may contain an order of abatement and/or an administrative fine. Among other things, the regulations establish the range of fines (from \$100 to \$2,500) which may be imposed by the EO, set forth seven factors which the EO must consider on a case-by-case basis in determining the amount of the fine, and establish a mechanism whereby the cited individual may 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. [15:2&3 CRLR 70; 15:1 CRLR 69] These regulations became effective on July 14.

At AC's December meeting, Executive Officer Marilyn Nielsen announced that staff is in the process of preparing an in-house manual for staff to use in implementing the citation and fine program.

Elimination of Tutorial Program. At its August 2 meeting, AC continued its discussion of a proposal to eliminate its tutorial program as a pathway to licensure. Under Business and Professions Code section 4938, a candidate for licensure may complete an AC-approved tutorial program instead of an AC-approved educational and training program; under section 4940, an AC-approved tutorial program must be supervised by an acupuncturist who has been licensed in California for at least five years and who has at least ten years of experience as an acupuncturist. [15:2&3 CRLR 71]

At the August meeting, AC noted that its Education Subcommittee had recommended elimination of the tutorial program pathway to licensure. Among other things, the Subcommittee found that the need for staff to supervise and conduct site visits to tutorial programs is a financial burden; the adoption of new regulations to strengthen the tutorial program would be expensive; many tutors fail to comply with existing requirements to submit quarterly reports; and the training received in tutorial programs is very narrow compared to the scope of acupuncture practice. During discussion, several Committee members noted that the legislature will wonder why AC is depriving applicants of a pathway to licensure they have had for years, and noted that the consumer is protected



because the final approval for licensure depends upon the passage of the written and practical exams. Committee members also expressed a preference for upgrading the tutorial program rather than eliminating it. Following discussion, AC tabled the matter to its October meeting; in October, the Committee again tabled this matter until further study is completed.

LEGISLATION

AB 446 (Assembly Committee on Higher Education), as amended September 7, is an omnibus bill which streamlines the postsecondary education provisions of the Education Code. With regard to AC, AB 446 adds section 4939 to the Business and Professions Code, which becomes effective on January 1, 1997. The new section requires the Committee to establish standards for the approval of schools and colleges offering education and training in the practice of an acupuncturist, including standards for the faculty in those schools and colleges, and tutorial programs, completion of which will satisfy the requirements of Business and Professions Code section 4938. The new section also requires institutions which have received initial approval by AC to receive full institutional approval in the field of traditional oriental medicine by the Council for Private Postsecondary and Vocational Education (CPPVE) within three years of initial AC approval, or AC's approval of the program will lapse. In the case of institutions located outside California, the new section requires those schools to receive approval by the appropriate governmental educational authority using standards equivalent to those used by the CPPVE within three years of initial AC approval, or AC's approval of the program will lapse. This bill was signed by the Governor on October 11 (Chapter 758, Statutes of 1995).

AB 1002 (Burton). Existing law, until January 1, 1997, defines the term "physician" as including acupuncturists for purposes of treating injured employees entitled to workers' compensation medical benefits. As amended March 30, this bill would delete the repeal date of January 1, 1997. [A. Ins]

AB 1003 (Burton). Existing law defines the term "physician" as including acupuncturists for purposes of treating injured employees entitled to workers' compensation medical benefits, and prohibits construing this provision as authorizing acupuncturists to determine disability for purposes of workers' compensation and disability benefits. As amended April 17, this bill would delete this prohibition, and instead provide that acupuncturists certi-

fied as Qualified Medical Evaluators may determine disability for purposes of workers' compensation and for purposes of unemployment compensation disability insurance. [A. Ins]

SR 28 (Watson, Solis), as introduced July 5, would state that California should be responsive to the needs and desires of health care for its citizens; significant numbers of persons choose alternative therapies to meet their health care needs; the people of California have demonstrated a need and desire for access to alternative health care services that can lead toward healthier lives; many citizens in this state seek alternative health care services, and California should facilitate access to and regulate delivery of these services to ensure the quality of alternative health care in order to minimize the potential for abuse; and the issue of access to alternative health care services has reached a point making it necessary for the legislature to enact a naturopathic physician licensing act to facilitate access, and regulate the delivery of, naturopathic medical services.

The measure would resolve that DCA's Division of Legislative and Regulatory Review, with the participation of MBC, AC, the Osteopathic Medical Board of California, the Board of Chiropractic Examiners, the California Association of Naturopathic Physicians, the California Citizens for Health, the California Citizens for Naturopathic Medicine, and the California Medical Association, is requested to study and report to the legislature on the state of the practice of naturopathy and the best method of establishing a naturopathic physician licensing act in California. The measure would further resolve that input be solicited from all interested naturopathic organizations, associations, and schools both in this state and nationally; that the report include a review of educational and training standards in existence, a scope of practice in other states that grant licenses, standards of conduct, title restrictions, and exclusions that should apply to naturopathic physicians; that MBC receive public testimony and provide a summary of public comments that includes a minority report, if any; that the report be submitted by September 1, 1996, to the Senate Health and Human Services Committee and to the Senate Business and Professions Committee; and that the Secretary of the Senate transmit copies of this resolution to DCA, MBC, AC, the Osteopathic Medical Board of California, the Board of Chiropractic Examiners, the California Association of Naturopathic Physicians, the California Citizens for Health, the California Citizens for Naturopathic Medicine,

and the California Medical Association. [S. B&P]

RECENT MEETINGS

At its August meeting in Sacramento, AC discussed recent reaction to DCA's August 1993 legal opinion defining the permitted scope of the practice of acupuncture in California. According to the legal opinion, acupuncture is but one area of the larger body of knowledge and philosophy of oriental medicine. In enacting the Acupuncture Licensure Act, the legislature intended to permit the practice of only those procedures enumerated in Business and Professions Code sections 4927(e) and 4937, "rather than the full range of procedures and treatments traditionally associated with oriental medicine." [14:1 CRLR 57] In response to several letters from a law firm representing the California Association of Acupuncture and Oriental Medicine demanding that AC cease and desist from using or distributing the legal opinion, AC reiterated that it has never formally adopted or endorsed the legal opinion as Committee policy, but uses it only as a "reference document."

Also at its August meeting, AC discussed whether to add an advisory panel to its Education Subcommittee. AC members expressed concern over the fiscal impact of such a panel, the impact on staff workload, and possible public perception that education is a "problem area" because of overregulation by AC. Following discussion, AC voted unanimously to support the concept of an advisory panel to the Education Subcommittee; Committee Chair Jane Barnett requested that AC member Jeanne Tumanjan assemble a statement of the mission and goals of the advisory panel and submit it to the Committee.

Also in August, AC again discussed its desires to become independent of the Medical Board and to change its name to "Board of Acupuncture" or "Acupuncture Board." [15:2&3 CRLR 71; 15:1 CRLR 70; 14:4 CRLR 76] Then-Executive Officer Jeff Wallack noted two areas in which AC is still bound to MBC: all AC regulatory changes must be approved by MBC's Division of Licensing, and all AC employees, including the executive officer, are employees of MBC. Wallack requested that AC take steps to eliminate these remaining ties to MBC, but AC took no action on this issue.

At AC's December meeting, DCA legal counsel Don Chang reminded Committee members that they serve as triers of fact and ultimate decisionmakers in enforcement cases; as such, they are not permitted to get involved in the investigation or prosecution of cases before they are



formally presented to AC for final determination. Chang urged AC members to refer complaints or questions they receive to staff so that Committee members do not become "tainted."

