cause DCA's Office of Examination Resources determined that it is not legally defensible; Mandel opined that BLA's return to an exam that is not legally defensible for strictly financial reasons is unacceptable. Following discussion, BLA agreed to offer the PELA once per year in one location; increase its examination fee by $100 (*see* MAJOR PROJECTS); negotiate with the its PELA examination vendor, HRStrategies, to lower contract costs; and consider establishing a second licensing category in order to raise revenue. BLA also discussed the feasibility of selling advertisement space in its newsletter as a way to increase revenue; DCA legal counsel Don Chang warned that such an action might appear to constitute an endorsement by the Board, but agreed to look into the matter further and report his findings to the Board at a future meeting.

FUTURE MEETINGS

November 18 in Sacramento.

MEDICAL BOARD OF CALIFORNIA

Executive Director: Dixon Arnett
(916) 263-2389
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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 public members appointed to four-year terms, is divided into two autonomous divisions—the Division of Licensing and the Division of Medical Quality. The Board and its divisions are assisted by several standing committees, ad hoc task forces, and a staff of 250 who work from 13 district offices throughout California.

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

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

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

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

MAJOR PROJECTS

MBC Overhauls Use of Medical Experts and Consultants. Following extensive debate at its July 29 meeting, the Medical Board adopted a proposal of its Task Force on Medical Quality Review which accomplishes two longtime goals of the Board: (1) It establishes minimum qualifications for physicians who review quality of care disciplinary cases and provide expert testimony at disciplinary hearings, and (2) it overhauls the Board's system of providing in-house medical review of disciplinary investigations by its employee district medical consultants (DMCs) and its employment of a single, full-time Chief Medical Consultant (CMC). The Board's vote was the culmination of nine public hearings of the Task Force since its creation soon after the March 1993 Medical Summit. *[14:2&3 CRLR 65–66; 14:1 CRLR 52; 13:4 CRLR 57–58]*

Compared to the restructuring of the DMC/CMC system, establishing minimum qualifications for expert witnesses and reviewers was relatively easy for the Board. Physicians wishing to serve as MBC medical experts must apply to DMQ for appointment or reappointment to two-year terms on a new statewide panel of experts, and must sign a written agreement to serve and to testify as needed in any case in which a written opinion is provided. Under the new criteria, MBC medical experts must be board certified by a specialty board approved by the American Board of Medical Specialties (ABMS) or in an "emerging" specialty, and must have a minimum of five years of practice in that specialty area. Experts must also have clear licenses with no prior discipline, no current accusation pending, and no complaints closed with merit, and must be in "active practice" (defined as at least 80 hours per month in direct patient care, clinical activity, or teaching) or be "non-active" for no more than two years at time of appointment to MBC's panel of experts. Peer review experience is recommended but not required. Experts must also successfully complete an eight-hour training program at least once every four years. The actual assignment of experts to disciplinary cases will be handled by the Board's DMCs, and the board certification or area of practice of the expert should match that of the respondent or the area of practice under review. The Board's action on the minimum qualifications proposal later prompted Governor Wilson to veto SB 1958 (Presley), a California Medical Association (CMA)-sponsored bill which would have established qualifications for medical experts in statute (*see* LEGISLATION).

Overhauling its system of using full-time, civil-service-protected DMCs and one CMC proved to be a much more difficult challenge for the Task Force and the Board. During the course of its deliberations, the Task Force considered but the full Board rejected a model proposed by MBC staff which was based on the system used by the Florida Board of Medicine; instead of using employee physicians like

MBC's DMCs to review quality of care complaints and investigations, the Florida board uses a group of 164 volunteer physicians to review these cases. Following the Board's February 1994 rejection of the Florida model, MBC President Bruce Hasenkamp instructed the Task Force and staff to undertake a four-part factfinding study in order to provide MBC members with detailed information on the functions, performance, and cost of the current system as opposed to alternatives.

During the summer of 1994, the Task Force met on June 1, June 20, July 11, and July 27 to study the results of the four-part study and produce a final report in time for the full Board's consideration at its July 29 meeting. The studies produced the following information:

• ***Desk Audit of DMCs***. Independent management consultant Carl Bergstrom conducted a "desk audit" consisting of personal interviews with each of the DMCs and a self-survey of their activities during a two-week period. The purpose of Bergstrom's audit was to identify the tasks performed by DMCs, the time committed to certain tasks, the qualifications of the expert medical witnesses and consultants who are retained by the DMCs, and the method(s) by which the DMCs choose these experts. Bergstrom presented his final report at the Task Force's June 1 meeting.

MBC's DMCs work from the Board's district offices; their role is to review medical records gathered by MBC investigators and to assist in determining whether a violation of the Medical Practice Act warrants disciplinary action and can be proven by clear and convincing evidence. One of their primary tasks is to select the medical experts who will review medical records in individual cases and serve as expert witnesses at evidentiary hearings. Analyzing a two-week "snapshot" of the functions reported by ten of MBC's DMCs, Bergstrom found that the DMCs spend 25% of their time reviewing medical records gathered by MBC investigators, 14% of their time dictating and proofing memos, 13% of their time in consultation with investigators, 5% of their time in consultation with deputy attorneys general from the Health Quality Enforcement Section (HQES) of the Attorney General's Office, and another 5% of their time in other administrative activities. The remaining 38% of their time is spent on approximately 18 other identifiable activities; significantly, only 3% of their time is spent selecting medical experts, another 3% is spent reviewing the reports of experts, and another 3% is spent consulting with experts.

The Bergstrom report also noted some serious deficiencies in the Board's DMC system. First, the report noted "confusion as to roles and reporting responsibilities.... The Chief Medical Consultant stated that he supervises the [DMCs] and that 'no non-physician' can supervise a physician. However, this is not the way the organizational chart appears, nor is it the interpretation of Executive staff: Consultants are supervised by the District Supervisors.... Medical Consultants saw their role like that of the physician in the hospital, *i.e.*, relatively independent of the administrative staff."

With regard to the DMCs' critical task of selecting and supervising physician experts to review investigative findings and testify at disciplinary hearings, the Bergstrom report found a lack of standardization among the district offices with regard to the selection and use of medical experts, a lack of communication or "sharing" of expert lists among district offices, and the complete absence of a centralized statewide database of information on medical experts used by the Board. Rather, under the old system, each DMC kept his/her list of experts individually, usually in a rolodex or card file. The criteria for selecting experts varied with each DMC; most said experts should be board certified, have no prior disciplinary action, and should be "actively practicing or recently retired" (although the definitions of these terms varied from district office to district office).

At the Task Force's June 1 meeting, MBC Chief Medical Consultant Dr. Richard Ikeda disputed Bergstrom's findings regarding the lack of standardized procedures used by the DMCs in selecting experts, stating that he had provided Bergstrom with a document setting forth the procedures which the DMCs should follow. Torrance District Office DMC Dr. Eugene Kompaniez stated that he would prefer a more structured team approach among investigators, medical consultants, and prosecutors, and a system wherein the deputy attorney general is assigned to cases earlier in the investigative process so as to provide legal guidance on the documents and evidence needed.

• ***HQES Survey***. The second step of the Task Force's study was conducted by HQES Chief Al Korobkin and presented at the Task Force's April 25 meeting. Korobkin surveyed a random sample of discipline cases prosecuted between March 1993 and February 1994 to determine the percentage which had been withdrawn or subject to early stipulation due to problems with the expert witnesses obtained by the DMCs. According to Korobkin's survey, expert witness problems caused the compromise of seven of the 93 cases reviewed (7.5%). However, if the focus is narrowed to quality of care cases where expert testimony is crucial to HQES/MBC prosecutorial success, the percentage of cases in which expert witness problems caused early compromise or withdrawal jumps to approximately 15%. Korobkin's survey uncovered several cases where MBC's experts had been discredited because they had been the subject of numerous medical malpractice claims or adverse peer review decisions, or had ceased practicing in that specialty years earlier. *[14:2&3 CRLR 65]*

At the Task Force's June 1 and June 20 meetings, the DMCs present all argued that the cases identified by Korobkin as having been compromised due to problems with the expert witnesses had actually been lost due to other reasons. Pleasant Hill District Office DMC Dr. Donald Calvo argued that they were simply "bad cases or incomplete cases which should be analyzed in detail by the investigators and consultants who handled the cases," rather than by HQES. The DMCs complained that they were being blamed for all of the problems of the Medical Board's physician discipline system, and that the real source of the problem is HQES, where—at that time—over 1,600 fully investigated cases were backlogged awaiting the filing of an accusation or a hearing.

The DMCs then presented their own proposal, which involved greater use of "multilevel screening" to screen out nonmeritorious cases at an early stage, regional monitoring of disciplined physicians, and an enhanced partnership between the investigators, HQES prosecutors, and the DMCs. Glendale District Office DMC Dr. Lawrence Yaeger and CMC Dr. Ikeda argued for greater use of volunteer regional peer review panels and an expanded ability on the part of investigators and DMCs to close cases and/or enter into voluntary, nondisciplinary agreements with physicians which would informally remove them from practice or restrict their practices, as an alternative to disciplinary prosecution by HQES.

• ***Analysis of MBC's Use of Medical Experts***. At the Task Force's June 1 meeting, MBC Deputy Director Doug Laue presented the final report on his inventory of the use of expert medical consultants by specialty, a computer analysis of the Board's use of medical experts from July 1992 to March 1994. According to the inventory, MBC used 944 experts during that 21-month period, for a total of 14,285 hours at a cost of $1,166,600. Over 85% of the hours claimed were for medical records review and report preparation; 5.3% of the hours claimed were for testimony at evi-

dentiary hearings. The DMCs were able to produce resumés of only 530 of the 944 experts used (56%). Of these 530 experts, 475 (90%) were ABMS-certified in their specialty. The most frequently used specialty was internal medicine, claimed by 16.4% of the experts as their specialty. The other most frequently claimed specialties were obstetrics/gynecology (14%), family practice (12.6%), and psychiatry (11.7%).

• ***Cost of Current System vs. Alternatives***. The fourth and final step—a breakdown comparison of the cost of the current system vs. the cost of recruiting, training, retaining, and providing support for a "volunteer" expert system like Florida's—was also presented on June 1. According to the analysis, it costs MBC $1.385 million to finance 10.5 DMC positions, and another $1 million per year for outside expert consultants. To maintain a panel of 432 volunteer outside experts (which MBC has estimated it would need to handle its caseload), it would cost the Board at least $1.1 million annually if a $100 per diem were paid; if normal expert witness fees were paid, it would cost the Board over $2.38 million per year. Thus, the DMCs argued that no significant savings would accrue by moving to the Florida model; they additionally argued that cases would take much longer to process if actively practicing outside physicians were used to review them instead of in-house DMCs.

By its July 11 meeting, the Task Force had prepared a preliminary draft proposal for discussion purposes which discarded the Florida "volunteer" model but also scrapped the full-time, civil service DMC and CMC positions in favor of a more flexible system. Among other things, the draft proposed that the DMC positions become "permanent intermittent" employees (no more than 3/4-time) rather than full-time employees, required DMCs to be board certified, and clarified that DMCs report to and are supervised by the Supervising Investigators of MBC's district offices. The draft proposal also abolished the full-time CMC position in favor of a more flexible position entitled "Medical Consultant to the Board"—of which there could be more than one—who would be selected by and report to the MBC Executive Director rather than to the Board. The proposal contemplated a much wider range of duties and responsibilities for the CMC than can be handled by one person, including research on specified emerging medical issues, legislative liaison duties on health and health care issues, research and assistance on scope of practice and licensure issues, and the development of various educational programs related to Board responsibilities.

