tion of an oral examination.

Existing section 2671 requires a landscape architect to include his/her license number in all public presentments; BLA's proposed amendments to section 2671 would further require that a landscape architect include his/her name and the words "landscape architect" in all public presentments.

BLA was scheduled to conduct a public hearing on these proposals on February 19 in San Diego.

LEGISLATION

Future Legislation. During the 1993–94 legislative session, BLA may pursue legislation which will require landscape architects to use 20% recycled materials in their design plans; revise the definition of the term "landscape architect"; and revise Business and Professions Code section 5959 to—among other things—make mandatory instead of optional the requirement that licensed landscape architects obtain a seal of the design authorized by BLA, bearing his/her name, license number, the renewal date of the license, the legend "landscape architect," and the legend "State of California."

RECENT MEETINGS

At its October 16 meeting, the Board elected Larry Chimbole to serve as President and Greg Burgener to serve as Vice-President during 1993. Also, the Board directed staff to publish a new version of its pamphlet, *Consumer's Guide to Hiring a Landscape Architect.*

FUTURE MEETINGS

May 7 in Sacramento.
July 16 in Los Angeles.
October 22 in Sacramento.

MEDICAL BOARD OF CALIFORNIA

Executive Director: Dixon Arnett
(916) 263-2389
Toll-Free Complaint Number:
1-800-MED-BD-CA

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 non-physicians appointed to four-year terms, is divided into three autonomous divisions: Licensing, Medical Quality, and Allied Health Professions.

The purpose of MBC and its three divisions is to protect the consumer from incompetent, grossly negligent, unlicensed, or unethical practitioners; to enforce provisions of the Medical Practice Act (California Business and Professions Code section 2000 *et seq.*); and to 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).

The functions of the individual divisions are as follows:

MBC's Division of Licensing (DOL) is responsible for issuing regular and probationary licenses and certificates under the Board's jurisdiction; administering the Board's continuing medical education program; and administering physician and surgeon examinations for some license applicants.

In response to complaints from the public and reports from health care facilities, the Division of Medical Quality (DMQ) 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. It also includes the suspension, revocation, or limitation of licenses after the conclusion of disciplinary actions. The division operates in conjunction with fourteen Medical Quality Review Committees (MQRC) established on a geographic basis throughout the state. Committee members are physicians, other health professionals, and lay persons assigned by DMQ to review matters, hear disciplinary charges against physicians, and receive input from consumers and health care providers in the community.

The Division of Allied Health Professions (DAHP) directly regulates five non-physician health occupations and oversees the activities of eight other examining committees and boards which license podiatrists and non-physician certificate holders under the jurisdiction of the Board. The following allied health professions are subject to the oversight of DAHP: acupuncturists, audiologists, hearing aid dispensers, medical assistants, physical therapists, physical therapist assistants, physician assistants, podiatrists, psychologists, psychological assistants, registered dispensing opticians, research psychoanalysts, speech pathologists, and respiratory care practitioners.

DAHP members are assigned as liaisons to one or two of these boards or committees, and may also be assigned as liaisons to a board regulating a related area such as pharmacy, optometry, or nursing. As liaisons, DAHP members are expected to attend two or three meetings of their assigned board or committee each year, and to keep the Division informed of activities or issues which may affect the professions under the Medical Board's jurisdiction.

MBC's three divisions meet together approximately four times per year. Individual divisions and subcommittees also hold additional separate meetings as the need arises.

MAJOR PROJECTS

Wagstaff Resigns Under Pressure; Revamped Board Hires Arnett as Executive Director. On October 23, then-MBC Executive Director Ken Wagstaff submitted a letter stating his "intention to resign" as of November 6, in the face of what he called "a desire on the part of an apparent majority of the Board to grant a request, recently communicated to [MBC President] Dr. [Fredrick] Milkie by the Governor's Chief of Staff, that I step aside."

Wagstaff's forced resignation was in fact orchestrated by the Wilson administration, which has declined to reappoint Board members originally selected by former Governor Deukmejian and recently gained a majority of Medical Board seats. The administration's embarrassment over the performance of Wagstaff and the Medical Board has grown steadily over the past several years. In particular, MBC's mishandling of egregious and sensational medical discipline cases caught the eye of the national news media, culminating in a June 1992 "Sixty Minutes" segment which, in the words of former State and Consumer Services Agency Secretary Bonnie Guiton, left her "angry, disappointed and embarrassed." In addition, recent allegations of "case dumping" orders and other serious misconduct by top MBC enforcement staff caused Department of Consumer Affairs (DCA) Director Jim Conran to order an independent investigation of the accusations. *[12:4 CRLR 88–89]* Although the investigation was ongoing at the time of Wagstaff's resignation, both Wagstaff and administration officials stated that its pendency had nothing to do with Wagstaff's ouster.

Wagstaff's unusual "letter of intent to resign" indicated that he hoped MBC members might have a change of heart by the Board's November 6 meeting. The Bagley-Keene Open Meeting Act requires state agencies to take personnel actions regarding executive officers at a public meeting instead of behind closed doors, and Wagstaff apparently believed some Board members might be unwilling to vote to fire him at an open hearing. At the meeting, however, MBC members disposed of the matter rather summarily, per-

mitting Wagstaff to catalogue the Board's accomplishments during his nine-year tenure, presenting him with a plaque of appreciation, and unanimously appointing Assistant Executive Director Tom Heerhartz to serve as Acting Executive Director until a permanent replacement could be found. No vote was taken, nor did Wagstaff request one.

Privately, however, several Board members voiced their strong objection to what they characterized as inappropriate political interference with the Board's autonomy and its choice of executive directors. Then-President Milkie wrote a letter to the Governor's office protesting the order to fire Wagstaff, stating that Wagstaff "is doing an outstanding job and in my opinion should remain the Executive Director." Milkie also stressed his "firm belief that the Medical Board of California should be as independent as possible from all outside influences, political or otherwise."

Also on November 6, the Board decided to appoint a four-member Search Committee to decide how to recruit candidates to replace Wagstaff, interview promising applicants, and present recommendations to the full Board. The Search Committee, which consisted of Dr. Jacquelin Trestrail, Dr. John Kassabian, Dr. Robert del Junco, and public member Ray Mallel, interviewed Dixon Arnett in a public session on November 23, and presented a unanimous recommendation that Arnett be hired at a December 16 public meeting of the full Board.

At the December 16 meeting, the Search Committee explained that it had not publicized the availability of the position in any way; it simply received Arnett's resume shortly after Wagstaff's resignation, interviewed him, and decided to recommend his hiring to the full Board. In the view of the Search Committee, Arnett—a former state Assemblymember with experience as a deputy undersecretary at the U.S. Department of Health and Human Services and as then-U.S. Senator Pete Wilson's legislative director—met the Board's hiring criteria, which included knowledge of medical issues and trends in health care, legislative expertise and an ability to represent the Board, and "an ability to get along with Board members."

Board President Milkie asked for Arnett's views on what he called the "appalling" efforts of some outside forces, including (according to Milkie) DCA Director Jim Conran, to remove the Medical Board's enforcement duties and transfer them to the Attorney General's Office or to a consolidated enforcement unit within DCA. Arnett responded, "These issues are not new. Routinely, over the years, the issues you're concerned about have been recommended, reviewed, and rejected over and over and over again. Must we spend time reinventing a legislative, political wheel? Those who urge consolidation of enforcement activities are dead in the water—it's a dead issue."

Some Board members were concerned about MBC's failure to advertise the position. Public members Karen McElliott and Gayle Nathanson expressed discomfort over the Board's "substantial departure" from its usual hiring process, and queried where the Search Committee obtained Arnett's application. Arnett responded that he served as a freshman Assemblymember with Pete Wilson; "he's a friend, and he happens to be Governor of California." When Nathanson repeated her concern that Wagstaff's firing and Arnett's hiring were not "decisions made by the Board but from outside the Board" and questioned whether "it [has] become a foregone conclusion for this Board that because the Governor has suggested your name, we must hire you," Arnett stated, "Let's lay something on the table. I appear before you as no one's puppet. I am not pulled by anyone's string." Regarding the independence of the Board from "outside forces," Arnett reminded the Board that it is, to a certain extent, a political body because appointments are made by elected officials, and each member reflects his/her appointing authority. Because the Board is a political body, his proposed selection as Executive Director is also a political matter, but not necessarily a partisan one. Arnett invited the Board to commence a more traditional search process if it so desired.

Search Committee members stated that they had already addressed these issues, and urged the full Board to adopt its recommendation. After almost no discussion, fifteen MBC members voted to hire Arnett; Nathanson abstained. The entire process took fifteen minutes.

In a brief acceptance speech, Arnett noted that the Medical Board needs "better public relations and better outreach so our 'reality' becomes the perception out there. We have a job to do with the media." In twice-repeated remarks, Board President Milkie urged Arnett to "preserve the integrity of the Medical Board" by "keeping people around who have knowledge of the Board's policies and procedures." Milkie's comments, obviously aimed at Assistant Executive Director Tom Heerhartz, ignored the fact that Heerhartz is one of the employees under investigation for alleged misconduct. Without naming Heerhartz, Arnett agreed, stating that he "had it very much in mind" to retain Heerhartz, but noted that he had not had an opportunity to consider personnel decisions.