Also in December, AC elected public member Shawn Steel as its chair for 1996, and acupuncturist Lloyd Wright as vice-chair.

■ FUTURE MEETINGS

March 5-6 in Los Angeles.
April 23-24 in Sacramento.
July 22-23 in San Francisco.
October 16 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.

■ MAJOR PROJECTS

HADEC Approves Rulemaking Package. At its August 4 meeting, HADEC discussed several draft changes to its regulations in Division 13.3, Title 16 of the CCR. Following discussion, HADEC approved the following draft changes for publication and hearing:

- An amendment to section 1399.111 would provide that an applicant whose application for licensure is incomplete shall be deemed to have abandoned the application if he/she does not submit all required documents, data, and information within one year from the date on which the applicant is notified that the application is incomplete.

- Amendments to section 1399.120, concerning HADEC's examinations, would delete a reference to time limits on each section of the written examination; establish an application filing deadline for the practical exam; add a stethoscope and other listening devices to the list of instruments and equipment whose use may be tested on the practical exam; and clarify that the applicant must bring all required instruments and equipment to the practical exam.

- New section 1399.122 would add a mechanism for appealing a failing grade on the practical exam and establish the grounds for such an appeal.

- Section 1399.129, which currently establishes fees to be charged by HADEC, would be repealed because these fees are set in statute.

- Amendments to sections 1399.140 and 1399.141 would require all licensees—effective January 1, 1997—to complete nine hours of continuing education (CE) per year; no more than three of the nine hours may be in ethics, advertising, marketing, or business practices. HADEC's existing regulations require only six CE hours per year. [15:2&3 CRLR 71; 15:1 CRLR 71]

- Finally, new Article 8 (sections 1399.146 and 1399.147) would phase in new educational coursework requirements for licensure. [15:1 CRLR 71; 14:4 CRLR 76; 14:2&3 CRLR 78] Under the proposed language, applicants who apply for hearing aid dispenser licensure between January 1, 1998 and December 31, 1998 must have completed not less than 15 semester units or 22 quarter units of coursework, or its equivalent, at the postsecondary education level. Applicants who apply for hearing aid dispenser licensure between January 1, 1999 and December 31, 1999 must have completed not less than 30 semester units or 45 quarter units of coursework, or its equivalent, at the postsecondary education level (including at least one course in business English). On and after January 1, 2000, all applicants for hearing aid dispenser licensure must have completed not less than 60 semester units or 90 quarter units of coursework, or its equivalent, at the postsecondary education level (including at least one course each in business English, business, ethics, aging, anatomy and physiology, and hearing aid fit-

ting). Because several trade association representatives expressed concern about the availability and affordability of these courses (especially in rural areas), HADEC agreed to insert a provision requiring it to reevaluate the required coursework in 2002.

On September 15, HADEC published these proposed regulatory changes for a public hearing on November 2 in San Diego. Immediately following the public hearing, HADEC Executive Officer Elizabeth Ware presented the proposed changes to MBC's Division of Licensing at its meeting later in the day on November 2 in San Diego; DOL approved them with one slight modification. At its November 17 meeting, HADEC approved the final statement of reasons for the regulatory changes; at this writing, staff is preparing the full rulemaking record on the proposed changes for submission to the Office of Administrative Law (OAL).

Enforcement Report. At HADEC's November 17 meeting, Committee member Deborah Kelly reviewed HADEC's latest annual enforcement statistics. During fiscal year 1994-95, HADEC received 361 complaints, filed 20 accusations, and took a total of 12 disciplinary actions (including seven revocations). HADEC also issued 45 citations without fines and 67 citations with fines.

Enforcement Coordinator Dianne Tincher reviewed fiscal year 1995-96 statistics. As of October 31, 111 complaints were open and pending; over 70 of those complaints allege fraud or misleading advertising. Thirty-six complaints were under investigation, seven accusations had been filed, and 21 investigated cases were pending at the Attorney General's Office. By October 31, HADEC had already taken nine disciplinary actions (including six revocations). Tincher's report also noted that, thus far in 1995-96, HADEC has recovered almost \$10,000 in refunds and restitution for consumers, and recovered \$4,700 of its investigative costs against disciplined licensees.

Licensing Report. At HADEC's November 17 meeting, Interim Licensing and Examination Coordinator Tamara Alexander reported on the Committee's licensing statistics. As of November 15, HADEC had a total of 1,495 permanent licensees, 94 temporary licensees, 690 delinquent licensees, and 49 revoked licensees. HADEC also had 313 current branch licenses and 199 delinquent branch licenses.

■ LEGISLATION

SB 563 (Rogers), as amended April 26, would require HADEC licensees to complete nine hours of CE per year in



prescribed subjects. [15:2&3 CRLR 71-72] Because HADEC is attempting to increase its CE requirement through rule-making instead of legislation, Senator Rogers will likely amend his bill in 1996. [A. Health]

■ LITIGATION

At HADEC's November 17 meeting, Executive Officer Ware reported that Attorney General Dan Lungren, along with the attorneys general of ten other states, filed a civil lawsuit on September 21 against Telebrands Corporation, a New Jersey-based company which manufactures and markets the "Whisper XL" hearing device. The suits allege that the company's advertising violates state and federal laws governing hearing aid sales. Although Telebrands claims that the Whisper XL is not a hearing aid but rather a hearing device with which a person with normal hearing can listen to the conversation of others within 100 feet, its ads feature entertainer Steve Allen—who is known to many members of the public to wear a hearing aid—saying "You'll love your Whisper XL—I guarantee it!" According to the Attorney General, the ads also promise consumers that they will "never miss a word—just imagine what it would be like to hear sounds that you could never hear before." Telebrands has been warned several times by both HADEC and the U.S. Food and Drug Administration that the Whisper XL falls into the definition of the term "hearing aid" and its advertisements are thus subject to state and federal regulation. [15:2&3 CRLR 72; 15:1 CRLR 72] The case, which is pending in San Diego County Superior Court, seeks an injunction to prevent the misleading advertising, civil penalties of at least \$600,000, and restitution to purchasers of the product.

Also in November, Executive Officer Ware noted that HADEC's defense of *Hughes v. State of California, et al.*, No. BS029050 (Los Angeles County Superior Court), continues to consume Committee funds intended for enforcement. In this matter, hearing aid dispenser Robert Hughes alleges that several HADEC licensing and examination policies and advertising guidelines are in fact "regulations" which must be adopted by the Committee through the formal rulemaking process and approved by OAL, and that HADEC's advertising guidelines and specified disciplinary policies are unconstitutional as violative of the first and fourteenth amendments. [15:2&3 CRLR 71; 15:1 CRLR 72-73] Following a hearing on October 25, the court found that HADEC violated the rulemaking requirements of the Administrative Procedure Act on two occasions: (1) its 1989

examination instructions, which required examinees to pass the skills portion in order to pass the exam; and (2) HADEC's denial of temporary licenses to those individuals who had been previously licensed but who had failed to renew their licenses prior to expiration. At this writing, the Attorney General's motion for reconsideration of this ruling is being briefed.

■ RECENT MEETINGS

At HADEC's August 4 meeting, Executive Officer Ware informed the Committee that staff recently updated several HADEC fact sheets, including *Guidelines for Hearing Aid Receipts and Advertising Guidelines for Hearing Aid Dispensers*. The Committee distributes these fact sheets, along with *What Hearing Aid Consumers Should Know About the Song-Beverly Consumer Warranty Act* and a fact sheet about HADEC, to consumers and licensees who request them.