During a three-hour hearing on July 11, another three-hour hearing on July 27, and a two-hour debate at the full Board's July 29 meeting, the DMCs and CMC Dr. Ikeda strongly opposed the draft proposal, arguing that its primary purpose is to relieve Ikeda of his job and is the product of a personality clash between Ikeda and MBC Executive Director Dixon Arnett. Task Force Chair Dr. Alan Shumacher and other members of the Task Force firmly denied the allegation and reiterated the problems they discerned from the existing system, including the lack of standardization and statewide centralization, the absence of clearly defined lines of authority, and the unwillingness of some of the DMCs and the CMC to accept the fact that the district office supervising investigators—and not the Chief Medical Consultant—supervise the DMCs. Dr. Shumacher noted his support for the concept of an independent CMC and DMCs, but stated that there is a difference between independence and accountability; according to Dr. Shumacher, "the CMC position as currently structured has no accountability" and needs to be revamped. Task Force member Dr. Jacquelin Trestrail agreed, stating that "the CMC job doesn't seem to have a concrete function."

Most of the opponents to the draft proposal focused on the "permanent intermittent" nature of the DMC positions, and the fact that part-time jobs might, in some cases, require the DMCs to secure other part-time medical employment. While this might maintain their skills and their connections to the medical community, it might also—according to the opponents—compromise their loyalty, the confidentiality of MBC cases in which they are involved, and the time they have to devote to their MBC duties. Additionally, some opponents stated that, because permanent intermittent employees lack civil service protection, their objectivity will be questionable because they will be under pressure to give the "correct" opinions on MBC disciplinary cases. Dr. Shumacher disagreed, stating that "I don't believe that being a permanent intermittent employee vs. a full-time employee should decrease a professional's ability to participate in this process." MBC President Bruce Hasenkamp also noted that MBC currently employs four part-time DMCs and has had no problems with this arrangement; he argued that the permanent intermittent system would provide the Board with flexibility in deploying its limited resources by enabling it to hire physicians who are currently in practice and to make a change when needed.

At the Board's July 29 meeting, several Board members strongly defended Dr. Ikeda and argued that the CMC position should remain full-time and reporting directly to the Board, rather than to the Executive Director. Representatives of the California Medical Association agreed, arguing that the Task Force's proposal is tantamount to "throwing out the baby with the bath water" and is a bad solution to a "personnel problem."

Center for Public Interest Law (CPIL) Supervising Attorney Julianne D'Angelo testified in support of the Task Force's proposal, stating that "it is a document which is dynamic and permissive, and which attempts to satisfy several goals—flexibility in management, accountability, and clarification of lines of authority and supervision which have been undeniably and improperly unclear." She reminded the Board that the physician discipline process is a legal proceeding in which state police power is exercised, not a medical procedure or private peer review; thus, it is not inappropriate that physician medical consultants, when acting as part of a law enforcement team, are supervised by law enforcement staff.

With regard to the DMCs, D'Angelo acknowledged that the "permanent intermittent" issue was very difficult for CPIL, but stated that the proposal appears to be an attempt to accommodate several interests which are sometimes competing, including the desire to employ DMCs who are maintaining their medical knowledge and skills, the need for undivided loyalty, adequate time in which to perform the duties of a DMC, and minimization of the chance of a conflict of interest. D'Angelo expressed support for the proposal but only if the Board adopts a strong code of ethics to prevent conflicts of interest, ensures that the DMCs are educated so they know when they must recuse themselves from a particular case, and exercises continued and vigilant supervision of the DMC system to fine-tune it when necessary.

As to the CMC issue, D'Angelo stated CPIL's support for one or more part-time "Medical Consultant to the Board" positions which report to the Executive Director, not to the Board. She noted that MBC is attempting to proactively move in new directions (*e.g.*, better allocation of health resources in underserved areas), and could use the services of several people with different strengths to advise it in the various fora in which the Medical Board should participate.

Following 16 months of debate, the Board approved the Task Force's proposal by a 9–5 vote. At this writing, MBC expects to implement the new system in the fall.

Continuing Problems with SB 916 Implementation. The Division of Medical Quality—which, under SB 916 (Presley) (Chapter 1267, Statutes of 1993), has been augmented to twelve members and split into two six-member panels for purposes of reviewing and deciding physician discipline cases *[14:2&3 CRLR 64]*—continued to experience serious attendance problems at its July 28 meeting. Attendance was so poor that neither Panel A nor Panel B was able to conduct business; however, enough members showed up to constitute a quorum of the Division, enabling it to meet and discuss the problem.

Under SB 916 and the Administrative Procedure Act (APA), DMQ has 90 days from receipt of an administrative law judge's (ALJ) proposed decision to determine whether to adopt the decision as its own, or nonadopt it and substitute its own decision; if DMQ fails to meet the deadline, the ALJ decision becomes final. When an ALJ decision is received, it is mailed with a ballot to the members of one of the Panels; the ballot requires members to vote to adopt, nonadopt, or "hold" the decision for discussion at the next Panel meeting. Panel meetings are scheduled in conjunction with DMQ's quarterly meetings, but sometimes interim Panel meetings must be scheduled to accommodate the 90-day deadline. At its July 28 meeting, DMQ addressed the ongoing attendance problems at its quarterly and interim Panel meetings, in addition to other impediments caused by the new process:

• ***Number of Votes Needed to Revoke a License Outright.*** Since the passage of SB 916, DMQ members have been confused about the number of votes needed to revoke a license outright. Prior to the bill's enactment, the law required five of the seven DMQ members to vote to revoke, and that provision was inadvertently left intact when DMQ was expanded to twelve members and split into two six-member panels. Thus, in order to revoke a license outright, five of the six Panel members must appear, and all of them must vote to revoke. At its May meeting, DMQ—on a 7–4 vote—approved a legislative proposal to reduce the number of votes needed to revoke outright to four. *[14:2&3 CRLR 64]* That proposal was amended into SB 1775 (Presley), which was signed by the Governor on September 30 (*see* LEGISLATION); thus, effective January 1, four votes to revoke a license outright will suffice.

• ***The "Hold" Category.*** At DMQ's July 28 meeting, CPIL Supervising Attorney Julie D'Angelo noted that DMQ may be creating more work for itself through its use of the "hold" category on the mail ballot. Under the APA, licensing boards are authorized to vote to "adopt" or "nonadopt" an ALJ proposed decision; a majority of "adopt" votes will overrule a minority of "nonadopt" votes. D'Angelo noted that the APA makes no provision for "holding" a case for later discussion, and it clearly does not permit one "hold" vote to delay an otherwise majority vote on an ALJ decision in a physician discipline case. She noted that the use of the "hold" category is requiring interim Panel meetings which are poorly attended, and argued that Division members who have problems with an ALJ decision should simply vote to nonadopt. DMQ agreed to place its use of the "hold" category on a future meeting agenda.

• ***Criteria for Nonadoption.*** D'Angelo also noted flaws inherent in the APA adjudicative process which may be contributing to DMQ's problems. The APA requires DMQ members to make a quasi-adjudicatory decision on the disciplinary status of a physician licensee based solely on the ALJ's proposed decision (which includes findings of fact, conclusions of law, and a recommended penalty). DMQ members are not present at the evidentiary hearing, have no opportunity to observe the witnesses or judge their credibility, and are generally unpracticed in the skills of judicial decisionmaking (*see* COMMENTARY on page 1 of this issue). D'Angelo noted that other regulatory agencies within the Department of Consumer Affairs, notably the Board of Psychology (BOP), have adopted criteria for nonadoption to guide them in determining whether and when to nonadopt the decision of a trier of fact who was present at the evidentiary hearing. For example, BOP's criteria state that, when a particular finding is based directly on the ALJ's perception of the credibility of a witness, that finding should generally not be disturbed upon review. *[14:1 CRLR 66–67]* Again, DMQ agreed to place this issue on a future meeting agenda.

• ***Attendance Problems.*** Finally, D'Angelo noted that other DCA boards have adopted attendance policies which require members to be excused in advance of a scheduled meeting due to unavoidable conflict; more than a set number of unexcused absences is grounds for an admonition or a request for resignation. DMQ asked staff to research the board member attendance policies of other DCA boards and report back at a future meeting.

MBC Decries So-Called "Unholy Alliance." In a June 8 letter to all Board members and released to the press, MBC President Bruce Hasenkamp alerted the Board to "a crisis of major proportions...the admitted, publicly acknowledged and outspoken new alliance between the Center for Public Interest Law and the California Medical Association—two traditional adversaries who have joined forces to kill the Board's enforcement division....We must move heaven and earth against this scheme."

Hasenkamp's hyperbolic letter was apparently an attempt to ward off a mythical piece of legislation to remove DMQ's authority to review proposed ALJ decisions in disciplinary cases; no such legislation materialized in 1994. For five years, CPIL has argued that regulatory boards composed of volunteers who do not attend disciplinary hearings and see the witnesses should not be second-guessing the trained triers of fact who do; CPIL believes such a review leads to inconsistent results and that the time and efforts of such board members are better spent reviewing the abuses demonstrated in those cases and adopting regulations to deter and prohibit them (*see* COMMENTARY on page 1 of this issue). Since 1989, CPIL has sponsored provisions in at least three bills to divest DMQ of its quasi-adjudicative role (SB 1434 in 1989, SB 2375 in 1990, and SB 916 in 1993, all authored by Senator Robert Presley); CMA and the Board opposed those provisions and they were deleted from the bills.

Over the past year, however, CMA leadership has reversed course and now agrees with CPIL's position. For five years, CMA has listened to DMQ members defend their territory by arguing that, when DMQ nonadopts an ALJ's proposed decision, it is to increase the penalty; thus, in trying to assure CPIL that DMQ's case review authority results in public protection, the Board alienated CMA. In addition to being furious with CMA for its new position, the Board claims that CMA's deliberation and debate of the issue was kept hidden from MBC, thus precluding Board members from providing any input on the matter, and has not been approved by CMA's membership.

Hasenkamp's letter sparked hostile commentary at the Board's July meeting; several Board members criticized CMA representatives for the organization's alleged "failure to communicate." Whether CPIL/CMA's "unholy alliance" is translated into legislation in 1995 remains to be seen.

Diversion Program Issues. At the request of DMQ, the staff of MBC's Diversion Program scheduled a special July 27 presentation on the Program at a time when no other meetings were scheduled and all Board members could attend. Unfortunately, only six (Ray Mallel, Dr. Alan Shumacher, Karen McElliott, Dr. Robert del Junco, Theresa Claassen, and Bruce

Hasenkamp) of the 19 Board members attended the presentation. The discussion featured presentations on the legislative history of the Diversion Program and a question-and-answer session with a "graduate" of the program, and raised questions as to the effectiveness of the Program's monitoring of substance-abusing physicians.

Created in 1980 in Business and Professions Code section 2340, the purpose of MBC's Diversion Program (DP) is to identify and confidentially rehabilitate physicians who are impaired due to substance abuse or mental illness. Self-abuse of drugs or alcohol is a violation of the Medical Practice Act and grounds for license discipline; however, according to several presenters at the July 27 meeting, the purpose of the Program is to forgive—that is, afford disciplinary immunity for—that violation if the physician commits to rehabilitation and a permanent lifestyle which supports sobriety.

According to Dr. Gene Feldman (who was MBC President at the time the DP was created), "the Diversion Program was enacted because a lot of doctors who came before us in discipline had hurt no one but themselves through the disease of substance abuse/chemical dependency. They were being disciplined at an average cost of $30,000 per case, and most had already gone into rehabilitation programs and were clean and sober. But we were required to discipline them and ruin their lives." As opposed to the lengthy and expensive disciplinary process, the DP was advocated as an expeditious and relatively cheap alternative which could immediately remove an impaired physician from practice if necessary, protect the public by providing consistent monitoring of participants, and encourage physicians to enroll and seek rehabilitation because participation is totally confidential and the self-abuse violation would be forgiven.

Unlike diversion programs at other occupational licensing agencies (whose administration is contracted out to private rehabilitation centers), MBC's Diversion Program is operated in-house and is overseen by CMA's Liaison Committee to the Diversion Program. Physicians may "self-refer" into the Program, or may be required to participate via a disciplinary order or stipulation approved by DMQ; approximately 60% of DP participants have self-referred into the Program. A physician who self-refers and has no pending disciplinary complaints is immediately scheduled for an interview by a DP case manager, a civil servant who monitors 50–60 impaired physicians at any one time. The case manager assesses the physician, may recommend treatment through a private clinic or psychotherapist if necessary, may ask the physician to voluntarily suspend practice, and encourages the physician to immediately begin attending bi-weekly counseling sessions led by a DP group facilitator (GF). The Program requires two random urine tests per month; one of them occurs at a group meeting.