CHP Investigation Ongoing. At this writing, the California Highway Patrol continues its investigation into allegations of widespread misconduct by upper staff of the Medical Board. The investigation was requested by DCA Director Jim Conran during the summer of 1992. *[12:4 CRLR 89]*

CHP's audit was initially assigned to one investigator and was scheduled to have been completed by October 31. However, CHP has added two more investigators, a physician, and an attorney to its team, and completion of the investigation is now scheduled for mid-January.

Enforcement Matrix and Annual Report Reveal MBC Disciplinary Performance. The latest version of MBC's "enforcement matrix"—a computer display of key enforcement statistics—was released on October 26 for discussion at DAHP's November 5 meeting. DAHP oversees the matrix and its functions, and reports to the full Board on its findings. According to DAHP President Dr. Madison Richardson, the matrix was developed solely to define areas of gridlock in the enforcement process, and not to gauge MBC's compliance with Business and Professions Code section 2319, which requires DMQ to fully investigate and close cases (either by dismissal or transfer to the Health Quality Enforcement Section (HQES) of the Attorney General's Office) within an average of 180 days from receipt.

According to the October 26 matrix, 72,902 physician licenses were in effect. Over 5,200 cases were pending against physicians at various stages of the investigative or prosecution process. The matrix also provides a breakdown of case accumulations at each stage of the process: 2,293 cases were pending with a consumer services representative at DMQ's Central Complaint and Investigation Control Unit (CCICU); 1,721 were under formal investigation; 473 were pending with a medical consultant; 381 fully investigated cases were pending in HQES awaiting the drafting of an accusation; and 337 cases in which an accusation has been filed were pending in HQES.

Once again, the matrix reflects a growing accumulation of cases in the CCICU. *[12:4 CRLR 89]* From April to October 1992, the number of cases backlogged in the CCICU increased from 1,379 cases to 2,293 cases—a 70% increase. At the same time, the number of cases pending in investigations has remained the same—

from 1,704 in April to 1,721 in October. This could indicate either that DMQ (1) has been deluged with an extraordinary number of incoming complaints; (2) is opening complaint cases on minor allegations so as to be able to close them quickly and reduce its average time for purposes of section 2319 compliance; or (3) is again holding cases in the CCICU and withholding them from its investigators, a past practice which landed DMQ in trouble with the Legislative Analyst and the legislature in 1987–90.

The October 26 version of the matrix also includes information regarding the average number of days complaints stay at various stages of the process. According to the matrix, physician complaints that are currently open spend an average of 116 days in the CCICU, 311 days under investigation, and another 62 days with a medical consultant. Then they spend an average of 515 days in HQES awaiting the drafting and filing of formal charges, and another 436 days in HQES post-filing during the hearing and decisionmaking process. These figures reflect currently open cases only, do not average in closed cases, and cannot be used to assess DMQ's compliance or noncompliance with section 2319.

DAHP members again expressed doubt about the usefulness of a matrix which does not reflect closed cases and which fails to indicate a target time period for each category. In the future, the matrix will include a comparison chart so that certain categories may be reviewed against past matrices. Furthermore, the target time period for each category will also be exhibited.

In December, MBC published its 1991–92 Annual Report, which demonstrates yet another view of the Board's enforcement performance. Pursuant to SB 2375 (Presley) (Chapter 1597, Statutes of 1990), MBC is required to report specific annual enforcement statistics. Although the Report's statistics appear internally inconsistent and are extremely difficult to decipher, the Board appears to have obtained 25 temporary restraining orders and 9 interim suspension orders against physicians in 1991–92 (a vast improvement over prior years); MBC received 63,668 consumer inquiries and 7,892 complaints; it referred 6,928 cases to other agencies or resolved them without any discipline; it referred 617 cases to the Attorney General or to a district attorney; and filed 270 accusations (formal charges).

The Annual Report claims that MBC is in compliance with section 2319's mandate that "an average of no more than six months will elapse from the receipt of a complaint to the completion of an investigation." The Annual Report states that, in 1991–92, complaints spent an average of 161 days at MBC from receipt to closure. The bottleneck, says MBC, is now in HQES, where the processing and filing of an accusation takes an average of 253 days. According to HQES Chief Al Korobkin, HQES is still understaffed for the number of cases now filed by MBC. He has recommended a budget change proposal to add at least 14 new attorney positions to handle the workload. Based on 1992–93 numbers thus far, MBC is on a pace to ship over 600 fully investigated cases to HQES for the filing of formal charges this year—over twice its 1991–92 caseload. Korobkin also notes that, with the increased use of interim suspension and temporary restraining orders, the average number of hours to handle a Medical Board case has increased from 148 hours to 166 hours.

The Annual Report includes other statistics which indicate that the Board's enforcement system does not aggressively attack physician incompetence. In 1991–92, the Board received a total of 833 reports of medical malpractice judgments or settlements in excess of $30,000. In addition, the hospital privileges of 179 physicians were revoked, suspended, or restricted for medical cause or reason (another 1,008 physicians were cited by hospitals for incomplete medical records). During the same year, however, the Medical Board disciplined the licenses of only 23 physicians for gross negligence or incompetence. Of the Board's 1992–93 total of 162 disciplinary decisions, the majority stem from discipline by another state or criminal conviction (50), drug offenses (28), dishonesty or fraud (8), and sexual misconduct (7).

HIV/HBV Transmission Prevention Committee Activity. At the full Board's November 6 meeting, MBC President Dr. Fredrick Milkie reported on the activities of the Board's HIV/HBV Transmission Prevention Committee, which is monitoring the Department of Health Services' (DHS) drafting of guidelines required to prevent the transmission of HIV and other bloodborne pathogens in the health care setting. These guidelines are required under both state (Health and Safety Code section 1250.11) and federal (Public Law No. 102-141) law, and must be equivalent to HIV transmission prevention guidelines issued by the federal Centers for Disease Control (CDC) in 1991. *[12:4 CRLR 90]*

Although Public Law No. 102-141 requires all states to promulgate guidelines by October 28, 1992, Dr. Milkie announced that DHS obtained a one-year extension on that deadline. In the meantime, DHS' task force, which includes MBC Chief Medical Consultant Dr. Richard Ikeda, had circulated draft guidelines to task force members but not to the public.

In December, DHS finally published the following "consensus statements" developed as a result of a June 18 meeting with representatives of health care profession boards and associations, licensed health care facilities and associations, organizations which advocate on behalf of people infected with HIV, and organizations representing consumers of health care. DHS promised to consider these statements when preparing its final statewide infection control policies, guidelines, and regulations.

In the area of infection control and immunization, the June 18 participants agreed to the following statements:

–State guidelines should recommend rigorous adherence to the 1987 and 1988 CDC infection control guidelines and should recommend the use of universal precautions in all health care settings as a minimum standard. The state should consider adopting other procedures, such as body substance isolation, as standards only after appropriate scientific evaluation.

–State guidelines should recommend use of the best available method to ensure that each patient is treated with sterile or properly disinfected devices.

–State guidelines should recommend that as part of the accreditation process, professional schools develop guidelines for the infection control curricula. As a prerequisite to admittance to a professional exam, state licensing boards should require evidence of adequate training in infection control procedures.

–State guidelines should recommend periodic infection control training and proficiency testing as a condition of health care worker (HCW) licensure or certification.

–State guidelines should recommend appropriate vaccination of all HCWs and trainees who are likely to be exposed to infectious diseases, except for individuals who can produce adequate evidence of immunity or for whom vaccination is contraindicated.

–State guidelines should recommend hepatitis B virus vaccination of all HCWs or trainees who are likely to be exposed to blood.

–The state should pursue additional research into infection control procedures and exposure incidents, and should disseminate timely information to practition-

ers through health profession board and association publications.

In the controversial area of testing and practice restrictions where an HCW tests positive, the participants agreed as follows:

–State guidelines should recommend counseling for HCWs and patients who may have been exposed to bloodborne pathogens through personal risk behaviors, blood products, or occupational accidents. These individuals should be encouraged to seek testing, if appropriate, in order to benefit from medical management. Testing should be voluntary rather than mandatory.

–State guidelines should explicitly prohibit restriction of HCWs' practices based solely on their infection with any specific bloodborne pathogen.

–The state should offer infected HCWs a voluntary expert review panel that would advise and guide infected HCWs in the practice of their profession. The panel would base its advice on data regarding each infected HCW's practice and ability to practice proper infection control procedures.

–The state and professional organizations should offer job counseling and retraining services for infected HCWs who can no longer work in their field.

In the area of notification to patients of an HCW's infection status and informed consent to further treatment, the participants agreed to the following statements:

–State guidelines should not recommend obtaining blanket informed consent from all patients of infected HCWs.

–State guidelines should not recommend routine post-treatment notification of patients treated by infected HCWs in the absence of a documented exposure incident.

–State guidelines should recommend notification of patients when an HCW's body fluid comes in contact with the patient parenterally or with their mucous membranes, regardless of the HCW's infection status.

The meeting participants noted and disagreed with the CDC's concepts of identifying exposure-prone procedures, restriction of practice of HCWs who perform such procedures, and informed consent of patients undergoing those procedures. *[12:1 CRLR 75]* However, the participants agreed that the above statements "are equivalent to the July 1991 CDC recommendations in that they offer equal or greater protection to the patients of infected HCWs."