Also in August, HADEC elected officers for 1995-96. The Committee re-elected Keld Helmuth as Chair and selected Marilyn Havens as Vice-Chair.

At HADEC's November 17 meeting, staff reported that, between January 1-October 31, 1995, 177 candidates took the computerized version of HADEC's written examination; 89 passed, for a 50% pass rate. Additionally, 53 examinees took the practical examination on November 4; 43 passed, for an 81% pass rate.

Also in November, Executive Officer Ware presented a revised statement of HADEC's goals and objectives for 1995-1999. The statement addresses long-term goals in the areas of enforcement, examinations, licensing, continuing education, management, and outreach for a five-year period. Some of HADEC's enforcement goals include a reevaluation of the sufficiency of a half-time position dedicated to enforcement; and an evaluation of a mediation program to resolve complaints, the effectiveness of the investigative work performed by DCA's Division of Investigation, possible lower-cost investigative alternatives, HADEC's disciplinary guidelines, and legislative/regulatory changes to enhance the Committee's enforcement program and consumer outreach. HADEC's examination goals include the finalization of its new practical exam (which is now scheduled to be administered in May 1996), and negotiating contracts to enable other states to pay royalties for the use of HADEC's computer-administered written exam. [15:2&3 CRLR 73] The Committee's licensing goals include implementation of its new educational requirements (see MAJOR PROJECTS) and consideration of amendments to section 1399.115, Title 16 of the CCR, to restrict

supervision of trainees to licensees who have practiced for a specified period of time. In the area of management, HADEC must prepare for its "sunset" review under SB 2036 (McCorquodale) (Chapter 908, Statutes of 1994), which begins with HADEC's preparation of a comprehensive report on its necessity and performance for a public hearing in the fall of 1999. [14:4 CRLR 20, 77] In the area of outreach, HADEC hopes to publish its News Bulletin newsletter on a quarterly basis and to work on establishing a national federation of hearing aid dispenser licensing boards; in a recent survey conducted by HADEC, 17 states recently expressed interest in such a federation.

■ FUTURE MEETINGS

March 22 in Sacramento.

July 19 in Sacramento.

November 15 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 13,970 physical therapists and 2,840 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.

At this writing, PTEC is functioning with only five members.

■ MAJOR PROJECTS

PTEC Inches Toward New PTA Supervision Regulations. In November 1991,



PTEC commenced its discussion of proposed regulatory amendments to section 1398.44, Title 16 of the CCR, which would more precisely define "adequate supervision" by a PT over a PTA. [12:2&3 CRLR 114; 12:4 CRLR 100] Four years, at least a dozen public hearings, scores of amendments, and thousands of pages of comments later, PTEC appears finally to have settled on regulatory language which—it believes—will not be overly burdensome on the profession and will enable it to better protect patients of PTs and PTAs. These amendments have been the source of increasingly hostile conflict within the profession, and especially between PTEC and the California Chapter of the American Physical Therapy Association (CCAPTA), the largest PT trade association in California.

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 supervisory requirements which will protect patients of PTs and PTAs. Additionally, PTEC has long been concerned that the provision's failure to require written documentation of the supervision provided by a SPT hinders its ability to take effective disciplinary action.

CCAPTA opposes elimination of the waiver provision, and has objected to previous versions of the amendments, claiming that (1) early versions were too strict and would impose requirements which are overly burdensome and unnecessary to patient protection [14:2&3 CRLR 80], and (2) later versions appeared to eliminate the requirement for onsite supervision of a PTA by the SPT. CCAPTA's more fundamental reason for its opposition to the proposed language appeared in its May 1995 newsletter: "If physical therapists are no longer needed to provide onsite supervision to PTAs, then other providers will most assuredly ask, 'Why can't we supervise PTAs? Wouldn't we be the perfect medical professional to be allowed to employ physical therapist assistants in our offices?'" [15:2&3 CRLR 73-74]

On December 8, PTEC published notice of its intent to hold a public hearing on yet another revised version of its amendments. The December 8 version is based upon language which was approved by the Committee at its May 1995 meeting, then

modified three times (July 14, August 11, and September 28) over the summer, and unanimously approved for publication by PTEC at its October 26 meeting—over the objection of CCAPTA.

Under the December 8 version of the amendments, a licensed PT must at all times be responsible for all physical therapy services provided by a PTA; the SPT has continuing responsibility to follow the progress of each patient, provide direct care to the patient, and assure that the PTA does not function autonomously. "Adequate supervision" includes the following:

- The SPT must be readily available in person or by telecommunication to the PTA at all times while the PTA is treating patients. The SPT must provide periodic onsite supervision and observation of the assigned patient care rendered by the PTA.

- The SPT must initially evaluate each patient and document in the patient's record, along with his/her signature, the evaluation and when the patient is to be reevaluated.

- The SPT must formulate and document in each patient's record, along with his/her signature, the treatment program goals and plan based upon the evaluation and any other information available to the SPT. This information must be communicated verbally or in writing by the SPT to the PTA prior to initiation of treatment by the PTA. The SPT must determine which elements of the treatment plan may be assigned to the PTA; assignment of these responsibilities must be commensurate with the qualifications—including experience, education, and training—of the PTA.

- The SPT must reevaluate the patient as previously determined, or more often if necessary, and modify the treatment goals and plan as needed. The reevaluation must include treatment to the patient by the SPT. The reevaluation must be documented and signed by the SPT in the patient's record, and must reflect the patient's progress toward the treatment goals and when the next reevaluation will be performed.

- The PTA must document each treatment in the patient's record, along with his/her signature. The PTA must document in the patient's record and notify the SPT of any change in the patient's condition not consistent with planned progress or treatment goals. A change in condition necessitates a reevaluation by a SPT before further treatment by the PTA.

- Within seven days of the care being provided by a PTA, the SPT must review, cosign, and date all documentation by the PTA or conduct a weekly case conference and document it in the patient's record. Cosigning by the SPT indicates that the SPT has read the documentation and, un-

less the SPT indicates otherwise, he/she is in agreement with the contents of the documentation.

- The SPT and PTA must hold regularly scheduled and documented case conferences regarding the patient. The frequency of the conferences is to be determined by the SPT based on the needs of the patient and the supervisory needs of the PTA, but must be at least every 30 calendar days.

- The SPT must establish a discharge plan. At the time of discharge or within seven days thereafter, the SPT must document in the patient's record, along with his/her signature, the patient's response to treatment in the form of a reevaluation or discharge summary.

At this writing, the public hearing on the December 8 version of the amendments to section 1398.44 is scheduled for February 2 in Los Angeles.

Proposed Fee Increases. On September 8, PTEC published notice of its proposal to amend sections 1399.50 and 1399.52, Title 16 of the CCR, to increase various license application fees. Specifically, the amendments to section 1399.50 would increase the PT application fee from \$30 to \$50, and the application fee for foreign graduates from \$60 to \$100. The amendments to section 1399.52 would increase the PTA application fee from \$30 to \$50.

Although PTEC scheduled a public hearing on these amendments for its October 26 meeting, the hearing was not placed on the October 26 meeting agenda, so PTEC could take no action on the matter. At this writing, PTEC is scheduled to act on these proposals at its February 2 meeting in Los Angeles.