The assessment of the case manager, the results of the urine testing, and input from the GF are forwarded to one of the DP's regional Diversion Evaluation Committees (DECs), which are composed of three physicians and two public members each; under section 2342, "[e]ach person appointed to a committee shall have experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse, or due to physical or mental illness." The DECs meet approximately four times per year.

Based on the information provided by DP staff and discharge summaries of and clinical evaluations performed by other apparently-unsuccessful rehabilitation programs, the regional DEC evaluates the applicant to determine the best course of treatment, and—if satisfied that the applicant is committed to rehabilitation—draws up a contract of participation for formal admission. "Formal admission" into the Program (and the immunity from disciplinary action for self-abuse which accompanies it) does not occur until the contract is signed by both parties. The contract contains numerous terms and conditions for participation (and may include required participation in a 12-step program or psychotherapy), the violation of which is grounds for termination from the Program and referral to DMQ's Enforcement Unit. At this point, the DEC may request that the physician stop practicing medicine. If the physician agrees to the request, it may become a term of the contract until the DEC is satisfied the physician can practice safely. If the physician refuses to agree to the request, formal admission is denied and the case is referred to DMQ's Enforcement Unit. If the DEC permits the physician to continue working, the contract usually requires the physician to obtain worksite monitors and to agree to worksite-based conditions on continued medical practice. Following the DEC's decision, the Diversion Program's monitoring mechanism takes place through the bi-weekly meetings with the DP GF.

Some physicians attempt to "self-refer" after a disciplinary complaint or misconduct report has been filed and DMQ's investigation has revealed the substance abuse problem. Physicians who are the subject of pending complaints and investigations may not be formally admitted into the Diversion Program without the approval of John Lancara, Chief of the Enforcement Program. Since his appointment as Enforcement Chief, Lancara's practice has been to encourage informal participation in the DP while Enforcement completes a full and thorough investigation of all pending complaints and reports of physician misconduct. This policy, which has been implemented upon the advice of the Attorney General, is due to controversial language in *Kees v. Board of Medical Quality Assurance*, 7 Cal. App 4th 1801 (1992), which states that "once a physician enters the...[diversion] program..., the Board halts all action against the physician, whether it is investigatory or disciplinary." Lancara's policy has sparked protests by Chief Medical Consultant Dr. Richard Ikeda and members of the CMA Liaison Committee, who complain that Lancara's investigations are unduly delaying the actual signing of the DP contract, which—according to CMA—has therapeutic and disciplinary value in and of itself. *[14:2&3 CRLR 67]* Because the broad language in the *Kees* decision restricts investigation as well as disciplinary action and does not appear to confine the Program-afforded immunity to self-abuse violations, the Medical Board is currently working with CMA to develop legislative language to clarify the decision.

At the July 27 presentation, DP Manager Chet Pelton stated that the Program's "success rate" is 78%. To "graduate" from the Program, a physician must be free of all alcohol and drug use for two years and must have developed a lifestyle which supports sobriety for the rest of his or her life. Pelton stated that only 4% of DP graduates are the subject of complaints, while 8–9% of non-DP graduates are the subject of complaints; thus, he asserted that "DP graduates are better risks to the public than non-DP graduates." The bulk of the Diversion Program is funded through physician licensing fees—to the tune of $750,000 per year; participants must bear the costs of their urine tests and pay $235 per month for the bi-weekly group meetings.

Dr. Rodney White, a former participant in the Program, also spoke at the July 27 presentation. Dr. White stated that prior to late 1982, he had been in and out of several unsuccessful drug abuse treatment programs; after nine months out of work and two hospitalizations, he finally contacted the Diversion Program at the advice of a hospital director in San Diego. He signed a DP contract in April 1983, participated in the Program for over four years, and has been sober for 11 years. When asked whether the Program had required him to

stop practicing medicine while in rehabilitation, Dr. White stated, "I physically wasn't able to practice. The real sick ones aren't practicing; they aren't able to."

Following the planned presentations, Dr. Robert del Junco expressed concern about the level of monitoring provided by the Program. He noted that any agreement by the physician not to practice medicine is not communicated to the Enforcement Unit; thus, Enforcement has no idea that a complained-of physician has agreed not to practice medicine, and—because the physician retains an unrestricted license to practice medicine—the Board's Consumer Information Unit will inform inquiring consumers that the doctor's license is "clean." Dr. del Junco argued that the contract not to practice medicine is legally unenforceable and may be reneged on by the physician at any time without the knowledge of the Program. CPIL Supervising Attorney Julie D'Angelo agreed with Dr. del Junco and noted that, while impaired physicians who are permitted to work undergo oversight at the workplace, impaired physicians who are not permitted to work are not monitored by the Program in any way other than the twice-a-week group sessions; thus, the most seriously impaired physicians who are not permitted to work are not meaningfully monitored to ensure they actually do not work. She expressed discomfort that—according to Dr. White's testimony—the public must wait until an impaired physician is physically unable to function before it can be truly assured that he or she is not practicing medicine.

Chet Pelton responded that, although there is no 100% guarantee that a physician who has agreed not to work will in fact not work, the Program relies upon information generated at the bi-weekly group meetings and from the case manager, who knows where the participant has practiced and "hopefully" where the participant has admitting privileges. According to Dr. White, the group meetings may shed more light on whether a physician has resumed substance use than whether he/she is working: "If someone walks into a group meeting loaded, that's not hard to pick up. You don't need a urine test to tell someone's using."

The July 27 program concluded with Dr. Shumacher's recommendation that some of the monitoring issues which had been raised be addressed, and Theresa Claassen's suggestion that the presentation be rescheduled during a full Board meeting so that all MBC members can become better informed about the Diversion Program.

At its July 28 meeting, the Division of Medical Quality received reports and made decisions on the following Diversion Program-related issues:

• ***Number of DECs***. DP Manager Chet Pelton reported that the DP has decided to reduce the number of DECs from six to five. Previously, one of the DECs was devoted to participants with mental illness (rather than substance abuse); that DEC was underused, however, due to the low number of participants. Additionally, Pelton reported that the average number of DP participants has dropped by about 30; thus, the members on the "mental illness" DEC will be redistributed to the other DECs.

• ***Medical Students in the Diversion Program***. The DP recently requested an Attorney General's Opinion on whether medical students may enroll in the Diversion Program, as the DP statutes restrict membership to licensed physicians. The Attorney General responded that medical students may participate if they are practicing in a supervised setting (such as a university teaching hospital); the CMA Liaison Committee recommended that medical students be admitted to the Program. Because participation in the Diversion Program is confidential, one DMQ member asked how DP medical students are supposed to answer the question on the application form relating to prior treatment for substance abuse; following considerable discussion, the Division voted to permit medical students into the Diversion Program once the confidentiality issues are worked out.

• ***Payment of Group Facilitators***. Finally, DMQ addressed an issue raised by CPIL relating to the issue of diversioners' direct payment to the GFs, a mechanism identified by the California Highway Patrol as an apparent—if not actual—conflict of interest. Although the DP characterizes GFs as "volunteers," CHP found that they are paid up to $235 per month directly by each participant; one such "volunteer" had thirty participants and made over $7,000 per month. Specifically, CPIL argued that this payment arrangement could impact the objectivity of GFs in reporting either adverse or positive information about a participant's performance in the program. *[14:2&3 CRLR 67; 14:1 CRLR 51–52; 13:2&3 CRLR 80]* CPIL suggested that diversioners pay the Program and that the Program reimburse facilitators based on a set formula. Dr. Alan Shumacher reported that he had reviewed the matter and found no allegation of impropriety but simply "an appearance of impropriety." He stated that he is at ease with the current payment arrangement; the Division took no action on CPIL's suggestion.

Implementation of Lay Midwife Licensure Program. DOL is still working on the implementation of SB 350 (Killea) (Chapter 1280, Statutes of 1993), which requires the Medical Board to establish a licensure program for lay midwives. *[14:2&3 CRLR 68–69; 14:1 CRLR 56; 13:4 CRLR 61]*

Under SB 350, there are two ways obtain licensure as a lay midwife: (1) graduation from an accredited three-year midwifery program and successful completion of a comprehensive licensing examination, or (2) completion of an educational program in another state with equivalent standards, as determined by MBC, and licensure in that state. An applicant may be deemed to have "graduated" from an accredited program in two ways: (1) by actually completing a three-year program, or (2) through a "challenge" process whereby an approved midwifery program permits students to obtain credit by examination for previous midwifery education and clinical experience. Under Business and Professions Code section 2513, the challenge mechanism is tied to an approved midwifery education program, and its proficiency and practical examinations must be approved by DOL.

Unfortunately, California has no accredited three-year midwifery educational program and, although approached by DOL members and California midwives, no out-of-state educational program has indicated interest in beginning one here. Further, the statute specifies that the challenge mechanism is tied to an approved midwifery educational program. Thus, short of moving to another state to either attend school for three years or the period of time needed to successfully challenge all the required coursework, there does not appear to be a practical way for currently-practicing lay midwives to become licensed in California. At DOL's July 28 meeting, lay midwife activist Rev. Faith Gibson noted that Senator Killea intended DOL's challenge mechanism to mirror that of the Board of Registered Nursing for its certified nurse-midwife specialty certification program (whose challenge mechanism is not tied to an educational program); however, DCA legal counsel Anita Scuri pointed out that SB 350 explicitly requires the challenge mechanism to operate through an approved educational program. DOL members expressed frustration at the language of the bill, but determined to persist in the rulemaking process to implement the bill, even though clean-up legislation will probably be necessary.

Toward that end, at its July meeting, DOL held public hearings on its proposal to adopt Article 3—Application for Licensure (sections 1379.10 and 1379.15) and

Article 4—Standards of Practice (section 1379.20), Title 16 of the CCR. As published, section 1379.10 would require licensure applicants to file a prescribed application form with DOL, accompanied by evidence, statements, and documents required by the form and the application fee required by section 1379.50. Section 1379.15 would require the following minimum number of clinical experiences to be verified: 20 new antepartum visits, 75 return antepartum visits, 20 labor management experiences, 20 deliveries, 40 postpartum visits within the first five days after birth, 20 newborn assessments, and 40 postpartum/family planning/gynecology visits. Section 1379.20 would implement Business and Professions Code section 2508 by requiring midwives who do not carry liability insurance for the practice of midwifery to disclose that fact to clients by the third visit or examination. The disclosure, whether verbal or written, must be noted and dated by the midwife in each client's file.

Following the public hearing, the Division decided to modify the language of sections 1379.15 and 1379.20 and release it for a 15-day comment period. DOL modified section 1379.15 to further require persons who apply for license as a midwife on or before December 31, 1997 to have obtained all of the verified clinical experiences within ten years immediately preceding the date of the application; persons who apply for license as a midwife on or after January 1, 1998 must have obtained at least 50% of the verified clinical experiences within five years immediately preceding the date of the application. DOL modified the language to section 1379.20 to require midwives who do not carry liability insurance coverage to disclose that fact not later than the time when the client relationship is established. At this writing, staff is preparing the rulemaking package on these proposed regulatory changes for submission to the Office of Administrative Law (OAL).

Continuing on its rulemaking calendar, DOL is scheduled to hold public hearings on proposed sections 1379.11 and 1379.21, Title 16 of the CCR, at its November 3 meeting. Section 1379.11 would set forth the processing times for applications for licensure as a lay midwife, and section 1379.21 would establish guidelines for physician supervision of midwives.

The supervision requirement is particularly thorny; SB 350 states that a midwifery license "authorizes the holder under the supervision of a physician to attend cases of normal childbirth...." The scope of this supervision requirement appears limited in a later provision of the bill, which states that midwives must disclose to their clients that a physician is being briefed regularly and is prepared to take care of complications in the hospital if necessary. However, the precise nature of the supervision requirement remains to be established through DOL rulemaking. SB 350 expressly states that the physician need not be physically present in order to satisfy the supervision requirement. Also, during the legislature's consideration of the bill, SB 350's opponents were twice defeated in an attempt to require a written agreement between a midwife and the supervising physician.