DMQ Adopts Rules Governing Use of "Board Certified" in Physician Advertising. At its November 5 meeting, DMQ held one last public hearing on its proposed rules implementing SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990), entertained comments from 15 physicians and physician trade associations, and finally adopted the regulations subject to two additional modifications suggested by the Southern California Chapter of the American College of Surgeons (ACS). SB 2036 amended Business and Professions Code section 651 to provide that a physician licensed by MBC may include a statement in his/her advertising that he/she is certified or eligible for certification by a private or public board or parent association only if that board or association is (1) a member of the American Board of Medical Specialties, (2) a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training (PGT) program that provides complete training in that specialty or subspecialty, or (3) a board or association with equivalent requirements approved by DOL (the so-called "equivalency option"). DMQ has spent the better part of three years attempting to adopt these regulations. SB 2036 set a January 1, 1993 effective date in order to give the Medical Board time to adopt implementing regulations; because MBC was unable to complete the rulemaking process within that time frame, AB 2180 (Felando) (Chapter 783, Statutes of 1992) extended that deadline to July 1, 1993. *[12:4 CRLR 90–91]*

New section 1363.5, Division 13, Title 16 of the CCR, would define the terms "specialty board" and "specialty or subspecialty area of medicine," and establish standards regarding purpose, size, funding, governance, and required functions of acceptable specialty boards whose members may advertise that they are "board certified" in California.

As noticed, the new regulation would provide that acceptable specialty boards must require all applicants who are seeking certification to have satisfactorily completed a PGT program accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC) that includes identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification; if the training required of applicants seeking certification by the specialty board is other than ACGME- or RCPSC-accredited, then the specialty board shall have training standards that include identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification and that have been determined by DOL to be equivalent in scope, content, and duration to those of an ACGME- or RCPSC-accredited program in a related specialty or subspecialty area of medicine. If the specialty board's training requirements do not meet the above standards, the specialty board may still be recognized if it requires applicants seeking certification to have completed (1) a minimum of six years of full-time teaching and/or practice in the specialty or subspecialty area of medicine in which the physician is seeking certification, and (2) a minimum of 300 hours of continuing medical education in the specialty or subspecialty which is approved under section 1337 and 1337.5 of MBC's continuing education regulations. As noticed, the new rule would also permit physicians who are members of existing or new specialty boards which are not members of ABMS to advertise their board certification for an eight-year "safe harbor" period while the specialty board is presumably seeking ABMS membership or ACGME/RCPSC accreditation.

Following lengthy testimony, DMQ agreed to modify its proposed regulation in two ways, at the request of ACS representatives. First, DMQ agreed to delete all references to "identifiable training" in its rule; ACS objected to the language because it appears to permit "parts of ACGME-approved training programs to be 'borrowed' to support non-ABMS boards. This 'borrowing' hardly seems equivalent to a 'postgraduate training program that provides complete training in that specialty or subspecialty'" as required by SB 2036. Second, DMQ agreed to shorten the eight-year "safe harbor" period to three years; if a specialty board cannot demonstrate its equivalency to ABMS boards in the three years following the effective date of these regulations, its members may not thereafter advertise certification by that board. However, DMQ added a year-to-year extension provision authorizing DOL to extend the three-year period on an annual basis to any board making a good faith effort to meet the equivalency requirements.

At this writing, DMQ intends to publish its modified regulation for an additional 15-day public comment period and submit the rulemaking file to the Office of Administrative Law (OAL) in early 1993.

Public Information Committee Unable to Reach Consensus. At DMQ's November meeting, Public Information Committee Chair Gayle Nathanson reported that the Committee was unable to agree on a public disclosure policy which would permit the Medical Board to release information on MBC investigations to inquiring consumers at an earlier point than it currently does. Presently, the Medical

Board refuses to disclose the fact that it is investigating physician misconduct until the investigation is completed, the case has been forwarded to HQES, the formal accusation has been filed, and ten days after the filing have elapsed. During 1992, the Committee held several public hearings at which it was urged to recommend a policy under which DMQ would disclose completed investigations to inquiring members of the public when the case has been referred to HQES. *[12:2&3 CRLR 97]* However, in a November 2 memo to Committee Chair Gayle Nathanson, then-Executive Director Ken Wagstaff claimed that both the Attorney General's Office and MBC enforcement staff advised against disclosure until the accusation has been filed. The majority of the Committee decided to defer to these recommendations.

During 1992, the Committee also considered the possible disclosure of other information currently collected by DMQ but not released to inquiring consumers, including criminal charges and convictions against physicians, medical malpractice judgments and settlements in excess of $30,000, and notices from hospitals that physician privileges have been revoked, suspended, or denied due to incompetence. Critics complain that DMQ's withholding of this information from inquiring consumers is affirmatively misleading. The Committee made no recommendation on these issues.

DOL Rulemaking. At its November 5 meeting, the Division of Licensing held a public hearing and adopted three proposed regulatory changes. *[12:4 CRLR 91–92]*

• ***Permit Reform Act Regulations***. DOL adopted Article 5 (commencing with section 1318), Division 13, Title 16 of the CCR, to implement the Permit Reform Act of 1981, Government Code section 15374 *et seq*. The Act requires the Medical Board to specify maximum timeframes for the processing of applications for licensure, permits, and other authorizations.

• ***Oral Examinations***. DOL also amended section 1329, Title 16 of the CCR, to specify that (1) any licensure applicant who is a diplomate of the National Board of Medical Examiners (NBME) and whose application for licensure as a physician will be issued under Business and Professions Code section 2151 shall be required to take and pass the oral examination if the application is received by MBC more than five years from the date of the issuance of his/her diploma or certificate by the NBME; and (2) any physician whose license has been expired for more than five years and who is applying for a new license under Business and Professions Code section 2428 shall be required to take and pass the oral examination before the new license may be issued.

• ***License Fee Increase***. DOL also amended sections 1351.5 and 1352, Title 16 of the CCR, to increase MBC licensing fees to their statutory maximums effective March 1, 1993. DOL took this action by a 6–1 vote despite oral and written opposition from the California Medical Association (CMA), which objected because this marks the third MBC license fee increase since August 1991 and because it believes the Governor and legislature may attempt to "raid" MBC's special fund in the 1993–94 budget bill (*see infra* LEGISLATION). Once approved by OAL, MBC initial and biennial licensing fees will be $250 per year, which is relatively low compared to other fees; podiatrists pay $400 per year and attorneys pay almost $500 per year.

At this writing, DOL staff is preparing the rulemaking file on the three changes described above for submission to OAL. Division staff is also preparing the rulemaking file on its July adoption of section 1304, Title 16 of the CCR, which will make ineligible for license renewal any physician who fails to complete and return MBC's biennial physician questionnaire prior to the time his/her license expires. *[12:4 CRLR 91–92]* Staff hopes to submit these rulemaking files to OAL in early 1993.

Significant Surgeries in Out-of-Hospital Settings. At MBC's November 6 meeting, the Committee on Surgeries in Unregulated Out-of-Hospital Settings updated the Board on the results of two public hearings it conducted with the Department of Health Services (DHS) during the summer. The Committee and DHS co-sponsored the hearings to receive comments and recommendations from physician and hospital organizations, insurance carriers, surgery center operators, and private accreditation organizations on the risks to public safety as the frequency of performance of major surgical procedures shifts from highly regulated hospital settings to outpatient facilities, some of which are wholly unregulated. *[12:2&3 CRLR 100]*

Committee chair Dr. Camille Williams noted that hearing participants consistently testified that there is a serious risk of patient harm from surgeries and certain levels of anesthesia provided in unregulated out-of-hospital settings. Witnesses also stated that some form of regulation of these currently unregulated settings where significant surgery and anesthesia are provided is warranted.

Based on this testimony, Committee members and staff met with members of CMA's Accreditation Association for Ambulatory Health Care and identified a range of regulatory options which provide varying levels of public protection:

–MBC could take an educational/information approach and use its *Action Report* newsletter to better inform physicians who perform surgery in unregulated settings, as well as patients who are considering surgery in these settings, of what the Board considers to be appropriate standards for these settings.

–With the assistance of existing accrediting agencies, MBC could publish general guidelines for physicians performing surgery and administering anesthesia in unregulated settings; the guidelines would address credentialing for physicians and anesthesia providers, allied health personnel credentialing and training requirements, facility safety and emergency training requirements, patient care monitoring procedures, medical record-keeping, and peer review procedures.

–MBC could adopt suggested standards as regulations (or as policy if it lacks the statutory authority to regulate in this area) and encourage voluntary accreditation from any of the multi-specialty professional organizations already accrediting office-based surgical practices.

–MBC would adopt the guidelines described above, and then seek legislation requiring "peer assessment"; that is, physicians would ask other physicians who also perform surgery in out-of-hospital settings to survey their surgical site. The reviewer would have to certify that the facility's standards and procedures meet the guidelines and that the staff and setting provide adequate safeguards for patients.

–MBC could draft regulations and legislation requiring accreditation by an existing multi-specialty review agency, instead of the less intrusive "peer assessment" described above.

–MBC could seek legislation requiring licensure of these facilities under Title 22 of the Health and Safety Code. This approach would require DHS review of every unregulated out-of-hospital surgery setting using the same standards required of hospitals.

After much discussion of the evils and benefits of outpatient surgi-centers, the Board decided to study the feasibility of requiring accreditation and whether this option would reasonably achieve the objective of protecting the public.