Performance of Physical Therapy by Medical Assistants. At its May 1995 meeting, the Medical Board's Division of Licensing (DOL) adopted a proposed amendment to its regulations which define the services which may be performed by unlicensed medical assistants (MAs). Specifically, the Division repealed subsection 1366(e), which states that "[n]othing in these regulations shall be construed to authorize a medical assistant to practice physical therapy." This action, which PTEC opposed, effectively permits physicians to train and supervise MAs in the performance of physical therapy tasks. [15:2&3 CRLR 74] At this writing, the rulemaking file on DOL's repeal of subsection 1366(e) is pending review by the DCA Director, after which it will be submitted to the Office of Administrative Law (OAL).

OAL Approves PTEC Proposal to Require Reapplication for Licensure After One Year. On November 20, OAL ap-



proved PTEC's proposal to adopt section 1398.21.1, Title 16 of the CCR, which clarifies that an application for licensure shall be deemed abandoned when an applicant fails to pass the examination within one year of the date of the original notice to appear for the exam. The applicant is then required to file a new application for licensure and pay a new application fee, and to apply for reexamination and pay the reexamination fee. [15:2&3 CRLR 74]

LEGISLATION

Future Legislation. At its August meeting, PTEC approved several legislative proposals which it hopes to sponsor or have included in DCA's 1996 omnibus bill, including the following:

- Once again, PTEC will seek a name change to "Physical Therapy Board of California."

- The Committee will also attempt to secure an amendment of Business and Professions Code section 2688 to increase the existing statutory ceiling on its initial license and biennial renewal fees to \$150. The fee increase is intended primarily to cover the costs of administering a newly-required exam on California's laws and regulations governing the practice of physical therapy, and PTEC's escalating enforcement costs; the actual fee level will be set by PTEC through rulemaking, up to the ceiling established by the legislature.

- PTEC also plans to seek legislation clarifying that "physical therapist license applicant" status (an applicant who has filed a PT application with PTEC and may perform as a PT under the direct and immediate supervision of a California-licensed PT) is available only upon initial application to the Committee. Many applicants who fail the examination believe they may simply submit a new application, receive "applicant" status, and continue to practice.

- PTEC also hopes to establish a minimum time period of at least three years between license suspension or revocation and a petition for reinstatement. Currently, the Administrative Procedure Act permits disciplined licensees to petition for reinstatement after only one year; PTEC's three-year proposal is patterned after a similar provision applicable to the Medical Board.

- PTEC hopes for legislation requiring it to promulgate regulations requiring a minimum standard of documentation in each patient's record; imposing a standard on the PT would assist PTEC in protecting the consumer when a complaint is filed. The Committee proposes that the statute require PTs to keep such patient records for a minimum of three years from the date of the last treatment.

- Finally, PTEC plans to seek legislation establishing that the commission of crimes involving bodily injury, sexual misconduct, dishonesty, fraud, or deceit, even if the victim is not a patient, is substantially related to the practice of physical therapy such that discipline may be imposed.

RECENT MEETINGS

Business and Professions Code section 2668(b) requires PTEC to review the activities and performance of its Diversion Program contractor on a biennial basis; PTEC's Diversion Program is intended to identify and rehabilitate substance-abusing PTs and PTAs, and the Committee has contracted with Occupational Health Services, Inc. (OHS) for administration of its program. As part of this review, the Committee must review files of participants in the program. At its August meeting, PTEC decided to utilize the services of an outside contractor, preferably one with expertise in substance abuse programs, to carry out the review requirement. In this way, all PTEC members would be available to participate in any subsequent disciplinary decision involving licensees who have participated in the Diversion Program.

At its October meeting, PTEC discussed ways to save money so it can publish a newsletter. Executive Officer Steve Hartzell suggested that the Committee establish a "Web page" on the Internet; this method would cost only \$600 annually and permit PTEC to post updated information at any time. PTEC directed Hartzell to pursue the idea.

Also in October, PTEC elected its 1996 officers. The Committee reelected PT Valerie Sinkus as its Chair, and elected PT Jerry Kaufman as Vice-Chair.

FUTURE MEETINGS

February 2 in Los Angeles.
May 17 in Sacramento.
August 15 in San Diego.
October 24 in San Francisco.

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 functions 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.

On January 1, 1996, the terms of PA Nancy Safinick, Dr. Schumarry Chao, and Judith Levy, three long-time members of the Committee, expire; at this writing, no appointments have been made to fill these positions, and PAEC is functioning with a total of four vacancies.

MAJOR PROJECTS

PAEC Adopts Citation and Fine Regulations. At its July 21 meeting, PAEC held a public hearing on the proposed adoption of regulations to implement its citation and fine authority as a means of more efficiently and effectively disciplining minor violations of its enabling act and regulations. [15:2&3 CRLR 75; 15:1 CRLR 75; 14:4 CRLR 80]

Proposed Article 6 (commencing with section 1399.570), Division 13.8, Title 16 of the CCR, would allow PAEC's Execu-



tive Officer to levy citations and/or fines between \$100 to \$2,500 per infraction against licensed PAs and individuals who are engaging in the practice of a PA without a license. The regulations would specify the format for citations, the range of fines for a violation of specified provisions, the factors to be considered in assessing the amount of an administrative fine, the consequences of a failure to comply with the order, and the method by which citations may be contested.

At the July meeting, no one presented oral testimony on the proposed regulations; however, PAEC could not vote to approve them because it lacked a quorum. The Committee unanimously approved the proposed regulations at its October 27 meeting; at this writing, the proposal awaits review and approval by the Department of Consumer Affairs and the Office of Administrative Law.

Committee Approves Proposal to Reduce Supervising Physician Fees. At its October 27 meeting, PAEC agreed to commence the rulemaking process to amend section 1399.553, Title 16 of the CCR, to reduce the initial approval fee for supervising physicians from \$75 to \$50, and the biennial approval fee for supervising physicians from \$100 to \$75; both fee reductions would become effective on July 1, 1996. For some time, PAEC has sought to reduce these fees [15:2&3 CRLR 76; 15:1 CRLR 75], in part to encourage the utilization of PAs by physicians.

At this writing, PAEC has not yet published this proposed regulatory change in the *California Regulatory Notice Register*.

PAEC Begins Preparations for 1997 Sunset Review. At PAEC's July 21 meeting, Dr. Richard Crable, the Committee's strategic planning consultant, outlined his plans for preparing the Committee for its 1997 "sunset" review under SB 2036 (McCorquodale). Under SB 2036, the Committee will cease to exist on July 1, 1999, unless the legislature affirmatively acts to extend its expiration date. [14:4 CRLR 80] The "sunset" date triggers a public hearing on the Committee's performance in the fall of 1997, prior to which the Committee must complete a comprehensive report on its performance and the need for regulating physician assistants.

PAEC's sunset review project is actually an outgrowth of its recent establishment of a long-term strategic plan [15:2&3 CRLR 75], and is called the Government Efficiency Management Study (GEMS). Preliminarily, Dr. Crable oversaw the creation and implementation of an enhanced data collection system intended to mea-

sure, analyze, and enhance the effectiveness and efficiency of PAEC staff operations. He also established a Project Advisory Group consisting of academicians in communication, public policy, and business management, and made contact with various legislative staffers and other agency personnel associated with the sunset review process.