As proposed by DOL on September 16, the supervising physician and midwife must have ongoing communication regarding the care of a pregnant woman or newborn, and agree upon written practice guidelines which define the individual and shared responsibilities of the midwife and physician, including but not limited to, a plan for communication, emergency transfer, and transport of a client who develops complications; appropriate communication between the midwife, the physician, and other health care providers; and periodic review and evaluation of cases and their outcomes.

In other rulemaking action related to lay midwives, DOL has finalized the rulemaking package on sections 1379.1, 1379.2, 1379.3, and 1379.5, Title 16 of the CCR. These rules set forth general provisions related to the lay midwife licensure program and establish license application ($300), renewal ($200), and delinquency ($50) fees to support the program. *[14:2&3 CRLR 69]* At this writing, these rules are pending at OAL.

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

• ***Public Letter of Reprimand***. On July 8, DMQ published notice of its intent to adopt new sections 1364.15–.17, Title 16 of the CCR, to implement MBC's "public letter of reprimand authority in Business and Professions Code section 2233. The proposed regulations authorize specified DMQ officials to issue, following an investigation, a public letter of reprimand in lieu of filing or prosecuting a formal accusation for minor unprofessional conduct violations. The letter must describe the nature and facts of the violation and be served upon the licensee by certified mail. Prior to formal service of the reprimand, DMQ must notify the physician of its intent to issue the letter; within 30 days, the licensee must indicate to DMQ in writing whether he/she will accept the letter. If the physician accepts, the letter will be served and its issuance shall be disclosed to members of the public who inquire about that physician's record. If the physician refuses to accept, DMQ is free to file and prosecute an accusation or evaluate the propriety of other sanctions, such as a citation and fine. *[14:2&3 CRLR 65]*

DMQ held a public hearing on the proposed regulations on August 23 in San Diego; at this writing, the Division is scheduled to adopt the proposed rules at its November 3 meeting.

• ***Contact Lens Notices***. At its July 28 meeting, DOL unanimously approved the addition of section 1399.233, Title 16 of the CCR, which requires registered contact lens dispensers to ensure that a written statement is enclosed with each contact lens container which directs the person named in the contact lens prescription to return to the prescribing physician or optometrist for an evaluation. *[14:2&3 CRLR 74; 14:1 CRLR 55–56]* At this writing the rulemaking package on this proposed regulatory change is pending at OAL.

• ***DAHP Rulemaking***. At its last meeting on May 4, the former Division of Allied Health Professions adopted a proposed amendment to section 1366.3, Title 16 of the CCR, which provides that a qualified medical assistant (MA) is one who is currently certified by the American Association of Medical Assistants (AAMA). DAHP's proposed amendment would include the American Association of Medical Technologists (AAMT) as a certifying body for qualified MAs who provide training to other MAs under the direction of a licensed physician. At this writing, the amendment to section 1366.3 is pending at OAL.

• ***Permit Reform Act Regulations***. On September 16, DOL published notice of its intent to adopt new section 1319.4, Title 16 of the CCR, to implement the Permit Reform Act of 1981. The new regulation would set forth the following information regarding the processing of applications for physician and surgeon licensure: the maximum time for notifying an applicant that an application is complete or deficient; the maximum time after receipt of a completed application in which DOL must issue or deny a license; and the minimum, median, and maximum actual processing times for issuance of a license during the past two years.

At this writing, DOL is expected to conduct a public hearing proposed section 1354.5 at its November 3 meeting.

• ***Temporary Fee Decrease***. Also on September 16, DOL published notice of its intent to amend section 1352, Title 16 of the CCR, which fixes MBC's biennial license renewal fee; currently, that fee is

$600. However, SB 916 (Presley) required the Board to temporarily reduce its renewal fee if CMA succeeded in its lawsuit challenging the state's 1992–93 transfer of physician licensing fees to the general fund; CMA won its case in February 1994, and the state agreed to return $2.6 million to the Medical Board (less $75,000 for CMA's attorneys' fees). *[14:2&3 CRLR 72–73]* Accordingly, the proposed amendment to section 1352 would temporarily decrease the biennial renewal fee to $575 for licenses expiring between January 1, 1995 through December 31, 1996.

At this writing, DOL is expected to conduct a public hearing proposed section 1354.5 at its November 3 meeting.

• ***Public Disclosure Policy Regulations***. At its July 28 meeting, DMQ directed staff to publish for public comment proposed section 1354.5, Title 16 of the CCR, which would codify the Medical Board's new public disclosure policy in regulation. The Board adopted its new policy in May 1993, and it became effective on October 1, 1993. *[See* LITIGATION; *14:1 CRLR 50; 13:4 CRLR 1, 56–57; 13:2&3 CRLR 79–81]*

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

At this writing, DMQ is expected to conduct a public hearing proposed section 1354.5 at its November 3 meeting.

LEGISLATION

SB 799 (Presley), as amended August 9, is MBC's so-called "fee fix" bill which (1) exempts MBC from certain provisions in the Budget Act of 1993 which require the transfer of physician licensing fees to the general fund, and (2) permits the payment of $75,000 to CMA from the $2.6 million in physician licensing fees returned by the state to MBC; CMA brought the action which resulted in the return of the funds to the Board. *[14:2&3 CRLR 70]* This bill was signed by the Governor on September 11 (Chapter 532, Statutes of 1994).

SB 1239 (Russell), as amended August 25, authorizes health care providers who experience significant exposure to blood or other potentially infectious materials of a patient to be informed of the HIV status of that patient. In order to allow such information access, this bill authorizes the blood or other tissue or material of a patient to be tested for HIV pursuant to a prescribed procedure, either with or without that patient's consent. This bill does not authorize the disclosure of the patient's identity. It does, however, exempt a health care provider from civil or criminal liability and from professional disciplinary action for performing an HIV test on a patient, and for disclosing the HIV status of that patient to prescribed persons so long as the health care provider believes in good faith that his/her actions are consistent with the bill's provisions. This bill was signed by the Governor on September 20 (Chapter 708, Statutes of 1994).

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 70–72:

SB 1775 (Presley), as amended August 25, is sponsored by MBC and referred to as "Presley IIA," as it makes approximately thirty technical and clean-up changes to the provisions of SB 916 (Presley) and other sections of the Business and Professions Code.

Among other things, SB 1775 empowers DOL (rather than DMQ) to adopt regulations governing the Board's disclosure of information about physicians; revises the procedure for the suspension or revocation of a physician's license after that physician is convicted of a felony; changes the name of the MBC committee created in SB 916 to the "Committee on Affiliated Healing Arts Professions"; prohibits a physician from knowingly permitting the use of his/her license; requires insurers to retain copies of certain documents related to reports of medical malpractice judgments and settlements for at least one year and to make those documents available for copying by MBC except in certain circumstances; repeals provisions which require MBC to prepare and issue a report at least once every two years containing certain information regarding its licensees, and which require every licensed physician to complete a questionnaire at least once every two years to provide information for MBC's report; eliminates requirements that MBC hold regular meetings in specific locations, and revises the quorum and vote requirements for meetings of the Board, its divisions, and panels of its divisions; repeals a provision which requires the DMQ president to rotate the membership of the panels of the Division at least annually; revises the contents of MBC's annual report to the legislature; extends the repeal date for the Medical Quality Hearing Panel within the Office of Administrative Hearings to January 1, 1999; requires the complete records of a disciplinary proceeding to be prepared by the Office of Administrative Hearings or the agency, and requires an extension of the thirty-day time period for preparation and delivery of the record for good cause shown; and revises existing law which requires medical or podiatric societies, licensed health facilities, and state or local governmental agencies that receive complaints about licensees to provide certain information to the complainant. This bill was signed by the Governor on September 30 (Chapter 1206, Statutes of 1994).

SB 1958 (Presley). SB 916 (Presley) authorized DMQ or the Health Quality Enforcement Section to establish panels or lists of experts as necessary to assist them in investigating and prosecuting violations of the Medical Practice Act. As amended August 22, this bill would have instead required the establishment of these panels, imposed minimum qualifications for a physician to serve as a Medical Board expert, and imposed certain restrictions regarding the length of time a person may serve as a Medical Board expert. On September 26, Governor Wilson vetoed this bill, noting that MBC recently completed a year-long process of developing a policy to establish criteria for the selection, use, and training of medical experts (*see* MAJOR PROJECTS); according to Wilson, this bill would "replace the policy of the Board with this new statutory scheme without any demonstration that the new Board policy is deficient."

SB 1886 (Presley). Existing law requires MBC to provide for representation of any person, not a regular MBC em-

ployee, but hired or under contract to provide expertise in evaluating the conduct of a licensee, who is named as a defendant in a civil action for defamation resulting from the opinion rendered, statements made, or testimony given by that person. Existing law provides that MBC shall not be liable for any judgment rendered against that person; provides that the Attorney General shall be utilized in those actions; and also requires MBC to provide representation in the same manner to persons who make reports to the Board regarding diversion evaluation. As amended July 1, this bill includes persons retained under any other arrangement, paid or unpaid, to provide that expertise to MBC among those to whom the Board is required to provide representation; adds malicious prosecution and any other civil cause of action to the actions that must be defended; instead provides that MBC shall be liable for any judgment rendered against the person, except any punitive damages award; requires that the defendant be liable to MBC for the full costs of representation if the plaintiff prevails in a claim for punitive damages; and provides that the Attorney General shall be utilized in those actions. This bill was signed by the Governor on September 28 (Chapter 1098, Statutes of 1994).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for MBC; creates a Joint Legislative Sunset Review Committee which will review MBC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which MBC and its performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether MBC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case MBC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

AB 595 (Speier), as amended August 24, prohibits, on and after July 1, 1996, any physician from performing surgery in an outpatient setting, as defined, using specified anesthesia unless the setting is one of enumerated health care settings, including a setting accredited by an accreditation agency approved by DOL; prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting, as defined, unless the setting is one of those enumerated settings; requires DOL to adopt standards for accreditation in accordance with prescribed criteria; requires DOL to adopt standards for approval of accreditation agencies to perform accreditation of outpatient settings; permits DOL or the accreditation agency to inspect outpatient settings accredited by an accreditation agency, and authorizes certain disciplinary actions to be taken with regard to outpatient settings and accreditation agencies that are out of compliance with the requirements of these provisions; and requires DOL to establish fees for approval of accreditation agencies. This bill was signed by the Governor on September 30 (Chapter 1276, Statutes of 1994).

AB 3497 (B. Friedman). The Medical Practice Act sets forth the required clinical instruction for applicants for licensure as a physician and specifies the required minimum amounts of instruction; under existing law, clinical instruction is required in surgery, medicine, pediatrics, obstetrics and gynecology, and psychiatry. As amended August 17, this bill adds four additional weeks of clinical instruction in family medicine to the instruction required to be completed by applicants; specifies that this added requirement applies only to applicants for licensure who graduate from medical school or a school of osteopathic medicine after May 1, 1998; provides that medical schools located outside of California may fulfill this requirement instead by a required clinical course in primary care medicine, provided that the school meets certain other criteria; and repeals this provision on June 30, 1999. This bill was signed by the Governor on September 19 (Chapter 657, Statutes of 1994).

SB 1642 (Craven), as amended August 11, authorizes a licensed physician approved to supervise a physician assistant (PA) to delegate to a PA under his/her supervision, and in a manner determined by the supervising physician (SP), the authority to administer or provide medication to a patient or transmit a prescription from the SP to a person who may lawfully furnish the medication or medical device to the patient. It requires the SP, prior to delegating prescription transmittal authority to a PA, to adopt a written, practice-specific formulary and protocols that specify all criteria to be considered for use of a particular drug or device, and any contraindications for the drug or device. The bill requires any SP's prescription that is transmitted by the PA to be based on either the physician's order for the particular patient or for a drug listed in the formulary. It prohibits a PA from administering, providing, or transmitting a prescription for Schedule II through Schedule V controlled substances without an order from the SP; imposes other requirements regarding the content of the prescription transmittal order; provides that when transmitting a prescription, the PA is acting on behalf of and as an agent for the SP; and authorizes a licensed pharmacist to dispense drugs or devices upon a transmittal order of a PA with certain authority. This bill was signed by the Governor on September 27 (Chapter 968, Statutes of 1994).