DAHP's Future in Question. The future of DAHP was again on the November agenda of both the Division and the full Board. In recent years, many allied health licensing programs (AHLPs) which function under DAHP's jurisdiction and even members of DAHP have questioned the

usefulness of the Division and the need for its future existence. *[12:2&3 CRLR 103]* The Division's legal authority varies with respect to each individual AHLP, and some are quite autonomous of DAHP. While some Division members suggested that DAHP be abolished and its members merged into DMQ to assist with the physician discipline system, DAHP member Dr. Mike Mirahmadi opined that, with the onset of "managed care" in California, allied health professionals will become much more involved in patient health care and will require more oversight. As any alteration in DAHP's function will require legislative amendments, the full Board directed Division staff to investigate various role changes for DAHP and to report back at the next meeting.

LEGISLATION

Future Legislation. At its November meeting, the three divisions and the full Board discussed numerous legislative proposals for the 1993–94 session, and tentatively agreed to pursue changes in the following areas:

• ***Licensing Fee Increase.*** MBC agreed to pursue a fee bill which will increase the statutory ceiling on its biennial licensing fees from $500 to $600. Increased revenue is needed to pay the escalating costs of the Board's discipline system (*see supra* MAJOR PROJECTS). In 1992, the Board sponsored SB 1119 (Presley), which would have increased MBC's biennial licensing fee to $550; however, opposition from CMA killed the proposal. Of concern this year to both CMA and MBC is a potential repeat of the "raid" on the special funds of occupational licensing agencies committed by the Governor and legislature in the 1992–93 budget bill, in spite of express language in MBC's enabling act prohibiting the transfer of its special fund money to the general fund. *[12:4 CRLR 1]* If the 1993–94 budget bill requires a similar transfer, CMA will almost certainly oppose a fee increase. MBC discussed the possibility of seeking outside counsel to research the legality of the 1992–93 raid, and will try to preclude future raids by again including language in its fee bill expressly prohibiting the transfer of physician licensing fees to the general fund.

• ***Physician Advertising.*** The Board also agreed to sponsor a bill requiring physicians, when advertising that they are "board certified," to include the full name of the specialty board in which membership is claimed.

• ***Deadline for Records Production.*** DMQ agreed to seek an amendment to establish a 15-day compliance deadline for the production of medical records requested of physicians and hospitals. Currently, DMQ's only recourse when a physician or hospital refuses to comply with a request for records is a court order.

• ***Undercover Investigations.*** DMQ will also seek, once again, an amendment to enable its investigators to wear an undercover wire while conducting investigations.

• ***MQRC Decisionmaking.*** SB 2375 (Presley) abolished the ability of MQRCs to make final decisions in petition cases. DMQ believes this amendment was "inadvertent" and agreed to seek to reinstate this authority.

• ***Unlicensed Practice.*** At the request of several district attorney's offices, DMQ agreed to seek amendments to make the unlicensed practice of medicine, including the aiding and abetting of such practice, a "wobbler," meaning it may be charged as either a felony or misdemeanor.

• ***Medical Injury Compensation Reform Act (MICRA).*** Finally, following a lengthy presentation by Jay Dee Michael, former CMA chief lobbyist and now head of "Californians Allied for Patient Protection" (CAPP), and distribution of CAPP's glossy "MICRA Legislative Kit," the full Board voted to endorse the reenactment of MICRA, which was enacted in 1975 but expires this year. Among other things, MICRA limits a patient's recovery for pain and suffering due to medical malpractice to $250,000, caps attorneys' contingency fees in medical malpractice actions, and permits juries in medical malpractice actions to learn that the plaintiff is eligible to recover payment for economic losses from "collateral sources" such as workers' compensation or health insurance. The 1975 MICRA statute also created the former Board of Medical Quality Assurance (whose name was changed in 1990), and charged its Division of Medical Quality with establishing and maintaining an aggressive physician discipline system.

Although both MICRA and DMQ were highly touted in 1975, many critics argue that neither promise has been fulfilled. Physician malpractice premiums have decreased considerably in California, but those savings have not been passed on to patients. Incompetent physicians are protected from deterrent-producing judgments (even where they are deserved) and, at the same time, DMQ is putting almost no physicians out of business. Thus, consumers are not protected from incompetent physicians by DMQ, and are unable to be fully recompensed for the injuries they suffer at the hands of doctors who simply should not be practicing.

Following Michael's presentation, the Board agreed that MICRA should be reenacted. The lone dissenting vote came from public member Bruce Hasenkamp, who maintained that MICRA's "physician-vs.-trial-attorney" focus on medical malpractice actions is not relevant to MBC's charge. Hasenkamp also objected to the fact that only one side of this important issue was presented before the Board took a position.

Following its selection of Dixon Arnett at its December 16 meeting, the Board agreed to pursue additional legislation during the 1993–94 session. MBC will seek authors for bills to (1) amend Business and Professions Code section 800(c) to limit the type of information from a physician's central file which MBC must disclose to the physician, and exclude from disclosure information which may jeopardize an investigation in progress; (2) amend section 804 to require liability insurers to maintain records on medical malpractice payouts in excess of $30,000 for up to one year; and (3) amend section 805.1 to require hospitals to keep records on and turn over for MBC inspection upon request all records (including medical records) related to any reportable peer review proceeding even where there is no formal adverse action taken by the health facility, and to establish a penalty for failure to provide such records when requested by MBC.

RECENT MEETINGS

At DOL's November meeting, staff presented an update on the Division's implementation of two bills recently passed by the legislature. AB 3426 (Filante) (Chapter 1130, Statutes of 1992) added section 2435.1 to the Business and Professions Code, and requires DOL to charge an additional $25 fee to applicants and licensees at the time of initial issuance and biennial renewal of a license. The $25 add-on is voluntary and physicians may refuse to pay it, but DOL must include it on its licensure and renewal forms. The voluntary fees will be collected and forwarded monthly to the Office of Statewide Health Planning and Development for support of the Song-Brown Family Physician Training Act. *[12:4 CRLR 92]*

DOL is also required to implement AB 1394 (Speier) (Chapter 50, Statutes of 1990), the "Family Support Program." The purpose of the program is to enforce child support orders issued to individuals licensed by a large number of occupational licensing agencies, including MBC. Under the new program, DCA will receive a computer file of persons certified by California district attorneys as delinquent

in child support payments. DCA will then compare this list to both first-time and renewal physician applicants. If DCA discovers a match, MBC must issue the applicant a 150-day temporary license; during this time, the temporary licensee must obtain a release from the appropriate district attorney in order to acquire a full-term license. If a release is not obtained, MBC may not issue a permanent license. DCA has established a centralized unit to handle the implementation of AB 1394, and DOL is attempting to resolve several procedural and fiscal problems it has identified with that unit.

At its November meeting, the Medical Board elected officers for 1993. Dr. Jacquelin Trestrail was elected Board President; public member Bruce Hasenkamp was chosen as Vice-President; and Dr. Robert del Junco was selected as Secretary.

FUTURE MEETINGS

May 6–7 in Sacramento.
July 29–30 in San Francisco.

ACUPUNCTURE COMMITTEE

Executive Officer: Sherry Mehl (916) 263-2680

The Acupuncture Committee (AC) was created in July 1982 by the legislature as an autonomous body; it had previously been an advisory committee to the Division of Allied Health Professions (DAHP) of the Medical Board of California. AC still functions under the jurisdiction and supervision of DAHP.

Formerly the "Acupuncture Examining Committee," the name of the Committee was changed to "Acupuncture Committee" effective January 1, 1990 (Chapter 1249, Statutes of 1989). That statute further provides that until January 1, 1995, the examination of applicants for a license to practice acupuncture shall be administered by independent consultants, with technical assistance and advice from members of the Committee.

Pursuant to Business and Professions Code section 4925 *et seq.*, the Committee issues licenses to qualified practitioners, monitors students in tutorial programs (an alternative training method), and handles complaints against licensees. The Committee is authorized to adopt regulations, which appear in Division 13.7, Title 16 of the California Code of Regulations (CCR). The Committee consists of four public members and five acupuncturists. The legislature has mandated that the acupuncturist members of the Committee must represent a cross-section of the cultural backgrounds of the licensed members of the profession.

Currently, one public member position on AC is vacant, due to Michael Brown's resignation in June 1992.

MAJOR PROJECTS

Public Information Brochure. AC plans to publish a brochure designed to provide information to the public concerning the practice of acupuncture in California. At its November 11 meeting, AC reviewed an initial draft assembled by AC staff and made several recommendations.

The brochure will answer basic consumer questions regarding the nature and purpose of acupuncture, the qualifications an individual must possess in order to be licensed as an acupuncturist, an acupuncturist's scope of practice, and methods of obtaining information about complaints filed against an acupuncturist. It will also include a glossary of acupuncture terms. AC planned to review and possibly approve the final draft at its February meeting.

Some AC members proposed that the brochure be drafted as a promotional piece to create interest in acupuncture as an alternative or "complementary" method of treatment, as well as convey consumer education. No Committee consensus was reached on this issue, although promotion of the acupuncture profession appears to conflict with AC's consumer protection mandate in section 4926 of the Business and Professions Code.

Also at its November meeting, the Committee discussed the possibility of publishing an AC newsletter (to be distinguished from the public information brochure). The purpose of the proposed newsletter is to inform licensees and others associated with the acupuncture profession of various regulatory and statutory changes which may affect them, and major actions taken by AC. A major hurdle for the newsletter, due to budget cutbacks, is the cost involved in printing and postage. AC committed itself to the publication of one newsletter and decided to discuss further publication at upcoming meetings.