LEGISLATION

SB 641 (Craven). SB 1642 (Craven) (Chapter 968, Statutes of 1994) authorizes a licensed pharmacist to dispense drugs upon a transmittal order of a physician assistant who has been delegated that authority by a physician. [15:2&3 CRLR 75; 15:1 CRLR 75-76] As introduced February 22, this bill would state the intent of the legislature to enact guidelines for pharmacists who accept Schedule II prescriptions from physician assistants in accordance with those provisions. [S. B&P]

AB 753 (Morrow). Existing law authorizes PAs to perform certain prescribed services under the supervision of a licensed physician provided that the PA is licensed by PAEC and the physician is approved to supervise the PA by MBC or the Osteopathic Medical Board of California. As amended April 26, this bill would also authorize a PA to perform these prescribed services while under the supervision of a licensed podiatrist, provided the podiatrist is approved by the Board of Podiatric Medicine (BPM) and the assistant is licensed by BPM as a podiatrist assistant. The bill would restrict a podiatrist to supervising no more than two podiatrist assistants and would require BPM to restrict podiatrists to supervising podiatrist assistants within the scope of practice of podiatric medicine. It would also require BPM to restrict podiatrist assistants to practicing only within the scope of podiatric medicine. [S. B&P]

LITIGATION

On November 10, PAEC and the National Commission on Certification of Physician Assistants (NCCPA) were sued by a group of international medical graduates seeking to become licensed as PAs in California.

In *Carchache, et al. v. State of California, et al.*, No. BC138471 (Los Angeles County Superior Court), plaintiffs—a group of physicians trained in foreign medical schools—allege that PAEC requires, as a condition of obtaining a license, passage of the Physician Assistant National Certifying Examination, which is given only by NCCPA; and that NCCPA has refused to allow plaintiffs to take the next exam because they have not com-

pleted an accredited PA training program. Plaintiffs further allege that they have completed medical school at institutions which are "accepted" by the Medical Board of California, and that the legislature has indicated its desire that foreign-trained physicians be licensed as PAs through its enactment of AB 1065 (Campbell) (Chapter 1042, Statutes of 1993), which established (but allocated no funding for) the International Medical Graduate Physician Assistant Training Program. [14:1 CRLR 64; 13:4 CRLR 68] Plaintiffs assert that NCCPA's refusal to permit them to take the exam and PAEC's denial of their applications for licensure because of their inability to take the exam violates their equal protection and due process rights.

At this writing, the Attorney General's Office has not yet filed a responsive pleading to plaintiffs' complaint.

RECENT MEETINGS

At the Committee's July meeting, the members present voted to recommend to the full Committee that the revised "Application for Licensure as a Physician Assistant" form be approved. PAEC has spent several months reviewing and revising its PA application form to elicit more information about applicants. [15:2&3 CRLR 76; 14:2&3 CRLR 83-84]; among other things, the Committee added a question asking whether the applicant has "a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety and without exposing others to significant health and safety risks." The full Committee approved the revised application form at its October 27 meeting.

At PAEC's October 27 meeting, staff member Jennifer Barnhart presented the Committee's licensing statistics for fiscal year 1994-95. As of June 30, 1995, PAEC's licensees include 2,614 PAs and 7,439 supervising physicians.

Also in October, staff member Glenn Mitchell reported on PAEC's enforcement statistics. As of October 1, nine complaints against PAs were pending at the Medical Board's Central Complaint and Investigation Control Unit (CCICU); 60 complaints against PAs were being investigated by MBC investigators; and 11 completed investigations were pending at the Attorney General's Office. During fiscal year 1994-95, PAEC disciplined a total of seven licensees: It revoked outright the license of one PA, and placed the licenses of six others on probation.

Finally, PAEC held its 1996 officer elections at its October meeting. The Committee reelected PA Robert Sachs as



Chair and elected PA Steven Johnson as Vice-Chair.

■ FUTURE MEETINGS

January 25 in San Diego.
April 18 in San Francisco.
July 18 in Los Angeles.
October 24 in Sacramento.

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.

On June 19, the Senate Rules Committee appointed former Senator Robert Presley to a full term as a BPM public member; Senator Presley was originally appointed to the Board in February 1995 to serve the last few months of a public member position which had been vacant since Karen McElliott was moved to the Medical Board several years ago. [15:2&3 CRLR 76] Senator Presley's new term expires on June 1, 1999.

■ MAJOR PROJECTS

BPM Resolves to Pursue Public Member Majority and Study of Merger with MBC. By a 4-1 vote at its November 3 meeting, BPM agreed to sponsor legislation that would require a majority of its members to be public members instead of podiatrists. The resolution approved by the Board noted that "the dominance of boards by licensee members weakens confidence among the public" and that a public member majority, "which has worked well with other licensing boards, would strengthen public confidence and provide a positive example." BPM's resolution also stated that any bill creating a public member majority on the Board should also provide for committees of DPMs to con-

tinue assisting BPM as medical consultants, expert reviewers, and witnesses in the enforcement program and as examination commissioners in the licensing program. BPM is the first California board which licenses health care practitioners to consider, much less adopt, such a resolution.

The Board approved the resolution with the strong support of the Center for Public Interest Law (CPIL), which has long sought to divest all occupational licensing boards of professional members who—according to CPIL—have an unavoidable conflict of interest between their role as government officials exercising state police power with public protection as the highest priority and their role as professionals with a profit stake in their own governmental decisionmaking. BPM's action, however, was denounced by the California Podiatric Medical Association (CPMA), which argued that "BPM's job is to protect the public, and doctors of podiatric medicine are the best qualified people to do that." CPMA argued that DPMs are "most likely" to recognize "incompetent and unethical doctors practicing our profession...and we have a lot to lose if they continue in practice." CPMA acknowledged that public members "have served the public and the profession well—but to make it the majority interest in dealing with our licensing and scope of practice issues? Absolutely not."

BPM also anticipated its upcoming "sunset" review under the terms of SB 2036 (McCorquodale) (Chapter 908, Statutes of 1994) [14:4 CRLR 20, 81-82], and resolved to pursue legislation continuing its existence after 1999 but also mandating a study and report by an independent office regarding the Board's strategic plan to merge with the Medical Board, including an analysis of pros and cons, comment by the Board and other interested parties, discussion of issues such as having a DPM on the Medical Board, and a proposed timeframe for implementation. [15:2&3 CRLR 76-77] CPMA also opposed this component of the resolution, arguing that "the public and the profession are best served by an independent Board of Podiatric Medicine that has as much knowledge and education about the profession as possible."

Citation and Fine Program Rulemaking. At its November 3 meeting, BPM held a public hearing on its proposal to amend section 1399.698(c)(1) and adopt new section 1399.705, Title 16 of the CCR; these regulatory changes are intended to enhance the Board's existing citation and fine program.

The amendment to section 1399.698(c)(1) would add a violation of Business and

Professions Code section 2474 (unlawful representation in any sign or advertisement by a person not holding a valid podiatric license that he/she is qualified to practice podiatric medicine) to the list of provisions which may justify the issuance of a citation and fine ranging from \$100-\$2,500.

New section 1399.705 would clarify that unlicensed persons engaged in the manufacture, recommendation, or sale of corrective shoes or appliances for human feet may not engage in the practice of podiatric medicine, or advertise in any manner that they are authorized to do so. This proposed regulation would specify that advertisements by unlicensed persons shall not cite medical conditions such as arthritis, diabetes, bunions, plantar fasciitis, hammertoes, neuromas, or ulcerations unless the advertisement clearly states that the person advertising is not licensed to diagnose, prescribe for, or treat these medical conditions.