SB 1557 (Thompson). Existing law authorizes an individual of sound mind and eighteen or more years of age to execute a declaration governing the withholding or withdrawal of life sustaining treatment; authorizes an individual to appoint an attorney in fact to make health care decisions for that individual in the event of his/her incapacity pursuant to a durable power of attorney for health care; provides that a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action for relying on a health care decision made by an attorney in fact under a durable power of attorney for health care in described conditions; and authorizes a health care provider to presume that a durable power of attorney for health care or similar instrument is valid. As amended August 18, this bill requires that health care providers who honor a request to forego resuscitative measures, as defined, are not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, under certain circumstances. This bill provides that, in the absence of knowledge to the contrary, a health care provider may presume that a request to forego resuscitative measures is valid. This bill was signed by the Governor on September 27 (Chapter 966, Statutes of 1994).

SB 1402 (Greene). The Intractable Pain Treatment Act authorizes a physician to prescribe or administer controlled substances to a person in the course of treatment of that person for a diagnosed condition causing intractable pain, as defined, and prohibits MBC from disciplining a physician for that prescribing or administering. However, this authorization does not apply to treatment of any person in a health facility, as defined. As amended April 18, this CMA-sponsored bill deletes this exception (thereby making the Act applicable to inpatients at licensed health

facilities), and provides that nothing in the Act is to be construed to prohibit the governing body of a hospital from taking disciplinary actions against a physician pursuant to certain professional peer review procedures. This bill was signed by the Governor on July 15 (Chapter 222, Statutes of 1994).

AB 3081 (Lee), as amended August 18, requires the Department of Health Services (DHS), provided that funds are available, to convene a conference to address the issue of testing or treatment to prevent neonatal group B streptococcal disease. It requires that there be representatives from certain organizations at the conference, that the conference convene at least once during the 1994–95 fiscal year, and that DHS develop a standardized written summary on group B streptococcal disease and guidelines on the prevention of neonatal group B streptococcal disease based on the conference. This bill was signed by the Governor on September 22 (Chapter 758, Statutes of 1994).

SB 366 (Maddy). Existing law requires clinical laboratories to be licensed by DHS, but exempts from the licensure requirement clinical labs owned and operated by a physician or podiatrist for the performance of lab work on his/her own patients. As amended August 12, this bill expands the exemption from the licensure requirement to include labs owned and operated by a partnership or professional corporation of five or fewer physicians or podiatrists which performs clinical laboratory tests or examinations only for the patients of the partnership or corporation. This bill was signed by the Governor on September 29 (Chapter 1141, Statutes of 1994).

AB 1392 (Speier), as amended August 17, is no longer relevant to MBC.

The following bills died in committee: **AB 3386 (Burton)**, which would have—among other things—required that the formulary of medications that may be administered by medical assistants not include certain types of medications, including those excluded by MBC because of their potential for substantial harm to the patient; **AB 3765 (Campbell)**, which would have required MBC to participate in a study on the practice of naturopathy and the desirability of establishing a "Naturopathic Practitioners Registration Act"; **SB 1566 (Watson)**, which would have established the Naturopathic Title Act to regulate the use of titles indicating any special credentials, knowledge, expertise, competence, or ability in the field of naturopathy; **SB 1048 (Watson)**, which would have established the Clean Needle and Syringe Exchange Pilot Project, and authorized physicians, among others, to furnish hypodermic needles and syringes without a prescription or permit, as prescribed; **SB 437 (Hart)**, which would have authorized a physician practicing in certain specialties or having certain medical training and who provides physical therapy as part of his/her practice to use one unlicensed physical therapy aide to perform patient-related tasks; **AB 1291 (Speier)**, which would have—among other things—revised the definition of the term "financial interest" for purposes of existing law which provides that it is unlawful for a licensed physician to refer a person for certain health care services if the licensee or his/her immediate family has a financial interest with the person or in the entity that receives the referral; **AB 1446 (Margolin)**, which would have required an applicant for a reciprocity MBC license to provide on the application a statement as to whether the employment or practice of the applicant has been suspended or terminated, or whether the applicant has resigned or taken a leave of absence from employment or practice, due to certain medical disciplinary investigations, causes, or reasons; and **AB 2156 (Polanco)**, which would have required reports filed with MBC by professional liability insurers to state whether the settlement or arbitration award has been reported to the federal National Practitioner Data Bank.

LITIGATION

In ***San Jose Mercury News, Inc., et al. v. Medical Board of California***, No. 377991 (Sept. 14, 1994), Sacramento County Superior Court Judge Roger K. Warren ruled in favor of three newspapers in their fight to obtain public information regarding California physicians contained in MBC's computer database. The case was a potential test case on the issue of how far a government agency must go to provide the public with information in its database which is not compiled or collated as described by the requestor; Judge Warren's holding, however, is a narrow one focusing specifically on the Medical Board.

The case began after MBC implemented its new public disclosure policy on October 1, 1993. Under the new policy, MBC decided to disclose to "inquiring consumers" certain items of public information which it routinely collects on physicians but had never before disclosed (including medical malpractice judgments and felony convictions). Along with its new policy, the Board adopted a procedure requiring "inquiring consumers" to write or telephone the Board regarding particular physicians; if consumers telephone the Board, they are permitted to ask for information on three physicians per call. The Board expressly decided that it would not compile "lists"—for example, a list of all physicians who have been convicted of a felony. *[13:4 CRLR 56–57]* The Board's "no list" policy was based on the preliminary advice of DCA legal counsel, who opined that the California Public Records Act (CPRA) does not require a government agency to create a document in response to a request; it only requires agencies to produce existing documents which are responsive to requests.

Following the Board's implementation of the new policy, *San Jose Mercury News* reporter Mitchel Benson filed a CPRA request seeking a computer tape containing all public information available on all physicians licensed to practice in California; the Board denied the request, stating that the information does not exist in the form requested and, as such, it is not required to produce the information. Benson renewed his request, and was joined by reporters from the *Sacramento Bee* and the *Los Angeles Times*. MBC staff presented the requests to the Board at its February 1994 meeting, and encouraged MBC to permit staff to research efficient and cost-effective ways to join the "information superhighway" and respond to requests for information about physicians. Staff specifically suggested the periodic compilation and release of a 9-track computer tape containing all public information on all California physicians, stating that this option would "make[] public information available at the least possible cost (both in money and staff time)." By a 3–1 ratio, the Board rejected staff's suggestions and the newspapers' request, prompting the newspapers to file a petition for writ of mandate in Sacramento County Superior Court to enforce the CPRA. *[14:2&3 CRLR 66–67]*

In briefs filed in anticipation of a July 6 hearing, MBC claimed that creating the computer tape would require writing a new program which would be prohibitively expensive and time-consuming and create an undue and onerous burden on the Board. Specifically, the Board estimated that creating a custom computer program to produce the requested information would take 215 hours of "journey level staff programmer time" at $61.60 per hour, or $13,244. The Board argued that the major difficulty in writing a program to produce the requested data is sorting confidential information from public information. MBC also maintained that the CPRA does not require it to respond to the requests because the information does not exist in the specific form requested, and

that an agency is only required to make reasonable efforts to produce responsive materials—not reorganize its filing system in response to each request.

The newspapers responded by claiming that MBC's cost and time estimates for compiling the requested information were grossly exaggerated. Additionally, the petitioners asserted that MBC staff had already admitted the feasibility of the production of the type of list requested, citing it as the most efficient method of public disclosure. The newspapers argued that MBC had not fulfilled its CPRA burden of establishing a substantial burden which clearly outweighs the public interest served by disclosure of the public information.

Following the July 6 hearing, Judge Warren ordered the two sides to agree to and pay an independent computer expert who would advise the court as to the probable amount of time and money it would take to produce the requested computer tape. At a September 14 hearing, Judge Warren reviewed the report of the expert, who estimated that it would take 48 hours to write the program and produce the tape. In an oral decision, Judge Warren ruled in favor of the newspapers; his decision narrowly focused on the Medical Board's conduct and its policy of limiting each request for information to three physicians. Judge Warren held that MBC "deliberately created a policy in such a way to facilitate access to the potential consumer but to discourage other members of the public....There was a deliberate policy of selective disclosure, and I don't think that can be done under the Public Records Act."

Judge Warren stated that there is no clear test on whether costs are too high or burdens too unreasonable to require an agency to fulfill a CPRA request. Rather, the decision should be made on a case-by-case basis, wherein the cost is weighed against the public interest in the disclosure. According to Judge Warren, "I conclude it would be a dangerous precedent for the court to say there is no circumstance in which a state agency has a duty to reprogram public records to make them accessible to the public." However, he stated that his ruling is not to be interpreted to require agencies to "do customized programming." Thus, he ordered the Board to produce the tape by December 6, the newspapers to pay for the cost of the programming and tape production (not to exceed $4,080), and the Board to pay the newspapers' costs and attorneys' fees. At this writing, the Board has not yet decided whether to appeal the ruling.

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

On May 11, 1994, CMA filed an amended petition for writ of mandate in the matter. The amended pleading repeats all of CMA's original claims and contentions, and adds a new basis which allegedly restricts MBC from disclosing completed investigations prior to the filing of an accusation. Specifically, CMA now argues that the state Information Practices Act (IPA), Civil Code section 1798 *et seq.*, which governs state agencies' disclosure of "personal information" they collect on individuals, prevents MBC from releasing information on fully investigated cases which have been referred to the AG's Office; the term "personal information" is defined to include "name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history." On June 23, MBC filed an answer to the amended complaint, again rejecting all of CMA's numerous bases for relief and asserting that its disclosure policy is fully authorized by the California Public Records Act and therefore falls within a statutory exemption to the IPA. Since the filing of MBC's answer, the parties have been engaged in settlement negotiations.

On June 15, the Medical Board won the first round in ***Dixon Arnett, et al. v. William Dal Cielo, et al.***, No. 734354-8 (Alameda County Superior Court), an important case of first impression testing whether Evidence Code section 1157, which protects hospital peer review records from "discovery," is applicable to administrative subpoenas of the Medical Board. During an investigation of complaints that an anesthesiologist was practicing medicine under the influence of narcotics taken from the hospital's supply, MBC issued an investigative subpoena to William Dal Cielo, Chief Executive Officer of Alameda Hospital, for the hospital's records of the anesthesiologist's drug use and rehabilitation program history. Asserting that its records are protected under section 1157, the hospital refused to produce them. MBC filed an action to compel compliance with the subpoena. Following a May 27 hearing, Judge James Lambden held that section 1157 only protects peer review records from discovery proceedings in civil actions and that, because the Medical Board is not a plaintiff or litigant in civil proceedings and does not engage in civil discovery proceedings, the records must be produced. Judge Lambden held: "If Evidence Code section 1157 were to be held applicable to investigations conducted by the Medical Board of California, the private physician peer review process taking place at local hospitals would effectively be the sole arbiter of physician quality control in California, which would subvert the statutory scheme and the mandated duties of the Medical Board of California to review the quality of medical practice carried out by physicians licensed in California, and to take appropriate action to protect the public from substandard medical practice." Dal Cielo has appealed Judge Lambden's ruling to the First District Court of Appeal, where it is pending at this writing.

Through its victory in ***Kenneally v. Medical Board of California***, 27 Cal. App 4th 489 (Aug. 4, 1994), MBC finally appears to have secured the courts' blessing on its long-running disciplinary proceeding against Dr. Leo Kenneally. Its final disciplinary decision, however, has sparked controversy among consumer advocates and has prompted a motion for reconsideration by the Attorney General's Office.