AC Rulemaking. On December 11, AC published notice of its intent to amend and adopt various regulatory sections in Division 13.7, Title 16 of the CCR. At this writing, written comments are due by January 25, and AC is scheduled to hold a public hearing on the proposed changes on January 26 in Sacramento. The proposed changes are as follows.

Existing section 1399.417 provides that an application for licensure is deemed abandoned if the applicant fails to complete the application, provide additional information as requested, or submit the required fees. The proposed amendment would provide that an application is deemed abandoned if an applicant for the examination fails to exercise due diligence in the completion of his/her application, or an applicant for licensure fails to submit the initial license fee within two years of notification of eligibility for licensure. An applicant who has abandoned his/her application would forfeit his/her application fees, and re-application and/or re-examination would be required.

Section 1399.436 currently sets forth criteria for AC's approval of schools and colleges offering acupuncture education and training. The proposed amendment would clarify the percentage of transfer credits that may be accepted between AC-approved and non-AC-approved schools and colleges.

Existing section 1399.441 provides that AC's examination will be administered in English, Chinese, Korean, Japanese, and any other language for which a translation is requested by a minimum of 5% of the total number of approved applicants. The proposed amendment would delete Japanese as one of the languages in which the examination is administered.

Section 1399.443 requires a minimum passing score of 70% on both the written and practical examination. The proposed amendment would delete the 70% minimum score requirement.

Section 1399.480 currently provides that acceptable continuing education (CE) courses must be directly related to the scope of practice of an acupuncturist. The proposed amendment to section 1399.480 would allow the Committee to approve continuing education courses related to business management and medical ethics, and proposed new section 1399.487 would allow acupuncturists to take up to four hours per year in these areas to meet AC's CE requirement.

Existing section 1399.481 requires CE providers to submit a description of their course to AC at least 30 days before the course is first offered. The proposed amendment would clarify that the required information must be submitted to AC at least 30 days before the course is scheduled to begin and that one hour of CE instruction equates to 50 minutes of classroom instruction.

Business and Professions Code section 4945.5 requires acupuncturists licensed prior to January 1, 1988 to complete 40 hours of CE by their 1993 license renewal

date in the following areas: general Oriental medical principles, technique, theory, basic western clinical sciences, location and use of acupuncture points, and case studies. Existing section 1399.485 requires licensed acupuncturists holding inactive licenses to complete 30 hours of approved CE within two years of their planned license reactivation date. The proposed regulatory amendment to section 1399.485 would provide that inactive licensees planning to reactivate their licenses prior to January 1, 1994 must complete the 40 hours of specified CE specified in section 4945.5. Additionally, AC proposes to add new section 1399.486, to specify the curriculum which is to be covered in the six subject matter areas and the minimum amount of CE hours required in each area. This rule is being re-proposed after rejection by the Office of Administrative Law (OAL) in July 1992. *[12:4 CRLR 96; 12:1 CRLR 77]*

Existing law provides that an acupuncturist who has failed to renew a license within five years after its expiration must either apply for a new license and pass the regular licensing examination or may, at the discretion of AC, establish that he/she is qualified to practice acupuncture. Proposed new section 1399.444 would require acupuncturists who fail to renew their licenses within five years after expiration to pass the regular licensing examination, and delete the option of establishing their qualification to practice acupuncture.

Existing law permits AC to establish a license renewal system based on licensee birthdates; existing regulation establishes AC's initial license fee at $325. Under proposed regulatory section 1399.460, AC would implement a *pro rata* license fee in order to establish the birthdate renewal program; however, no license will be issued for less than six months.

In other rulemaking action, AC approved amendments to regulatory section 1399.439 at its November meeting; this rule change will now be submitted to DAHP, the Department of Consumer Affairs (DCA), and OAL for review and approval. The amendments would require AC-approved acupuncture schools to submit to AC a course catalog and specified information about the school's curriculum, faculty, and financial condition. *[12:4 CRLR 96; 11:4 CRLR 92]*

LEGISLATION

Future Legislation. AC plans to pursue several legislative changes in the 1993–94 session. First, AC will seek to make the unlicensed practice of acupuncture an infraction, and wants authority to police unlicensed activity through required disconnection of telephone service to nonlicensees holding themselves out as licensees; last session, these provisions were enacted and made applicable to other DCA agencies in SB 2044 (Boatwright) (Chapter 1135, Statutes of 1992). AC has already prepared language for inclusion in DCA's 1993 omnibus bill.

AC also approved proposed clean-up language to Business and Professions Code sections 4936 (deleting certain terms licensees may use in describing themselves as acupuncturists), 4940 (requiring that acupuncturists who supervise tutorial programs be licensed in California for five years), 4947 (adding physicians and surgeons to the list of individuals exempt from this chapter), 4961 (reducing the period of time in which a licensee may submit a late renewal from five years to three), 4966 (requiring late renewals to pay all accrued renewal fees), and 4970 (allowing the AC to prorate renewal fees to comply with birthdate renewals). Furthermore, various sections will be amended to replace the word "certificate" with "license."

RECENT MEETINGS

At AC's November 11 meeting, Committee Chair David Chen complimented Executive Officer Sherry Mehl on her efforts in reorganizing AC's headquarters office and instilling a positive change in attitude since her arrival. *[12:4 CRLR 95–96]* Chen remarked that he sees new leadership in the office. Mehl stated that, although the office is understaffed, she is trying to rebuild AC's enforcement program and work with Medical Board staff in expediting AC's disciplinary cases. In recent weeks, she has approved approximately 20 supplemental accusations, some of which had originally been issued in 1990. Mehl indicated that enforcement is her top priority and that she would be training other staff members to perform enforcement functions.

On October 9, AC finally succeeded in revoking the license of former Committee chair Chae Woo Lew. Lew is serving five years in prison for selling AC's licensing exam to numerous licensure candidates. *[10:2&3 CRLR 103; 9:4 CRLR 65; 9:2 CRLR 64]* According to the acupuncture community, the shame he brought to AC is finally being erased. Furthermore, legal actions to revoke the licenses of those who allegedly purchased the exam from Lew are in the final stages.

FUTURE MEETINGS

May 25–26 in Los Angeles.
August 3–4 in Sacramento.
November 2–3 in San Diego.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer: Elizabeth Ware (916) 263-2288

Pursuant to Business and Professions Code section 3300 *et seq.*, the Medical Board of California's 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 is authorized to issue licenses and adopt regulations pursuant to, and hear and prosecute cases involving violations of, the law relating to hearing aid dispensing. HADEC has the authority to issue citations and fines to licensees who have engaged in misconduct. HADEC recommends proposed regulations to the Medical Board's Division of Allied Health Professions (DAHP), which may adopt them; 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.

As of December 31, HADEC has one hearing aid dispenser vacancy. Governor Wilson is responsible for appointing a replacement for Byron Burton, whose term ended in December 1991 and whose grace year expired on December 31, 1992.

MAJOR PROJECTS

Advertising Guidelines. HADEC's recent "call for contracts" identified common errors made by hearing aid dispensers on their contracts and receipts, and the Advertising Issues Task Force convened by HADEC and the Speech-Language Pathology and Audiology Examining Committee recently identified several problem areas in advertising by hearing aid dispensers. *[12:4 CRLR 97]* As a result, a HADEC subcommittee drafted advertising guidelines for hearing aid dispensers and presented them for discussion at HADEC's December 5 meeting. The draft guidelines address how hearing aid dispensers may best comply with Business and Professions Code sections 651, 3301, 3401(f), and 3428 regarding advertising.

The guidelines define the terms "advertising" and "public communication," and specify what the law requires (such as exact price advertising that is clearly identifiable) and what the law prohibits (such as use of the term "doctor" or "audiologist" unless authorized by law). The draft guidelines also include discussion of the following topics, among others:

- business names—names should not be so broad as to connote comprehensive and diagnostic hearing services, unless the dispenser is also licensed as a physician or audiologist;
- hearing tests—the guidelines caution dispensers against advertising a "free hearing test" because this term implies a comprehensive test; any use of that term should be accompanied by a statement that the test merely determines if the person needs a hearing aid;
- education credentials—dispensers holding a Ph.D. should not use the title "Dr." since most consumers interpret that title as referring to a medical degree; dispensers should advertise only those degrees relevant to the practice of hearing aid dispensing;
- use of the terms "dispenser" and "specialist"—since the licensing law provides for the licensing of "dispensers" and not "specialists," the title "hearing aid dispenser" must be used whenever referring to licensure; and
- national and yellow pages advertising—both types must comply with applicable advertising laws; any advertising run in California should be in compliance with California law and standards.

At its December meeting, HADEC discussed the draft guidelines and determined that more examples would be helpful in clarifying the intent of the guidelines. The draft will be modified and discussed at a future Committee meeting.

Three-Day Cancellation Requirements for Out-of-Office Sales. At HADEC's December meeting, Executive Officer Elizabeth Ware presented a new fact sheet reminding hearing aid dispensers of their legal obligations when they sell hearing aids outside the site where they normally conduct business. Civil Code sections 1689.5–.7 state that transactions in an amount over $25 that are made outside the office at "other than appropriate trade premises" are subject to the following requirements: the purchase agreement must be written in the same language used in the oral sales presentation; certain language ("You, the buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right") must appear in ten-point bold type on the first page of the purchase agreement next to the space provided for the buyer's signature; and, in addition to the written notification prescribed above, the seller must verbally advise the buyer of his/her right to cancel the order.