Although BPM received no oral comments at the public hearing, it received written opposition to proposed section 1399.705 from the California Medical Association. CMA argued that, rather than clarifying the unlicensed practice of podiatry, "the regulations suggest that licensed podiatrists may diagnose and treat any medical condition, without qualification whatsoever." Specifically, CMA complained that section 1399.705's references to arthritis and diabetes imply that podiatrists are permitted to diagnose and treat all forms of these diseases in all areas of the human body, when a DPM's scope of practice is limited to the foot, ankle, and tendons that insert into the foot. CMA offered a proposed revision which deletes the references to arthritis and diabetes and expressly prohibits unlicensed persons from diagnosing and treating podiatric medical conditions.

BPM adopted the proposed rules subject to a consultation with its legal counsel about CMA's objections; at this writing, the Board is scheduled to revisit this matter at its February 13 meeting.

BPM Amends Information Disclosure Regulation. On June 5, the Office of Administrative Law (OAL) disapproved BPM's adoption of new section 1399.700, Title 16 of the CCR, which would establish BPM's information disclosure policy in regulation. [15:2&3 CRLR 77; 14:4 CRLR 81; 13:2&3 CRLR 92] OAL found that the rule failed to comply with the clarity, consistency, and necessity standards of Government Code section 11349.1.

BPM's rule mirrored the original version of MBC's information disclosure rule (found at section 1354.5, Title 16 of the



CCR), which has been the subject of litigation by CMA for three years. At its July meeting, MBC agreed to amend its information disclosure rule in order to resolve the litigation; due to MBC's agreement and CMA's failure to oppose the amended version, the court dismissed CMA's lawsuit as moot in September (*see* agency report on MBC for related discussion). On December 6, BPM published a modified version of section 1399.700, which is very similar to the revised version of MBC's information disclosure regulation. Under the December 6 version, BPM will disclose to inquiring consumers the following information about any doctor of podiatric medicine licensed in California:

(a) current status of the license, issuance and expiration date of the license, podiatric medical school of graduation, and date of graduation;

(b) any public action filed against any podiatrist and any disposition thereof, including but not limited to accusations, decisions, temporary restraining orders, interim suspension orders, citations, limitations on practice ordered by BPM, and public letters of reprimand. If the accusation has been withdrawn for any reason after public disclosure, BPM shall offer to the respondent the choice of (1) continued disclosure of both the accusation and the withdrawal, (2) immediate termination of disclosure and removal from the Board's files of the accusation and withdrawal, or (3) retention in the Board's files of the accusation and withdrawal for a period of one year after the accusation was withdrawn;

(c) "priority cases" which the Office of the Attorney General has "accepted" (*see below*);

(d) 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 court, and an appropriate disclaimer including but not limited to the accuracy of the information provided;

(e) discipline imposed by another state or the federal government reported to the Board on or after January 1, 1991, including the discipline imposed, the date of the discipline, the state where the discipline was imposed, and an appropriate disclaimer including but not limited to the accuracy of the information provided; and

(f) California felony convictions reported to the Board on or after January 1, 1991, including the nature of the conviction, the date of conviction, the sentence (if known), the court of jurisdiction, and an appropriate disclaimer including but

not limited to the accuracy of the information provided.

Under the revised rule, the term "priority case" means a case in which an accusation will be filed which contains any of the following types of allegations: (1) sexual misconduct with two or more patients; (2) repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances; (3) fraud involving five or more patients being treated under the workers' compensation law; (4) drug or alcohol abuse by a podiatrist and involving death or serious bodily injury to a patient; (5) an extreme departure from the standard of care which involves death or serious bodily injury to a patient, such that the podiatrist presents a danger to the public; (6) gross negligence, involving death or serious bodily injury to two or more patients; (7) incompetence, involving death or serious bodily injury to a patient; or (8) cases in which the Attorney General's Office has decided to seek an interim suspension order or temporary restraining order to halt a DPM's practice pending the conclusion of the disciplinary matter. The term "accepted" means that the Attorney General's Office has fully evaluated the case and has determined that all investigation necessary to file an accusation has been completed, that no referrals for non-prosecutory action (such as referral to the Diversion Program) are to be made, that an accusation will be filed, and the nature of the charges.

The public comment period on the December 6 version of section 1399.700 closed on December 21; at this writing, BPM staff is in the process of preparing the rulemaking file for resubmission to OAL.

OAL Approves Podiatric Medical Education and Training Regulations. On December 11, OAL approved BPM's recent amendments to regulatory sections 1399.662, 1399.666, and 1399.667, to standardize podiatric medical education and training. These amendments came in response to the findings set forth in two recent reports—the 1993 *Report on the General Medical and Surgical Components of Podiatric Residency Training* by Thomas Nelson, MD, and Franklin Medio, Ph.D. [14:1 CRLR 64], and a 1994 report authored by Medical Board member Robert del Junco, MD, which concurred with the Nelson-Medio recommendations for enhanced podiatric medical education and training.

Amended section 1399.662 permits (rather than requires) BPM to approve all colleges of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association, thus preserving the

Board's discretion to reject CPME-approved curricula which provide insufficient podiatric medical education and training. Amended section 1399.666 requires that "equivalent training," for purposes of Business and Professions Code section 2483, be undertaken through educational programs approved by the CPME and which meet all requirements of the Business and Professions Code. Amended section 1399.667 specifies that hospitals approved to provide postgraduate training to podiatric medical residents must meet minimum requirements set by CPME, and further specifies that hospitals must have designated a Director of Medical Education, provide emergency medical 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. [15:2&3 77; CRLR 15:1 CRLR 77]

LEGISLATION

SB 609 (Rosenthal), as amended September 6, is the Medical Board's omnibus enforcement bill containing numerous legislative changes relating to MBC's physician discipline system, many of which apply to DPMs and BPM (*see* agency report on MBC for details). In addition, SB 609 amends Business and Professions Code section 2416 to authorize physicians and podiatrists to conduct their professional practices in a partnership of physicians and podiatrists, if both of the following conditions are satisfied: (1) a majority of the partners and partnership interests in the professional partnership are physicians and surgeons or osteopathic physicians and surgeons, and (2) a partner who is not a physician and surgeon may not practice in the partnership or vote on partnership matters related to the practice of medicine that are outside his/her scope of practice; all partners may vote on general administrative, management, and business matters. The Governor signed SB 609 on October 10 (Chapter 708, Statutes of 1995).

AB 1471 (Friedman), as amended June 19, revises the curriculum required for licensure as a DPM, effective January 1, 2000, to delete psychology and add behavior science, pediatrics, and women's health. This bill was signed by the Governor on August 2 (Chapter 279, Statutes of 1995).

AB 753 (Morrow). The Medical Practice Act provides for the licensure of podiatrists and physicians and defines their scopes of practice. Existing law authorizes a physician assistant (PA) to perform cer-



tain prescribed services under the supervision of a licensed physician, provided that the PA is licensed by the Physician Assistant Examining Committee and the physician is approved to supervise the PA by MBC or the Osteopathic Medical Board of California. As amended April 26, this CPMA-sponsored bill would also authorize a PA to perform these prescribed services while under the supervision of a licensed podiatrist, provided the podiatrist is approved by BPM and the assistant is licensed by BPM as a podiatrist assistant. The bill would restrict a podiatrist to supervising no more than two podiatrist assistants and would require BPM to restrict podiatrists to supervising podiatrist assistants within the scope of practice of podiatric medicine. It would also require BPM to restrict podiatrist assistants to practicing only within the scope of podiatric medicine. [S. B&P]

At its November 13 meeting, BPM members voiced serious concerns with AB 753, especially in light of a DCA fiscal analysis which indicates that the new licensing programs (BPM approval of both supervising podiatrists and assistants) would bankrupt the Board. CMA opposes AB 753, on grounds that the PA curriculum provides minimal training in the area of the foot and ankle, and enforcing the podiatric scope of practice limitation on PAs, who have broader training, would be difficult. CMA recommends the creation of a separate classification of podiatrist assistant with its own educational curriculum and examination/certification procedure.