In 1990, DMQ filed an accusation against Kenneally, charging him with gross negligence and incompetence in the performance of abortions on six patients, three of whom died soon after undergoing the procedure. In October 1991, Kenneally filed a federal court action which only served to delay the commencement of his disciplinary hearing until April 1993 *[12:4 CRLR 93–94]*; in the meantime, the Board filed two supplemental accusations against Kenneally in February 1993, charging him with gross negligence and incompetence in the performance of abortions on two additional patients. Just before the start of his disciplinary hearing in April 1993, Kenneally filed a state court suit alleging that the Administrative Pro-

cedure Act adjudicatory process for revoking or suspending a doctor's license violates the equal protection provision of the fourteenth amendment because it is not identical to the procedures which govern attorney disciplinary proceedings by the State Bar, especially with regard to the taking of depositions prior to the hearing. Specifically, under the State Bar Act, a lawyer facing disciplinary proceedings may avail himself/herself of the Civil Discovery Act, including the right to take depositions prior to the disciplinary hearing; by contrast, physicians facing disciplinary proceedings may not depose witnesses prior to the hearing under Government Code section 11151 (with limited exceptions). The trial court agreed with Kenneally and enjoined the disciplinary hearing; the Board appealed.

On appeal, the Second District preliminarily held that the proper standard of reviewing Government Code section 11151 is the rational basis test; although Kenneally argued that the statute should be subject to strict scrutiny, the Second District rejected his claim, noting that physicians are not a suspect class and that, for equal protection purposes, Dr. Kenneally has no fundamental right to a prehearing deposition or to continue to practice his licensed profession. Examining the legislative history of section 11151, the court found that the taking of depositions is restricted in order to prevent undue delay, expedite the proceedings, and reduce the overall cost of disciplinary proceedings for all parties. Noting that "physicians have a far greater and immediate impact on the health and life of those they serve than do attorneys... [such that] reduction of delay is more imperative in physician disciplinary proceedings than in attorney disciplinary proceedings," the court held that section 11151 is rationally related to a legitimate governmental purpose and reversed the trial court's order.

In the meantime, Administrative Law Judge Milford A. Maron presided over Kenneally's disciplinary hearing, which consumed 38 sessions between May 6, 1993 and February 9, 1994. On May 27, 1994, ALJ Maron issued a proposed decision in which he evaluated the evidence submitted on eight cases. In two, the patients had died; in two others, the patients had hysterectomies following abortions performed by Kenneally. In all but one of the eight cases, ALJ Maron made multiple findings of gross negligence and incompetence; he further noted that Kenneally's license has been disciplined twice since 1976. However, he made "special findings in mitigation and extenuation," including the fact that Kenneally's abortion clinics charge low fees to patients who are "without funds or insurance...[t]he community is underserved and respondent has in his employ 22 persons at two clinics widely separated geographically." ALJ Maron found that Kenneally's clinics "meet current State requirements for providing abortion surgeries" and that Kenneally's "complication rates do not appear to be below average." According to ALJ Maron, "[t]he weight of the evidence demonstrates that respondent is an unselfish and committed provider serving the poor in a community that is grossly underserved medically. There is presently an enormous need for his services in the communities which he serves, where he is the 'price floor' for elective abortions. The very areas in which his offices are located are those in greatest need of family planning services. His absence would make it much more difficult for disadvantaged women to obtain such services." Instead of recommending revocation of Kenneally's license, ALJ Maron recommended a suspension of one year and ten years' probation.

On August 9, DMQ adopted ALJ Maron's proposed decision, prompting Women's Advocate Director Jeannette Dreisbach to call on Governor Wilson to demand the resignations of the Medical Board members. "Your Medical Board appointees are guilty of gross negligence against women as medical consumers, especially young, low income minority women....Based upon the shameful, outrageous injustice of today's decision by the Medical Board to fail to revoke the license of the infamous Dr. Leo Kenneally, you must exercise responsible leadership and fire the Medical Board members for gross failure to protect women from negligent, incompetent doctors such as Kenneally." On September 1, Kenneally's attorney secured a stay of the Board's disciplinary order pending a September 16 hearing; simultaneously, the Attorney General's Office announced that it will petition DMQ to reconsider its decision and revoke Kenneally's license.

In ***Kerins v. Hartley***, 27 Cal. App. 4th 1062 (Aug. 23, 1994), the Second District Court of Appeal held that damages for emotional distress due to fear of acquiring AIDS may be recovered from an infected health care provider only if the plaintiff is actually exposed to HIV or AIDS as the result of the defendant's negligent breach of duty, and that it is more likely than not he or she will become HIV-positive or develop AIDS due to that exposure. The decision appears to be another in a recent series of cases cutting into a patient's right to "informed consent" about medical treatment. *[14:1 CRLR 55]*

Jean Kerins consulted Dr. James Gordon at the Women's Medical Group of Santa Monica (WMG) after experiencing severe abdominal pain. Diagnosis of a fibroid tumor was followed by non-invasive therapy, which proved ineffective. On November 5, 1986, Gordon performed surgery on Kerins. A detailed operative report did not indicate that Gordon had sustained any cuts, or that there were any unusual occurrences during the surgery. On November 10, 1986, Gordon received blood test results indicating HIV seropositivity, the probable causative agent of AIDS. He informed the staff at WMG and continued to actively practice medicine.

Gordon subsequently developed AIDS, and announced his illness in a television interview regarding his AIDS discrimination suit against his WMG partners, who had refused to allow him to further practice medicine after recovering from an AIDS-related illness. His partners also appeared in the same program, commenting on the frequency with which surgeons cut or poke themselves during surgery, criticizing Gordon's refusal to obtain informed consent from his patients, and arguing that their patients should be protected from even a remote risk of exposure to AIDS.

Within one day of the broadcast, Kerins underwent an test for HIV seropositivity, and approximately two weeks later received negative test results. Kerins brought suit against Gordon, his partners, and WMG, claiming general and punitive damages based on health care expenses, lost past and future earnings, and compensation for severe mental anguish and emotional distress which she suffered upon discovering that Gordon had performed surgery on her at a time when he was infected with HIV.

The trial court granted summary judgment in favor of defendants. On appeal, the Second District allowed recovery of emotional distress damages due to the fear of developing AIDS for the "reasonable window of anxiety" between the time that Kerins learned of Gordon's HIV seropositivity and the time she received "fear-relieving information," such as proof of nonexposure or negative HIV test results. The California Supreme Court granted review and remanded the case to the Second District with directions to vacate its decision and reconsider the case in light of *Potter v. Firestone Tire and Rubber Co.*, 6 Cal. 4th 965 (1993), a decision on the related issue of whether emotional distress damages are available for fear of developing cancer or other illness from toxic exposure.

On remand, the Second District noted that Kerins was not claiming Gordon had

failed to use due care during the surgery, and that Gordon had complied with the existing Centers for Disease Control guidelines governing performance of exposure-prone obstetric/gynecological procedures (which fail to require HIV-infected health care workers to notify patients of their condition as part of "informed consent"). The gist of Kerins' claim was that she had expressed particular concerns to Gordon about the danger of contracting AIDS and had even inquired about Gordon's health; he responded that he went to a gym regularly and jogged every morning—neglecting to mention the possibility that he was infected with HIV or AIDS. However, the court rejected her claim. "Assuming for the very limited purpose of argument that an independent duty of disclosure was created by [Kerins'] specific inquiries about the state of Dr. Gordon's health, [Kerins'] claim for negligently inflicted emotional distress damages nevertheless fails under *Potter*....Damages for fear of AIDS may be recovered in the absence of physical injury or illness only if the patient is exposed to HIV or AIDS as a result of the defendant's negligent breach of a duty owed to the plaintiff, and the plaintiff's fear stems from knowledge, corroborated by reliable medical or scientific opinion, that it is more likely than not he or she will become HIV seropositive and develop AIDS due to the exposure." Since expert testimony revealed statistically insignificant risks that a surgeon would transmit HIV during a surgical procedure and that Kerins' negative HIV test was 95% accurate, the court found that the surgeon violated no duty to disclose his HIV risk and that Kerins' fear of contracting AIDS was unreasonable as a matter of law, and precluded her claim for damages due to emotional distress.

In ***Mir v. Charter Suburban Hospital***, 27 Cal. App. 4th 1471 (Aug. 31, 1994), the Second District Court of Appeal held that a trial court's finding that a hospital's disciplinary action against a physician was not supported by substantial evidence does not entitle the physician to recover $45,000 in legal fees.

Jehan Zeb Mir, a cardiothoracic surgeon, had staff privileges at Charter Suburban Hospital. In June 1988, the hospital's Medical Executive Committee filed a statement of charges against Mir and recommended that his admitting privileges be terminated. A panel of three physicians (Judicial Review Committee) heard evidence, including expert evidence, concerning the hospital's charges against Mir. In December 1988, the Judicial Review Committee rendered a decision against Mir on only one of the charges involving a particular patient, and placed Mir on temporary probation. The hospital's Board of Directors reviewed and upheld the decision in April 1989. Mir filed a petition for writ of mandate, claiming in part that there was no substantial evidence to support the corrective action taken against him. The court granted the writ and found that there was no substantial evidence that anyone could have done any better than Mir and the determination of poor medical judgment could not stand. Charter's appeals were unsuccessful. Following the resolution of the appeal, Mir filed a motion in the trial court for an order awarding attorneys' fees under Business and Professions Code section 809.9. He contended that the hospital's conduct in disciplining him was unreasonable and without foundation. The court granted the motion and ordered the hospital to pay Mir's attorneys' fees in the amount of $45,205.

In a 2–1 decision, the Second District reversed. Because he obtained declaratory relief from the trial court, the appellate court found that Mir was a "substantially prevailing party" under section 809.9. Under that section, a claimant may request attorneys' fees and costs if "the other party's conduct in bringing, defending, or litigating the suit was frivolous, unreasonable, without foundation, or in bad faith." However, the language in the statute is ambiguous and does not define the terms "unreasonable" or "without foundation." The majority concluded that "a grant of a petition for writ of mandate due to a lack of substantial evidence does not amount to a finding that the defense to the petition was unreasonable or without foundation so as to merit an award under section 809.9." The court stated that the statute requires a strong, affirmative showing in order to uphold sanctions, and that the legislature did not intend to merely offer attorneys' fees to all who prevail on a mandamus petition. The majority also stated that "[t]o require a hospital to pay a physician's attorney fees whenever a physician prevails in a mandamus proceeding inevitably would chill the peer review process....Facing the specter of attorney fees, hospitals would have to consider taking the safer course and ignoring all but the most egregious malfeasance."

In compliance with the court's April 25 order in ***Engineers and Scientists of California (ESC), et al. v. Division of Allied Health Professions***, No. 532588 (Sacramento County Superior Court), the Medical Board published an August 19 notice in the *California Regulatory Notice Register* stating that section 1366(b)(4), Title 16 of the CCR, is invalid in its entirety. The section, which permits unlicensed medical assistants to perform "automated visual field testing, tonometry, or other simple or automated ophthalmic testing" under certain conditions, was invalidated by the court due to procedural irregularities in the rulemaking process. *[14:2&3 CRLR 73; 13:4 CRLR 63, 79; 13:2&3 CRLR 85–86, 100]*

RECENT MEETINGS

At its July 29 meeting, the full Board adopted the Guidelines for Prescribing Controlled Substances for Intractable Pain which emerged from the March 1994 "Effective Pain Management Summit" co-sponsored by MBC. *[14:2&3 CRLR 73–74]* The guidelines begin with a quote from Business and Professions Code section 2241.5(c): "No physician and surgeon shall be subject to disciplinary action by the Board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." The guidelines state that physicians should not fear disciplinary action if they follow California law, use sound clinical judgment, and follow accepted professional standards in the areas of patient medical history and physical examination, documentation of the treatment plan and objectives, informed consent, periodic review of the treatment plan, consultation with specialists, recordkeeping, and compliance with controlled substances laws and regulations. At this writing, the Board plans to publish the new guidelines in the October 1994 issue of its *Action Report* newsletter.

Also on July 29, MBC approved the expenditure of $45,000 to help finance the implementation of a recent study by the Controlled Substance Prescription Advisory Council created by SCR 74 (Presley), which calls for the replacement of the state-required triplicate prescription form for controlled substances with electronic (computerized) monitoring of controlled substances prescriptions. MBC is co-funding the project with the Department of Justice and the Board of Pharmacy.