The fact sheet also explains the meaning of the phrase "other than appropriate trade premises" and contains a sample Notice of Cancellation which complies with the law.

Enforcement Report. HADEC is still working directly with the Department of Consumer Affairs' Division of Investigation (D of I) on the issue of catalog sales. *[12:4 CRLR 98]* HADEC discovered that several companies were illegally selling hearing aids through the mail. To date, D of I has had several meetings with postal inspectors regarding this problem. Two of the eleven companies at fault have agreed to print a disclaimer that reads: "Unavailable in California."

LEGISLATION

Future Legislation. At its December 5 meeting, HADEC reviewed three proposals that it has submitted for inclusion in the Department of Consumer Affairs' 1993 omnibus bill. First, the Committee agreed to seek an amendment to Business and Professions Code section 3452, to provide that an expired license may be renewed at any time within three years after its expiration (reduced from the present five years), so long as the licensee completes the appropriate form and pays the renewal fee in effect on the last renewal date. Second, HADEC will pursue amendments to section 3454, to provide that a licensee who allows his/her license to lapse for more than three years is required to apply for a new license.

Finally, the Committee will seek a repeal of Business and Professions Code section 3365(g). This section requires dispensers to state that they do not perform examinations, diagnoses, or prescriptions as would a person licensed to practice medicine or audiology, and therefore any examination made by them must not be regarded as medical or professional advice. Many dispensers who are also licensed as physicians or audiologists object to this required disclosure; dispensers who are not dual-licensed also object, arguing that their advice does in fact constitute "professional advice." *[12:4 CRLR 98]*

RECENT MEETINGS

At HADEC's meeting in December, the Committee viewed a videotape on the Peritympanic hearing instrument. This device is the first true custom-molded deep canal instrument worn entirely within the auditory canal without surgical intervention. Members of hearing aid dispenser agencies in other states have expressed concern about having hearing aid dispensers conduct this type of deep canal filling without extensive training. The device's invasive fitting process could be the source of consumer lawsuits. While it may be appropriate in the future to suggest legislation to regulate this procedure in order to protect both consumer and dispenser, the Committee decided to take no action on the product or procedure at this time. HADEC decided to publish an article in its newsletter outlining the procedure and recommending guidelines regarding the specialized training needed before its performance by licensees.

Also in December, Executive Officer Elizabeth Ware reported on HADEC's procedure for warning dispensers who are in violation of the law applicable to hearing aid dispensers. Notices are mailed specifying the particular violation and what should be done to rectify it. Although the notices are in the form of citations, no penalty fees have been demanded. On a related issue, HADEC's follow-up on its "call for contracts" continues, although it no longer accepts contracts for evaluation to see if they comply with the law. *[12:4 CRLR 97]* Instead, HADEC mails fact sheets to the requesting dispenser detailing how the dispenser's contract can avoid violating the law.

At its December meeting, HADEC honored Byron Burton for his eight years of service on the Committee by presenting him with a framed certificate commending him for service to the State of California.

FUTURE MEETINGS

July 16 in Sacramento.
November 12 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 approximately 14,200 physical therapists and 2,300 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 functions under the general oversight of the Medical Board's Division of Allied Health Professions (DAHP).

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.

The Committee currently has two public members and three PT members. At this writing, no replacement has been named for public member Mary Ann Meyers, who resigned in November 1990. Additionally, the terms of another public member and one PT member have expired. Both members will continue to serve until June 1993, when their one-year grace periods expire.

MAJOR PROJECTS

PTEC Rulemaking. At its October 22 meeting, PTEC held regulatory hearings on two rulemaking packages, one pertaining to physical therapists' supervision and use of PTAs and physical therapy aides (proposed amendments to sections 1398.44, 1399, and 1399.1, Division 13.2, Title 16 of the CCR), and the other regarding PTA licensure standards (proposed amendments to section 1398.47). *[12:4 CRLR 100]*

PTEC received a substantial number of comments on both proposals; the comments suggested grammatical changes to remove inconsistencies and substantive changes to create requirements that more adequately reflect the needs of PTs in the various settings in which they perform services. Because the comments were both numerous and complex, PTEC resolved to analyze all of the testimony submitted and modify the language of the proposed regulatory changes based upon the comments. The Committee decided to address the modifications at its January 22 meeting before considering whether to adopt the regulatory changes.

In other PTEC rulemaking action, the Office of Administrative Law (OAL) approved the Committee's amendments to regulatory sections 1399.50 and 1399.52 on November 19. These changes increase various examination and licensing fees for PTs and PTAs. *[12:4 CRLR 100]* The Committee decided to withdraw its proposed amendment to section 1399.54, which would have increased the biennial renewal fee and established a delinquency fee for PTs certified to perform electromyography. On November 16, OAL approved PTEC's amendment to section 1398.4, regarding delegation of all functions necessary to dispatch the Committee's business in the absence of its executive officer. *[12:4 CRLR 101]*

KEMG/ENMG Examination/Certification Controversy. At its October 22 meeting, PTEC considered a petition from Jim Ferguson, a licensed PT seeking certification to perform electroneuromyography (ENMG). PTEC administers an exam in kinesiological electromyography (KEMG) and a separate exam in ENMG; the Committee has always interpreted regulatory section 1399.65(a) to require an applicant for ENMG certification to first take and pass the KEMG exam, and then take and pass the ENMG exam. Ferguson took both tests on the same day, scoring 98% on the ENMG exam and 68% on the KEMG exam. Ferguson questioned PTEC's application of section 1399.65(a) to his case, arguing that section 1399.65(b) is more applicable. That section states that "[a]pplicants who possess no electromyography certification may be administered one examination including the subject areas of sections 1399.66 and 1399.67 in order to be certified in electroneuromyography." Ferguson asked the Committee to either average his two scores together (which would give him a passing score of 82%) or discontinue requiring passage of the KEMG exam as a prerequisite to ENMG certification; Ferguson argued that the two procedures are completely different from each other and one should not be conditioned upon the other.

Executive Officer Steve Hartzell stated that, under his reading of the statutes and regulatory sections 1399.65–.67, PTEC is not authorized to grant a restricted certification in ENMG only; an applicant must first pass the KEMG exam, and then may be additionally certified to perform ENMG. Department of Consumer Affairs (DCA) legal counsel Greg Gorges, who advised the Committee when the relevant regulatory sections were adopted several years ago, commented that PTEC's intent in adopting the provisions was to have one certification "build on" the other, such that ENMG licentiates could perform both ENMG and KEMG procedures. Gorges opined that if the Committee believes this is no longer appropriate, regulatory changes are required to certify ENMG and KEMG separately.

PTEC Chair Norma Shanbour charged staff with analyzing the history of the development of the ENMG and KEMG certification regulations; the Committee will address this issue at future meetings.

RECENT MEETINGS

At PTEC's October 22 meeting in Sacramento, Executive Officer Steve Hartzell announced that, as a result of the Committee's severe budget restraints, the PTEC newsletter will be published only once during the year. One of the topics to be covered in the newsletter is the identification of PTs and PTAs whose licenses have expired. The purpose of this section is to remind PTs and PTAs of their obligation to renew their licenses.

Also in October, Hartzell announced that PTEC has once again contracted with Professional Examination Service to provide the PT and PTA licensure examinations. PTEC then approved two dates for the administration of its electroneuromyography and kinesiological electromyography examinations—March 3 and November 17, 1993.

PTEC's October meeting ended with the Committee's election of officers for 1993. PT Norma Shanbour was reelected as PTEC Chair and PT Carl Anderson was reelected as PTEC Vice-Chair.

FUTURE MEETINGS

July 9 in San Francisco.
October 7 in Anaheim.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale
(916) 924-2626

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 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's objective is to ensure 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 regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

PAEC's nine members include one member of the Medical Board of California (MBC), 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 a member of any division of MBC, three PAs, and two public members. PAEC functions under the jurisdiction and supervision of MBC's Division of Allied Health Professions (DAHP).

On January 1, 1993, the terms of PAEC members Nancy Edwards (physician assistant), Joseph Tate (physician assistant), Janice Tramel (physician assistant/educator), and Jacquelin Trestrail (MBC member) expire. Governor Wilson is responsible for filling these vacancies.

MAJOR PROJECTS

Implementation of Family Support Program. At its October 9 meeting, PAEC discussed its implementation of AB 1394 (Speier) (Chapter 50, Statutes of 1992), the "Family Support Program." The purpose of the program is to enforce child support orders issued to individuals licensed by a large number of occupational licensing agencies, including PAEC. Under this new program, the Department of Consumer Affairs (DCA) will receive a computer file of persons certified by California district attorneys as delinquent in child support payments. DCA will then compare this list to both first-time and renewal PA applicants. If DCA discovers a match, PAEC must issue the applicant a temporary initial or renewal license good for only 150 days. During this time, the temporary licensee must obtain a release from the appropriate district attorney in order to acquire a full-term license. If a license is not obtained, the individual will not be issued a permanent license.

Diversion Program. At its October meeting, PAEC received the latest statistics on its diversion program for substance-abusing licensees. The program is currently administered by Occupational Health Services (OHS) under contract to PAEC. Since the program's inception in 1990 *[10:2&3 CRLR 107]*, nine PAs have been referred to the program; seven of these were self-referrals and two were referred by PAEC staff. Of the seven cases which have been closed, six voluntarily withdrew and one was dismissed for noncompliance. None of the nine individuals has successfully completed the program.