RECENT MEETINGS

At its November 13 meeting in Los Angeles, BPM adopted a policy that the *Preferred Practice Guidelines* of the American College of Foot and Ankle Surgeons reflect the standard of care for DPMs.

FUTURE MEETINGS

March 11 in Sacramento.
May 3 in San Francisco.
November 1 in Los Angeles.

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.

The Senate Rules Committee recently appointed Mary Ellen Early as a new public member of BOP.

MAJOR PROJECTS

BOP Amends Continuing Education Regulations. On September 29, and in response to numerous complaints by licensees, BOP published notice of its intent to amend numerous provisions of its recently-adopted continuing education (CE) regulations; these regulations implement SB 774 (Boatwright) (Chapter 260, Statutes of 1992), which requires psychologists, effective January 1, 1995, to complete CE requirements as a condition of license renewal. [15:2&3 CRLR 78; 15:1 CRLR 77-78; 14:4 CRLR 82]

The Board held a public hearing on its proposed amendments at its November 18 meeting in Sacramento. Following the public hearing, the Board adopted the proposed changes subject to several minor revisions. Among other changes, the Board:

- amended section 1397.60(c), Title 16 of the CCR, to include "presentations" (such as conferences, in-service training programs, and grand rounds) in addition to "courses" as qualifying CE;
- amended section 1397.60(d) to include video conferencing and distance learning technologies within the definition of CE;
- amended section 1397.61(b) to clarify the required content of the mandatory one-time-only CE course in the detection and treatment of alcohol and other chemical dependency;
- amended section 1397.61(d) to grant CE credit for any course that is approved by the American Psychological Association (APA) and sponsored or cosponsored by APA's Continuing Education Committee;
- added subsection 1397.61(e) to grant CE credit for taking courses sponsored by the academies of the specialty boards of the American Board of Professional Psychology;

- added subsection 1397.61(f) to grant CE credit for taking courses in hospital-based in-service settings, such as grand rounds;

- amended section 1397.63(b) to authorize CE credit for licensees who serve the Board as selected participants in any written or oral examination development-related function, and for selected Board experts who attend Board-sponsored Expert Training Seminars;

- amended section 1397.64(a)(2)(B) and (a)(2)(D) to more specifically set forth the responsibilities of a Board-recognized CE course accreditation agency;

- amended section 1397.65(j) to clarify that providers may grant partial credit for CE conferences, in-service training programs, and grand rounds which have been approved by a Board-recognized accreditation agency;

- added new subsection 1397.65(m) to specify the manner in which providers may obtain approval for granting CE credit for grand rounds activities;

- amended section 1397.66 to require approved CE providers to submit course materials to BOP;

- amended section 1397.67 to provide that a licensee who has an inactive license must submit evidence of completion of 36 hours of CE in the previous two years to activate the license, and clarify that licensees with a delinquent license may, within three years of license expiration, apply for renewal and provide documentation of completion of the required CE hours; and

- adopted new section 1397.70 to provide that a license may not be renewed if CE documentation is inadequate or improper; if a deficiency is not corrected within six months, the license will be cancelled.

The Board released the modified version of its CE amendments on November 30, and is preparing the rulemaking record for submission to the Office of Administrative Law (OAL) at this writing.

Citation and Fine Regulations. On November 24, BOP published notice of its intent to adopt Article 9 of Division 13.1 (commencing with section 1398.50), Title 16 of the CCR, to implement its authority to issue citations and fines for minor violations of its enabling statute and regulations. [15:2&3 CRLR 79; 15:1 CRLR 78; 14:4 CRLR 82]

The proposed regulations would authorize BOP's Executive Officer or Enforcement Coordinator to issue citations, which may include an order of abatement and/or a fine, to Board licensees for any violation of law or regulation which would be grounds for discipline by the Board. The rules would also specify the format



for the citations; the range of fines for a violation of specified provisions; the factors to be considered in assessing the amount of an administrative fine; the consequences of a failure to comply with an order of abatement; and the method by which citations may be contested. The regulations would also authorize BOP to issue citations and fines for unlicensed practice, issue an order of abatement which requires the unlicensed person to cease unlawful advertising, and notify the telephone company furnishing service to the cited person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

At this writing, BOP is scheduled to hold a public hearing on its proposed citation and fine regulations at its January 26 meeting in San Francisco.

OAL Approves Examination Regulations. On August 11, OAL approved BOP's amendments to sections 1388, 1388.5, 1389, and 1390, Title 16 of the CCR, which alter its examination structure and limit a licensure candidate's ability to appeal the results of the Board's oral examination.

Specifically, the Board amended section 1388 to specify that administrative action may be taken against any licensure applicant found cheating during the licensing exam; repealed language in section 1388.5(b) which provided that an applicant who fails to obtain a grade of 75 in the oral exam will be given reasons in writing why the failing score was issued, and inserted language which instead provides that any applicant who sits for the oral exam will be provided with oral exam feedback; amended section 1388.5(c) to require BOP to keep an electronic recording of each oral exam for one year following the date of the exam; amended section 1389(a) to provide that all requests for reconsideration of a failed oral exam must be submitted in writing to BOP within 30 days following notification of failure, and provide that requests for reconsideration must be based on procedural errors during the administration of the exam; repealed section 1389(b), which provided that a failed oral exam will be reconsidered by BOP if the applicant receives a grade of 72.1 or greater, and authorized BOP to reconsider an exam with a grade of less than 72.5; amended section 1389(d) to provide that there shall be no reconsideration of the grade received on the written licensing examination administered by the Board; and amended section 1390(b) to authorize an examinee to inspect the electronic recording of his/her oral exam within one year following the exam. [15:2&3 CRLR 78-79; 15:1 CRLR 78]

BOP Publishes Newsletter. In October, BOP published the second issue of its *BOP Update* newsletter. Included in the newsletter is an overview of the Board's enforcement activity between 1990 and 1995. The overview reveals that the number of consumer complaints filed with BOP increased from 483 in 1990 to 574 in 1995; the number of investigations opened by BOP increased from 140 in 1990 to 163 in 1995; and the number of disciplinary decisions increased from 38 in 1990 to 59 in 1995. Sexual misconduct accounts for a disproportionate percentage of BOP's disciplinary actions. In 1995, 19 of the Board's 59 disciplinary actions were for sexual misconduct; 13 were for gross negligence or incompetence.

■ LEGISLATION

SB 609 (Rosenthal). Existing law authorizes the Board to impose probationary conditions upon a license after an administrative hearing. As amended September 6, this bill authorizes an administrative decision that imposes probationary conditions to also include a requirement that the licensee pay the costs of monitoring the probation. This bill was signed by the Governor on October 9 (Chapter 708, Statutes of 1995).