State and Consumer Services Agency (SCSA) Secretary Joanne Corday Kozberg attended the Board's July 29 meeting to officially inform it that the Wilson administration has agreed to sponsor a "Summit on Health Policy and Resources" to focus on incentives to enhance the number of primary care physicians, balance the geographic distribution of health care providers, and improve the cross-cultural language abilities of health care providers. The Summit was suggested by MBC member Dr. Robert del Junco and his Task Force on Health Policy and Resources. *[13:4 CRLR 63]* Kozberg noted that the pro-

posed Summit provides a unique opportunity to bring together representatives from several state agencies in attacking a problem of critical importance; she noted that the Summit planning committee, which has begun to meet, includes representatives from SCSA, the Health and Welfare Agency, Cal-OSHA, DCA, MBC, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, and the Board of Registered Nursing.

Finally, the Board said farewell to former MBC President Jacquelin Trestrail and public member Theresa Claassen, two longtime MBC members whose terms have expired.

FUTURE MEETINGS

October 6–8 in Oxnard (Board retreat).
November 2–4 in San Diego.
February 3–4, 1995 in San Francisco.
May 11–12, 1995 in Sacramento.
July 28–29, 1995 in Los Angeles.
November 2–3, 1995 in San Diego.

ACUPUNCTURE COMMITTEE

Executive Officer: Sherry Mehl
(916) 263-2680

The Acupuncture Committee (AC) was created by the legislature in 1982. Pursuant to the Acupuncture Licensure Act, Business and Professions Code section 4925 *et seq.*, the Committee issues licenses to qualified practitioners, establishes standards for the approval of schools and colleges which offer education and training in the practice of acupuncture, establishes standards for the approval of tutorial programs (an alternative training method), receives and investigates complaints against licensees, and takes appropriate enforcement action against the licenses of practitioners who have committed disciplinary violations. The Committee is authorized to adopt regulations, which appear in Division 13.7, Title 16 of the California Code of Regulations (CCR), and submit them for approval to the Medical Board of California (MBC).

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

On July 22, Governor Wilson reappointed Marguerite Mei-Yu Hung of Chula Vista to another term on the Committee. Hung is a self-employed acupuncturist, and has served on AC since 1992.

MAJOR PROJECTS

Performance of Acupuncture by Other Healings Arts Professionals. At its August meeting, AC reviewed a June 30 legal opinion by Department of Consumer Affairs (DCA) legal counsel Don Chang on whether other healing arts professionals—including physicians, physical therapists (PTs), registered nurses (RNs), dentists, and podiatrists—may lawfully perform acupuncture within their scope of practice.

Chang concluded that the practice of acupuncture falls within a physician's scope of practice under Business and Professions Code section 2051, which permits physicians to "sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions." Thus, according to Chang, physicians may perform acupuncture without having to pass an examination which demonstrates his/her competency in acupuncture.

As to RNs, Chang noted that Business and Professions Code section 2725(b) permits registered nurses to provide "direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents... ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist...." Interpreting a 1984 Attorney General's Opinion, Chang concluded that an RN may perform acupuncture as a "therapeutic agent" if instructed by a physician, but that "it would be a departure from the standard of care if a physician were to order a nurse to administer acupuncture and the physician did not possess the knowledge and skill of acupuncture to direct and supervise the nurse." Thus, when directing an RN to administer acupuncture, a physician should be competent to administer it and supervise its administration, and should consider the RN's education, training, and experience as well.

Although Business and Professions Code section 2620.5 authorizes PTs to perform tissue penetration, Chang found that the purpose of a PT's tissue penetration is evaluative, not therapeutic. After analyzing the four acupuncture modalities which require licensure, Chang concluded that a PT license does not confer authority to practice acupuncture, either independently or under the supervision of a physician.

Business and Professions Code section 4947 permits dentists and podiatrists to practice acupuncture if they have completed a course of instruction. In accordance with this section, both the Board of Dental Examiners and the Board of Podiatric Medicine have adopted regulations authorizing their licensees to practice acupuncture if they have completed a specified curriculum approved by the board or at an AC-approved school. Therefore, Chang concluded that dentists and podiatrists who have completed the curriculum may practice acupuncture within the scope of their licenses.

1995–96 Budget Change Proposals. At its August meeting, AC reviewed and approved two budget change proposals (BCPs) for 1995–96. The first BCP would double the Committee's examination budget to $322,000, in order to allow it to administer its licensing examination twice per year instead of once per year. AC's exam is a two-part test consisting of a one-day written exam and a two-day clinical component held approximately six weeks after the written exam. AC seeks to offer its exam twice per year to enable candidates who complete their educational requirements to take the exam (and candidates who have failed either portion to retake it) without undue delay which causes financial hardship. Due to the large number of candidates who need to pass the clinical exam, AC also directed Executive Officer Sherry Mehl to explore the possibility of administering a second clinical exam in early 1995 just prior to the regularly scheduled clinical exam.

The second BCP would add $141,000 to AC's budget to enable it to hire a contract consultant to perform an occupational analysis of the practice of acupuncture. An occupational analysis profiles the tasks actually performed in a particular trade or profession, and identifies the knowledge, skills, and abilities needed to perform them competently. The last occupational analysis of the acupuncture profession was performed in 1989–90, and AC needs an updated analysis to ensure that its current licensing examination is relevant, valid, and legally defensible.

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

• ***Continuing Education Regulations.*** On June 29, AC held a public hearing on its proposal to overhaul its continuing education (CE) regulations in Division 13.7,

Title 16 of the CCR. Specifically, AC proposes to repeal several of its existing CE regulations (sections 1399.480, 1399.481, 1399.483, and 1399.484) and replace them with new regulations which would clarify AC's CE program. *[14:2&3 CRLR 74–75]*

The Committee received no public comment on the proposed regulatory changes, and adopted all of them with only one modification. Specifically, AC modified proposed section 1399.489(f) to clarify that instructors of CE courses may accrue one hour of CE credit for each classroom hour completed as an instructor of an AC-approved CE course. On July 5, AC released this modification for a 15-day public comment period ending on July 20. MBC's Division of Licensing (DOL) approved these changes at its July 28 meeting. At this writing, AC's proposed changes to its CE regulations await review and approval by the Director of the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL).

• ***Fee Regulation***. On June 23, OAL approved AC's adoption of section 1399.460, which creates a license renewal system based upon licensee birthdate and establishes a new fee schedule. OAL had previously disapproved section 1399.460 in February 1994, but AC revised the language and resubmitted it in May. *[14:2&3 CRLR 75]*

On June 29, AC held a public hearing on its proposal to revise the fee schedule established in section 1399.460; among other things, the revisions reduce AC's annual license renewal fee from $325 to $200. Following the hearing, the Committee unanimously approved the regulatory changes; DOL approved the changes at its July 28 meeting. At this writing, the revisions to section 1399.460 await review and approval by DCA and OAL.

• ***Examination Languages***. Also on June 23, OAL approved AC's amendments to section 1399.441, which specifies the languages in which AC's exam will be administered. *[14:2&3 CRLR 75]*

• ***Transfer Credits***. On May 26, OAL approved AC's amendments to section 1399.436, which clarify the percentage of transfer credits which may be accepted by AC-approved training programs from AC-approved and non-AC-approved schools and colleges. *[14:2&3 CRLR 75]*

• ***Schools' Reports to AC***. On May 26, OAL disapproved AC's amendments to section 1399.439, which would require each approved acupuncture school to annually submit to AC a course catalog for that year with supplemental information detailing any courses added, deleted, or significantly changed from the previous year's curriculum; any changes in faculty, administration, or governing body; any major changes in the school facility; and a statement regarding the school's financial condition which enables AC to evaluate whether the school has sufficient resources to ensure the capability of the program for enrolled students. The amended regulation also provided that if AC determines an onsite visit is necessary, the school is required to reimburse the Committee for direct costs incurred in conducting such review and evaluation. OAL rejected the proposed amendments because they are unclear as to the date upon when schools must submit the specified information, and fail to include a finding that the reporting requirements are necessary for the health, safety, or welfare of the people of California as required by Government Code section 11346.53(f).

At its June 29 meeting, AC adopted modifications to the language of section 1399.439 to require schools to submit a current course catalog and the other specified information within 60 days after the close of the school's fiscal year. The Committee released the modified language for an additional 15-day comment ending on July 20; DOL approved the changes at its July 28 meeting. On September 21, AC resubmitted the rulemaking file on section 1399.439 to OAL, where it is pending at this writing.

LEGISLATION

SB 2101 (McCorquodale), as amended July 7, extends until January 1, 2000 the time period during which an independent consultant is required to administer AC's licensing examination, with technical advice and assistance from AC. This bill also provides that petitions for reinstatement or modification of penalty may be made after certain minimum time periods have elapsed from the date of the decision ordering the disciplinary action. This bill was signed by the Governor on September 30 (Chapter 1275, Statutes of 1994).

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 76–77:

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for AC; creates a Joint Legislative Sunset Review Committee which will review AC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which AC's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether AC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case AC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

SB 1279 (Torres). Existing law prohibits the imposition of monetary liability on professional societies and members of peer review committees that review the quality of various professional health care services for acts performed within the scope of the functions of peer review, if that committee or member acts without malice, has made a reasonable effort to obtain the facts, and acts in reasonable belief his/her action is warranted. As amended August 25, this bill extends this prohibition to peer review bodies, and members of peer review bodies, that review acupuncturists.

Existing law exempts from discovery as evidence the proceedings and records of peer review bodies. This bill extends this exemption to the proceedings and records of acupuncturist review committees.

Existing law conditionally authorizes certain licensed health care professionals to own shares in various professional corporations. This bill similarly authorizes certain licensed health care professionals to be shareholders in an acupuncture corporation. This bill was signed by the Governor on September 25 (Chapter 915, Statutes of 1994).

AB 3765 (Campbell), as amended April 28, would have required the Medical Board of California, with the participation of AC, the California Medical Association, the California Naturopathic Association, the Osteopathic Medical Board of California, and the Board of Chiropractic Examiners, to study and report to the legislature by July 1, 1995, on the practice of naturopathy and the desirability of establishing a "Naturopathic Practitioners Registration Act." This bill died in committee.

RECENT MEETINGS

At AC's May 25 meeting, Committee Chair Jane Barnett appointed the membership of AC's Executive, Education, Enforcement, and Examination subcommittees. She also clarified the Committee's policy on public comment at meetings. *[14:2&3 CRLR 77]* Barnett noted AC will comply with a recent amendment to the

Bagley-Keene Open Meeting Act which requires state bodies to hold a public comment period at each meeting, and said that public comment will not be limited to items which are on the Committee's agenda. At the Committee's August 17 meeting, Barnett further noted that once AC has discussed an item on its agenda, the item will be open to public comment before any vote is taken on it by the Committee.

At AC's August 17 meeting, Executive Officer Sherry Mehl presented a new draft of the Committee's consumer brochure for review. AC members made several suggestions for changes to the brochure, which will be incorporated into a revised draft. *[13:4 CRLR 64; 13:1 CRLR 50]* AC agreed that the revised draft should be circulated to all members, schools, and associations for their review; at this writing, AC is scheduled to revisit this issue at its October meeting.

Also in August, AC voted to sponsor several legislative proposals during 1995, including one provision which would amend Business and Professions Code section 4933 to delete the existing requirement that MBC approve AC's regulations. MBC representative Tony Arjil stated that the Medical Board would probably not oppose such legislation, but that AC should work with the California Medical Association, which has traditionally been strongly opposed to any separation of AC from MBC.