PAEC discussed a proposal to discontinue its contract with OHS and instead participate in the Medical Board's in-house diversion program; although the Medical Board refused to permit non-physicians to participate in its program for many years, it has recently agreed to administer the diversion programs of the Board of Podiatric Medicine and the Board of Examiners in Veterinary Medicine. The Committee agreed to look into this matter.

Surgical Procedures by PAs. At its October meeting, the Committee discussed the possibility of drafting a regulation to limit a PA's ability to perform surgical procedures in a hospital operating room when the PA's supervising physician is not present. Representatives from the California Academy of Physician Assistants (CAPA) announced their objection to any such regulation, as rural hospitals often require PAs to perform minor procedures in operating rooms because the lighting is better than in other rooms. A representative from the California Medical Association voiced concern over PAs' capabilities and training to perform surgical procedures. The Committee tabled the issue until its staff and CAPA obtain more information through investigation.

Compilation of Laws and Regulations. PAEC is still working on the compilation of its enabling act and implementing regulations. *[12:4 CRLR 103]* At this writing, publication is expected during the spring of 1993.

LEGISLATION

Future Legislation. At its October meeting, PAEC agreed to pursue legislation to increase the maximum number of PAs which a physician may supervise from two to three. The Committee also discussed tentative plans to sponsor bills to allow nurse practitioners and PAs to supervise medical assistants when a physician is not onsite, and to clarify the authority of PAs when transmitting orders to a registered nurse. *[12:4 CRLR 102–03; 12:2&3 CRLR 117]*

RECENT MEETINGS

At PAEC's October meeting, staff member Jennifer Barnhart presented a status report on current licensing and enforcement statistics. As of June 30, there were a total of 2,183 PAs and 4,441 supervising physicians. As of September 30, the Medical Board's Central Complaint and Investigation Control Unit was processing 15 complaints against PAs, and 33 cases against PAs were being actively investigated. Fourteen cases against PAs are pending at the Attorney General's Office awaiting the drafting of a formal investigation. Thirteen accusations have been filed and are pending; and the licenses of seven PAs are on probation.

In October, PAEC members voiced concern about Committee members who frequently miss meetings. No existing legal provisions permit the Committee to remove a member who continually misses meetings. Executive Officer Ray Dale suggested he could strongly urge the resignation of any member who misses more than one meeting per year, and also proposed that PAEC develop guidelines regarding meeting attendance at its next meeting.

Also in October, PAEC elected Nancy Kluth as its chair and Nancy Edwards as vice-chair for 1993.

FUTURE MEETINGS

July 30 in Long Beach.
October 1 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.

MAJOR PROJECTS

Consensus Builds for BPM Independence from Medical Board. Currently,

BPM is designated as one of the allied health licensing programs (AHLPs) under the jurisdiction of the Medical Board's Division of Allied Health Professions (DAHP). Recently, strong support has developed for legislation to transfer BPM out of the Medical Board and make it a separate board within the Department of Consumer Affairs. In an October 30 statement, BPM described several reasons for the desired transfer. First, DPMs are recognized as physicians; they are not "allied health professionals" like physician assistants or respiratory care practitioners regulated by other AHLPs. In addition, DPMs and orthopedic surgeons (MDs) are in direct economic competition. In the opinion of BPM, it is bad government to structurally locate one board under the jurisdiction of another board made up of members who have an unavoidable conflict of interest; further, the podiatry profession is not represented on the Medical Board. The California Podiatric Medical Association's (CPMA) position is that BPM's current location in DAHP, under the Medical Board, is unacceptable. CPMA prefers independence from the Medical Board, or inclusion in the Medical Board with proper representation.

BPM Seeks to Establish Podiatric Residency Programs in UC Hospitals. BPM is in the process of trying to establish a program of residency rotations for podiatric graduates in University of California-affiliated hospitals. A November 12 BPM staff discussion draft regarding 1993 residency legislation contains a proposed amendment to Business and Professions Code section 2484. The proposed amendment reads: "It is the intent of the Legislature that podiatric medical residents should have access to participation in training rotations in state-supported medical teaching centers of the University of California. The university shall, in consultation with the Department of Consumer Affairs and the Council on Podiatric Medical Education, provide appropriate rotations for at least a minimum number of podiatric residents in each training center as early as practicable but no later than January 1, 1996."

Currently, podiatric residents are largely shut out of the UC system. Historically, podiatric residency programs have been developed by the few podiatrists who have been accepted on staff at some of the smaller hospitals and have been able to develop training programs. A podiatric residency program at the UC hospitals would expose podiatric residents to a wider ranger of situations and improve the level of training received. Podiatrists are currently absent from UC residency programs in part because podiatrists are seen as competitors to orthopedic surgeons, who are already established at the UC level and who—according to the podiatric community—seek to prevent podiatrists from locating residency programs in UC-affiliated hospitals.

Debate Over Licensing Fees Continues. On September 18, CPMA President Jon Hultman issued a letter to BPM President Michael Vega requesting a reduction in BPM's annual licensing fees from the current $400 to $240, the amount paid by MDs to the Medical Board. Hultman expressed concern that BPM's $400 fee, currently the highest license fee of any medical profession in the state, is being used in part to support a staff that is proportionately larger in relation to the number of licensees than exists at other health profession regulatory boards. Hultman also decried the recent transfer of podiatrist licensing fees from BPM's reserve fund to the general fund as double taxation on podiatrists. *[12:4 CRLR 1, 106]*

In an October 1 reply, Board President Vega stated that the reason BPM's fees and staff/licensee ratio are higher than those of some other boards is the relatively small number of licensees. Because of the transfer of funds, BPM will be faced with a serious deficit unless it raises fees or cuts costs. Last March, BPM resisted pressure from legislative staff to increase fees, and is committed to making up for lost reserves by cutting costs. Vega also expressed concern that the fee reduction requested by CPMA would bring the Board's enforcement program to a halt, and noted that many people believe the Medical Board's licensing fees are too low and its enforcement program is inadequate.

In a December 2 letter to CPMA Executive Director John Bailey, BPM Executive Officer Jim Rathlesberger reiterated that BPM remains committed to not raising fees, and expressed concern about a recent headline in CPMA's newsletter which reads "CPMA seeks license fee decrease, BPM says increase is a possibility." The headline appeared after Board President Vega had responded to Hultman's September 18 letter and addressed CPMA's concerns.

■ RECENT MEETINGS

At its September 25 meeting, the Board unanimously voted to cancel its scheduled December 11 meeting in San Diego as a cost-cutting measure.

■ FUTURE MEETINGS

November 5 in Los Angeles.

BOARD OF PSYCHOLOGY

Executive Officer:
Thomas O'Connor
(916) 920-6383

The Board of Psychology (BOP) (formerly the "Psychology Examining Committee") is the state regulatory agency for psychologists under Business and Professions Code section 2900 *et seq.* Under the general oversight of the Medical Board's Division of Allied Health Professions, 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. Currently, Louis Jenkins, Judith Fabian, Linda Hee, Frank Powell, and Philip Schlessinger are BOP's psychologist members, and Bruce Ebert and Linda Lucks are its public members. One BOP public member position is vacant.

■ MAJOR PROJECTS

Proposed Supervised Professional Experience Regulations. Following further discussion at its November 7 meeting, BOP on December 22 released a modified version of its proposed changes to sections 1387 and 1386(c) and its proposed addition of section 1387.3, Division 13.1, Title 16 of the CCR. Collectively, these regulatory changes would implement the provision in Business and Professions Code section 2914 requiring applicants for psychologist licensure to have engaged for at least two years in "supervised professional experience [SPE] under the direction of a licensed psychologist, the specific requirements of which shall be defined by the Board in its regulations, or such suitable alternative supervision as determined by the Board in regulations duly adopted under this chapter, at least one year of which shall be after being awarded the doctorate in psychology." *[12:4 CRLR 107–08; 12:2&3 CRLR 123]*

Under the modified regulations, a qualified primary supervisor (QPS) overseeing "supervised professional experi-

ence" means a psychologist who is engaged in rendering professional services a minimum of one-half time in the same work setting at the same time as the person supervised in obtaining SPE. Effective July 1, 1994, a QPS must have not less than three years of professional post-licensure experience. The QPS may delegate a portion of the supervision for which he/she is responsible to another licensed psychologist or, effective July 1, 1994, to a person who meets the qualifications set forth in new section 1387.3 (*see infra*). One year of SPE shall consist of not less than 1,500 hours, which must be completed within 30 consecutive months. Two years of SPE are required, one of which must be completed after being awarded the doctoral degree. After July 1, 1994, each of these two years must be supervised by a different QPS.

Section 1387(o) defines "suitable alternative supervision" as supervision by a psychologist licensed or certified in another state or territory of the United States, a diplomate of the American Board of Professional Psychology, or by a psychologist who holds a doctorate degree in psychology and who has a minimum of three years of professional post-doctoral experience. Section 1387(o)(2) states that a maximum of 750 hours of "suitable alternative supervision" may be under a primary supervisor who is a licensed professional other than a psychologist, including but not limited to, board-eligible or board-certified psychiatrists, educational psychologists, or clinical social workers. Effective July 1, 1995, the primary supervisor referenced in subsection 1387(o)(2) shall be limited to a board-certified psychiatrist with three years of post-certification experience as a psychiatrist, or other licensed mental health professional who has three years of post-licensure experience as a mental health professional.