SB 1119 (Watson), as amended June 13, would provide that if a licensed psychiatrist or psychologist is appointed as an expert witness by a court in a matter relating to child custody, no court-directed activity by that person within the scope of that appointment may be the subject of any disciplinary investigation or action by his/her licensing body, except for acts of unprofessional conduct constituting gross negligence. [S. *Jud*]

SB 777 (Polanco), as amended May 2, is CPA's bill to authorize psychologists with special training to prescribe drugs. [14:4 CRLR 82] This bill would require BOP to establish and administer a certification program to grant licensed psychologists prescriptive authority, as defined, and to develop procedures for that certification with the advice of the state Department of Health Services and the Board of Pharmacy; require each applicant for certification to satisfy certain educational and training requirements; and delete the existing exclusion of the prescribing of drugs by certified psychologists from the practice of psychology. [S. *B&P*]

AB 1586 (House), as introduced February 24, would expand the class of persons required to be licensed in order to practice psychology by repealing Business and Professions Code section 2910, which currently exempts from the Psychology Licensing Law persons who are

salaried employees of accredited or approved academic institutions, public schools, or governmental agencies. [A. *Health*]

AB 944 (Gallegos). Under existing law, the rules of a health facility may enable the appointment of clinical psychologists on the terms and conditions that the facility may establish. As introduced February 22, this bill would instead require the rules of a health facility to include provisions for the use of the facility by, and staff privileges for, duly licensed clinical psychologists. The bill would provide that medical staff status in health facilities with respect to the practice of psychology shall include the right to practice full clinical privileges for holders of an M.D. degree or a doctorate degree in psychology within the scope of licensure. This bill would require a health facility to establish a staff to regulate the admission, conduct, suspension or termination of the staff appointment of clinical psychologists. [A. *Health*]

■ RECENT MEETINGS

At its November meeting, BOP continued its discussion of the Myers-Briggs Type Indicator (MBTI) instrument. In September 1994, the Board issued an opinion stating that Business and Professions Code section 2903 requires that one be licensed as a psychologist in order to administer tests of personality characteristics, similar to the MBTI. In response to recent complaints about its opinion, BOP invited several proponents of the MBTI to its May 1995 meeting to give their opinion on the test's significance. These representatives claimed that the MBTI is not a test designed to diagnose mental disorders, but an instrument which measures personal preferences or style. For this reason, the instrument is most often used in counseling and advising persons on career choices. As stated in its instruction manual and supporting materials, the MBTI was not designed to measure pathology or psychological dysfunction; as such, the MBTI proponents recommended that the Board not limit its use to licensed psychologists. [15:2&3 CRLR 80] Following discussion and the receipt of more testimony, BOP decided to take no official position on whether the MBTI is a psychological test.

■ FUTURE MEETINGS

January 26 in San Francisco.
March 8-9 in Sacramento.
May 17-18 in Los Angeles.
August 16-17 in San Francisco.
November 15-16 in San Diego.



SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Interim Executive Officer:
Marilee Monagan
(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

Executive Officer Retires; SPAEC Searches for Replacement. In August, longtime Executive Officer Carol Richards announced her retirement, and SPAEC commenced a recruitment process for her replacement. The Committee received 72 applications, and SPAEC Chair Steve Sinclair, Ph.D., developed criteria for their review. Six finalists were chosen, and four were interviewed on October 17. At its November 24 meeting, SPAEC held a closed session and agreed to offer the position to DCA Assistant Deputy Director Marilyn Nielsen. Nielsen accepted the position, but later withdrew her acceptance in order to take a post as Executive Officer of the Acupuncture Committee. On December 27, SPAEC appointed Marilee Monagan, formerly with DCA's Bureau of Electronic and Appliance Repair, as Interim Executive Officer while the selection process continues. At this writ-

ing, SPAEC is expected to select a permanent replacement for Carol Richards at its January 12 meeting in San Diego.

SPAEC Rulemaking. On October 17, SPAEC held a public hearing on several proposed changes to its regulations in Division 13.4, Title 16 of the CCR:

- Amendments to the title of Division 13.4 and to section 1399.152 would accurately reflect SPAEC's name and the name of the Medical Board of California, and make minor technical changes.

- Section 1399.158 currently states that an applicant for licensure as a speech-language pathologist or audiologist must complete 275 clock hours of clinical practice; this section would be amended to require 300 clock hours of clinical practice for applicants who completed their graduate program after December 31, 1992. [15:2&3 CRLR 82; 15:1 CRLR 79]

- Section 1399.160 defines the term "qualifications deemed equivalent by the Committee" to include a supervisor who holds a Certificate of Clinical Competence or holds a statement of certification equivalence issued by the American Speech-Language-Hearing Association in the field for which licensure is sought. SPAEC proposed to delete the words "or holds a statement of certification equivalence."

- SPAEC proposed to amend section 1399.186 to decrease the biennial renewal fee for licenses which expire between July 1, 1996 through June 30, 1998 from \$75 to \$20; thereafter, the fee will increase back up to \$75. [15:2&3 CRLR 82]

- Section 1399.189 would be amended to require all licensees and applicants for licensure to notify SPAEC in writing within 30 calendar days of any change in mailing address.

- SPAEC also proposed to repeal section 1399.198, its citation and fine regulation, and to adopt new sections 1399.195-.198 in its place. This proposal would recodify SPAEC's existing citation and fine regulations in a new format, make a few changes to the regulatory scheme. Proposed section 1399.195 would clarify that the citation must inform the cited person of his/her right to a citation review conference and administrative hearing. Proposed section 1399.196 would expand the violations for which citations may be issued, and widen the range of fines which may be assessed for some violations. Proposed section 1399.198 would clarify that orders of abatement may be extended for good cause, state the consequences of failing to abate a violation or pay a fine if the cited person does not contest a citation or does not prevail on an appeal of a citation, and specify the consequences of failing to pay a fine after a citation is final.

- Finally, SPAEC proposed to amend section 1399.199, which specifies the procedure for contesting a citation by requesting a citation review conference with the executive officer; among other things, the amendments would extend the time within which a cited person may request a citation review conference and the time within which the executive officer must serve a copy of his/her decision on the cited person.

At the October 17 hearing, no comments were presented. At its November 24 meeting, SPAEC adopted the proposals subject to one modification. SPAEC decided to charge no biennial renewal fee between July 1, 1996 and June 30, 1998; this modification will reduce SPAEC's reserve fund to three months' worth of operating capital. SPAEC released the modified version for an additional 15-day comment period on November 21; at this writing, staff is preparing the rulemaking file on the proposed changes for submission to the Office of Administrative Law.

LEGISLATION

SB 563 (Rogers), as amended April 26, would increase the continuing education (CE) requirement for hearing aid dispensers licensed by the Hearing Aid Dispensers Examining Committee (HADEC) from six to nine hours per calendar year. This bill would affect a large number of SPAEC licensees, as 50% of SPAEC's licensee population dispense hearing aids as part of their practice and are cross-licensed by HADEC. Senator Rogers will likely amend or drop SB 563 in 1996, as HADEC has decided to increase its CE requirements through rulemaking instead of legislation (*see agency report on HADEC for related discussion*). [A. Health]

RECENT MEETINGS

SPAEC's July 21 meeting in Orange County was cancelled.

At its November 24 meeting, SPAEC honored outgoing Executive Officer Carol Richards, who retired after 22 years with SPAEC and 35 years of state service (*see MAJOR PROJECTS*).

FUTURE MEETINGS

January 12 in San Diego.

March 22 in Monterey.

July 12 in Los Angeles.

November 8 in Sacramento.