New section 1387.3 outlines the qualifications of supervisors. Any person making an application to supervise must be a licensed psychologist or a board-certified psychiatrist. Effective July 1, 1994, the psychologist must have not less than three years of professional post-licensure experience. Any person wishing to provide supervision under section 1387(o)(2) (*see supra*) must be a board-eligible or board-certified psychiatrist, an educational psychologist, a clinical social worker, or other licensed mental health professional. Effective July 1, 1995, the applicant must be a board-certified psychiatrist or a licensed mental health professional with not less than three years of professional post-certification or post-licensure experience.

BOP reopened the public comment period on these modified regulations until January 22.

Board Continues Work on Draft Disciplinary Guidelines. BOP Executive Officer Tom O'Connor has been working with members of the Board to establish a set of recommended penalty guidelines to assist deputy attorneys general in prosecuting and administrative law judges in determining correct punishments for violations of the Psychology Licensing Law. A second draft was presented to the Board at its November meeting. While the proposed disciplinary guidelines are not intended to be an exhaustive catalog of possible offenses and penalties, the guidelines cover the most common violations. Further, the penalty guidelines have been divided into maximum and minimum penalties for each type of violation. A final draft should be ready for the Board's March meeting.

LEGISLATION

Future Legislation. Currently, Welfare and Institutions Code section 5603 requires that Department of Mental Health to review and approve requests from local mental health programs for waivers of professional licensure for persons who are gaining qualifying experience to become licensed as psychologists. The Department of Mental Health intends to propose that BOP become responsible for reviewing and approving these requests for waiver. This proposal would require amendments to two code sections: Welfare and Institutions Code section 5603 would be amended to eliminate the reference to the Department of Mental Health, and section 2909 would be added to the Business and Professions Code, requiring persons seeking a waiver of the licensure requirement to apply to BOP.

RECENT MEETINGS

At the November meeting, Chet Pelton from the Medical Board of California (MBC) described a new computerized probation tracking system that is being implemented in California. Six MBC investigators have been assigned to track BOP probationers. The Medical Board claims that computerizing the probation department will benefit BOP because the Board will receive a monthly report updating the status of each psychologist whose license is on probation; each allied health licensing program under MBC's jurisdiction will now be served by a specific group of investigators (rather than having all 40 MBC investigators work with all probationers under the Medical Board's jurisdiction); and BOP will receive a statistical breakdown that may help it identify the types of offenses which lead to probation violations.

Also in November, Executive Officer Tom O'Connor discussed his efforts to implement SB 774 (Boatwright) (Chapter 260, Statutes of 1992). SB 774 established minimum continuing education requirements as a condition of license renewal for psychologists. *[12:4 CRLR 109]* O'Connor believes that the Board will have to hire new staff in order to comply with the requirements of the bill, and thus has submitted a budget change proposal to the Department of Consumer Affairs.

In November, BOP discussed elimination of the language in regulatory section 1388(b) requiring the use of the Examination for Professional Practice in Psychology (EPPP) as the Board's only form of written examination. The EPPP covers problem definition and diagnosis; intervention; research; professional, legal, and ethical issues; and applications to various social systems. However, BOP has recently received confirmation that the specialty examinations issued by national boards which are members of the American Board of Professional Psychology cover the same five dimensions, and BOP desires the flexibility to accept these exams in lieu of the EPPP. The Board agreed to commence the rulemaking process to accomplish this regulatory change, and tentatively scheduled a regulatory hearing for its March 20 meeting.

FUTURE MEETINGS

May 14–15 in Los Angeles.
September 17–18 in San Diego.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards (916) 263-2666

The Speech-Language Pathology and Audiology Examining Committee (SPAEC) consists of nine members: three speech-language pathologists, three audiologists and three public members (one of whom is a physician). SPAEC functions under the jurisdiction and supervision of the Medical Board's Division of Allied Health Professions (DAHP).

The Committee administers examinations to and licenses speech-language pathologists and audiologists. It also registers speech-language pathology and audi-

ology aides. SPAEC hears all matters assigned to it by the Division, 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 DAHP 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).

At this writing, two Committee members—one audiologist and one public member—are serving under a grace period, having completed the maximum term of service without replacement. In addition, three SPAEC positions are vacant: one audiologist, one speech-language pathologist, and one public member position appointed by the Assembly Speaker.

MAJOR PROJECTS

SPAEC Proposes Regulation Specifying Exam Waiver Criteria. On November 27, following discussion at its October 17 meeting, SPAEC published proposed amendments to section 1399.159(b), Division 13.4, Title 16 of the CCR, to define the criteria it will apply in deciding whether to grant a request for an exam waiver under Business and Professions Code section 2532.2(e). The rulemaking effort stems from a formal petition filed by the Center for Public Interest Law, which SPAEC granted at its April 1992 meeting. *[12:4 CRLR 109–10; 12:2&3 CRLR 125]*

The proposed amendments provide that licensure applicants who have taken and passed the national examination and who (1) are licensed in another state, or (2) hold a certificate of clinical competence issued by the American Speech-Language-Hearing Association in the field for which licensure is sought, or (3) were previously licensed in this state but whose license has lapsed under Business and Professions Code section 2535.4, and can prove they have been continuously employed (except for usual and customary absences for illness and vacations) in the field for which licensure is sought for three years prior to the date on which their application was filed with SPAEC, shall be deemed to have satisfied the examination requirement in regulatory section 1399.159(a) even though the national exam was taken more than five years prior to the date on which their application was filed with SPAEC. Continuous employment in the field for which licensure is sought is defined as documented employment of not less than 15 hours per week during the three years specified above while maintaining a license in the state where the applicant was employed. The proposed regulation would also allow an applicant who has less employment experience than required to submit proof of continuing education in the field for which licensure is sought; SPAEC will review this combination on a case-by-case basis.

SPAEC was scheduled to hold a public hearing on this proposed regulatory change at its January 16 meeting in San Diego.

SPAEC Prepares to Tighten the Budget Belt. The budget cuts set forth in the 1992–93 Budget Bill require special-funded agencies, including SPAEC, to reduce expenditures by 10% from 1991–92 and to transfer that 10% to the general fund on June 30, 1993. *[12:4 CRLR 110]* SPAEC will be allowed to transfer this amount from its reserve account rather than actually reduce expenditures, although the agency is expecting a true 10% cut in expenditures to be mandated for the 1993–94 budget. Further, SPAEC will no longer be allowed to keep a reserve fund containing one year's worth of operating expenses. At the end of the fiscal year, all funds in excess of two months' worth of operating expenses will be transferred to the general fund.

SPAEC has also endured some travel cuts, but they have been insignificant as compared to other agencies which travel a great deal. However, the reduction in out-of-state travel funds has meant the curtailment of travel to national events and the opportunity to maintain a broad outlook on national developments.

Advertising Issues Task Force. At SPAEC's October meeting, Committee Chair Robert Hall reported that, as the result of the Advertising Issues Task Force's July 31 meeting *[12:4 CRLR 110]*, the Hearing Aid Dispensers Examining Committee (HADEC) has drafted a document entitled "Advertising Guidelines for Hearing Aid Dispensers," which is an effort to educate the industry and put potential violators on notice of what is and what is not acceptable in the advertising of hearing aids and related products. (*See supra* agency report on HADEC for related discussion.)

LEGISLATION

Future Legislation. SPAEC may pursue several legislative changes during the 1993–94 session, such as charging a fee for the exam waiver interview and further refinement of the definition of audiology to keep up with developing technologies which require new methods of diagnosis and treatment. Department of Consumer Affairs (DCA) legal counsel Greg Gorges has warned that some procedures used by audiologists border on what are normally described as "invasive" procedures, such as the making of earmold impressions. The Legislation/Regulation Subcommittee will look into these areas, as well as the need for legislation regarding mandatory continuing education (*see infra*) and a recent question regarding the faxing of audiology results for review and whether a reviewing audiologist is allowed to do this under the current definition of audiology.

RECENT MEETINGS

SPAEC held its fourth and final meeting of 1992 in San Francisco on October 17. Executive Officer Carol Richards noted the many changes taking place within DCA. Of special interest is DCA's willingness to focus on unlicensed practice and push for more enforcement in this area. SPAEC has been and is continuing to develop an enforcement program aimed at unlicensed activity as specified in SB 2044 (Boatwright) (Chapter 1135, Statutes of 1992). *[12:4 CRLR 110]* The legislature has determined that the sanction for unlicensed activity should be "swift, effective, appropriate," and should create a strong incentive to obtain a license. SPAEC planned to publish a newsletter for release in January to specify the unlawful activities, including but not limited to practice without a license, and the related fines that could be imposed upon imposition of a citation. Fines range between $250–$1,000; the newsletter will provide further notice that practicing without a license is an infraction.

SPAEC also discussed the need for rules or legislation regarding mandatory continuing education (CE). SPAEC has considered the need for mandatory CE in the past *[12:2&3 CRLR 126]* and, with passage of SB 2044, it will attempt to locate an author and submit legislation which complies with SB 2044.

FUTURE MEETINGS

June 26 in Los Angeles.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Executive Officer: Ray F. Nikkel (916) 263-2685

Pursuant to Business and Professions Code section 3901 *et seq.*, the Board of Examiners of Nursing Home Adminis-