FUTURE MEETINGS

October 18–19 in San Francisco.
January 24, 1995 in Los Angeles.
April 12, 1995 in Sacramento.
July 25, 1995 in San Francisco.
October 25, 1995 in Sacramento.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer: Elizabeth Ware (916) 263-2288

Pursuant to Business and Professions Code section 3300 *et seq.*, the Hearing Aid Dispensers Examining Committee (HADEC) prepares, approves, conducts, and grades examinations of applicants for a hearing aid dispenser's license. The Committee also reviews qualifications of exam applicants and issues hearing aid dispenser licenses to qualified individuals. HADEC is authorized to take disciplinary action against its licensees for statutory and regulatory violations, and may issue citations and fines to licensees who have engaged in misconduct. HADEC functions under the jurisdiction of the Medical Board of California (MBC); it submits proposed regulatory changes to MBC for approval. HADEC's regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

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

MAJOR PROJECTS

McCorquodale Legislation to Merge HADEC and SPAEC Fails. SB 2037 (McCorquodale), an omnibus agency restructuring bill which would have—among other things—merged HADEC with the Speech-Language Pathology and Audiology Examining Committee (SPAEC), was killed on the Senate floor on August 31. The bill, an outgrowth of the Fall 1993 hearings by the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, called for the merger of the two committees and creation of a new "Speech-Language Pathology, Audiology, and Hearing Aid Dispensers Board" under the jurisdiction of the Medical Board. *[14:2&3 CRLR 77–78; 14:1 CRLR 58]* The bill was killed for reasons unrelated to HADEC, SPAEC, or their proposed merger; it died after the Senate refused to concur in the Assembly's removal of a provision to merge the Cemetery Board with the Board of Funeral Directors and Embalmers (*see* reports on those agencies for related discussion). Thus, HADEC and SPAEC will continue to function as separate committees under the jurisdiction of the Medical Board.

Enhanced Educational Requirements for Dispenser Licensure. At its July 22 meeting, HADEC approved a proposal from its Examination and Continuing Education Subcommittee which—if enacted by the legislature—would phase in considerably enhanced education and training requirements for licensure as a hearing aid dispenser. *[14:2&3 CRLR 78; 14:1 CRLR 59]*

Finalized by the Subcommittee at its July 15 meeting, the proposal would first require a high school diploma or its equivalent as a prerequisite to licensure; that provision was included in SB 2037, and will be responsored by HADEC in 1995. Effective January 1, 1998, the proposal would require 60 units of experience and training beyond high school. This component of the proposal involves elimination of HADEC's existing trainee licensure program and replacement of the temporary trainee permit with a field placement permit; by January 1, 2000, licensure candidates will be placed in a hearing aid dispenser's office for practical training as part of the 60-unit requirement (or may demonstrate equivalent experience as a licensed practicing dispenser in another state or country). Additionally, specific course completion requirements will be added by January 1, 2002; and requirements for the full 60-unit program will be specified by January 1, 2004. No other state or jurisdiction requires the equivalent of an associate of arts degree for licensure as a hearing aid dispenser; however, HADEC believes that the Canadian province of British Columbia plans to require two years of postsecondary education effective September 1996. HADEC instructed its legal counsel to begin drafting legislative language to implement its proposal.

Enforcement Report. At HADEC's July 22 meeting, Committee member Deborah Kelly reported on HADEC's final enforcement statistics for fiscal year 1993–94. HADEC issued 85 citations without fines and 15 citations with fines; nine of these citations were dismissed after appeal. Also during 1993–94, HADEC revoked three licenses, issued one conditional license, placed five licenses on probation, and accepted three voluntary surrenders. A total of 169 enforcement cases are pending: 37 are being reviewed by a consumer services representative (CSR) at the Medical Board's Central Complaint and Investigation Control Unit; 47 are under formal investigation by an MBC investigator; two are being reviewed by an expert consultant; 68 investigations have been forwarded to HADEC's Executive Officer; seven fully investigated cases are pending at the Attorney General's Office; and the Attorney General has filed an accusation in another eight cases.

Kelly also presented a "case aging report" compiled by the Medical Board on the lengthy enforcement process. The report outlines the average total number of days HADEC cases spend in each of the six stages of enforcement. First, the report indicates that complaints against HADEC licensees sit at the MBC CSR stage for an average of 131 days, followed by a 457-day investigation period. Quality of care cases are usually submitted to an outside expert, which takes an average of 239 days. Completed investigations must be approved by HADEC's Executive Officer,

which takes an average of 18 days. Once forwarded to the Attorney General's Office, cases sit for an average of 366 days before the formal accusation is filed, and then spend another 252 days at the AG's Office during the hearing and post-hearing decisionmaking process. Thus, it takes an average of 1,211 days—or 3.3 years—from the time a complaint is received until the filing of the accusation, and over four years from complaint receipt to final disciplinary decision. Much to HADEC's frustration, only 18 days of those four years are within the offices and control of HADEC, and the complaint cannot be made public until the accusation is filed. HADEC has made some progress in reducing the average time of this process through its utilization of investigators from the Department of Consumer Affairs' (DCA) Division of Investigation instead of MBC investigators; additionally, effective July 1, HADEC took over its own complaint processing and mediation.

Licensing Report. At HADEC's July 22 meeting, Licensing Coordinator Yvonne Crawford reported on the Committee's licensing statistics. Between March 31 and July 15, 30 temporary licenses were issued, bringing the total number of temporary licenses to 101. During the same timeframe, 24 permanent licenses were issued. As of July 15, HADEC's cumulative license figures include 1,517 current licenses, 672 delinquent licenses, and 37 revoked licenses. Also during the same timeframe, 35 branch licenses were issued, bringing that cumulative total, as of July 15, to 197 current licenses and 638 delinquent licenses.

LEGISLATION

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 78–79:

SB 2037 (McCorquodale), as amended August 30, would have (among other things) merged HADEC and SPAEC into a single board under the jurisdiction of MBC. This bill died on the Senate floor on August 31 (*see* MAJOR PROJECTS).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 on HADEC; creates a Joint Legislative Sunset Review Committee which will review HADEC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which HADEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether HADEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case HADEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

AB 1392 (Speier), as amended August 17, is no longer relevant to HADEC.

RECENT MEETINGS

At HADEC's July 22 meeting, Committee staff reported that a total of 59 candidates took the computerized version of HADEC's written examination between April and June of 1994; of these candidates, 36 passed for a pass rate of 61%. The electronic administration of HADEC's written exam by Assessment Systems, Inc. (ASI) began on April 8. *[14:2&3 CRLR 79; 14:1 CRLR 58–59]* A total of 43 candidates took HADEC's practical exam on June 25 in Sacramento; of those, 29 passed for a 67% pass rate. Of seven applicants retaking the exam, six passed. The overall pass rate for this examination is 7% lower than the November 1993 practical examination, while the retake pass rate is higher than any previous examination and 18% higher than the November 1993 examination.

Since the July meeting, the administration of HADEC's written exam in electronic form has run into some problems. Although the Committee believes the computerized format is an excellent means of testing and is being successfully utilized, HADEC received a September 14 letter from ASI which the Committee believes is a departure from the agreement between HADEC and ASI. HADEC says the original contract provided that testing would be available at least once per week at each of five ASI testing centers, that testing would be available to candidates within 3–14 days of their request, and that any changes to that schedule must be negotiated in advance and approved by both HADEC and ASI in writing. However, ASI informed HADEC of a change in the exam schedule effective September 17, limiting exam administration to only once per month at each of the five testing centers. HADEC states that it did not agree to this change nor was it consulted in advance. At this writing, HADEC is deciding on its response to this schedule change, and the Examination and Continuing Education Subcommittee is scheduled to discuss the issue at its scheduled October 18 meeting.

At HADEC's July 22 meeting, staff distributed the final printed version of the Committee's Revised Disciplinary Guidelines and Model Disciplinary Orders. The guidelines are intended to provide guidance to deputy attorneys general, administrative law judges, and HADEC itself as to the Committee's preferred sanction for any given violation of HADEC's statute or regulations.

Also in July, HADEC reelected Keld Helmuth as Committee Chair and Betty Cordoba as Vice-Chair.

FUTURE MEETINGS

November 18 in Sacramento.

PHYSICAL THERAPY EXAMINING COMMITTEE

Executive Officer: Steven Hartzell (916) 263-2550

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

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

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

On August 15, Governor Wilson appointed Gerald Kaufman of San Diego as the Committee's newest PT member.

MAJOR PROJECTS

Supervision Requirements. On August 26, PTEC once again published notice of proposed amendments to section 1398.44,

Division 13.2, Title 16 of the CCR, to establish protocols and requirements for PTs' adequate supervision of PTAs. For several years, PTEC has attempted to draft and adopt a regulatory definition of "adequate supervision" by a PT over a PTA. PTEC's earlier drafts set forth separate requirements for the inpatient/outpatient facility setting and the home health care setting, and included a requirement that, in the inpatient/outpatient facility setting, the supervising physical therapist (SPT) must be present in the same facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty. These proposals generated strong opposition by the California Chapter of the American Physical Therapy Association, such that PTEC finally dropped them in January 1994 *[14:2&3 CRLR 80]* and redrafted the entire regulation.

As published on August 26, the proposed amendments eliminate the 50% actual presence requirement and do not appear to differentiate between inpatient/outpatient facility settings and the home health care setting. Proposed section 1398.44 would require the licensed SPT to be readily available in person or via electronic means to the PTA at all times for advice, assistance, and instruction. The SPT must initially evaluate each patient prior to the provision of physical therapy treatment by the PTA, and document the evaluation and the date of the next scheduled reevaluation in the patient's record. Based on the evaluation and other information available to the PT, the SPT must formulate and record in each patient's record a treatment program, and determine which elements thereof may be delegated to the PTA; the SPT must sign the treatment program. The SPT must reevaluate the patient as determined necessary in the initial evaluation, modify the treatment program as necessary, and document and sign each reevaluation in the patient's record.

The proposed amendments further provide that the SPT and PTA must conduct a case conference on each patient prior to the PTA providing care; the SPT must document the case conference in the patient's record. The SPT must provide treatment at least monthly, or more frequently if necessary, on each patient being seen by the PTA; the SPT must document and sign the treatment in the patient's record. Each week, the SPT and PTA must conduct a case conference on all patients. In case of the patient's unanticipated medical complications, regression, and/or lack of progress, the SPT must determine the patient's condition and appropriate follow-up. The SPT must document and sign the case conference and any appropriate follow-up actions in the patient's record.

At this writing, PTEC is scheduled to hold a public hearing on the proposed amendments to section 1398.44 on October 13.

Personnel Identification. On August 26, PTEC published notice of its intent to adopt new section 1398.11, Division 13.2, Title 16 of the CCR. This section would require PTs, PTAs, applicants for PT and PTA licenses, and aides who provide PT services to wear an identification badge to indicate their title. This regulation would not apply to sole PT offices which do not employ supportive personnel to assist in patient-related PT services.

At this writing, PTEC is scheduled to hold a public hearing on proposed section 1398.11 on October 13.

Exam Fee Increases. Also on August 26, PTEC published notice of its intent to amend sections 1399.50 and 1399.52, Division 13.2, Title 16 of the CCR. The amendment to section 1399.50 would increase the PT examination and re-examination fees from $140 to $225; the amendment to section 1399.52 would increase the PTA examination and re-examination fees from $140 to $225. PTEC will hold a public hearing on these proposed fee increases on October 13.

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

• ***Physical Therapy Aide Supervision***. In January 1994, PTEC adopted amendments to section 1399 and the addition of section 1399.1, to stiffen the supervision requirements for physical therapy aides, unlicensed individuals who may be employed by PTs to perform both patient-related and non-patient-related tasks. The amendments to section 1399 require a mandatory evaluation of the patient by the SPT prior to the initiation of care by the aide, as well as a written treatment program in which specific patient-related tasks are assigned to the aide. New section 1399.1 would restrict a PT to supervising not more than one aide who is performing a patient-related task at any one time. *[14:2&3 CRLR 80]* On September 8, PTEC submitted the rulemaking file on these changes to the Office of Administrative Law (OAL), where they are pending at this writing.

• ***PTA Training and Experience Requirements***. Also in January 1994, PTEC adopted proposed amendments to section 1398.47, which describe numerous combinations of training and experience which PTEC believes are equivalent to its education requirements for PTAs. The amendments also specify that, after June 30, 1996, applicants for PTA approval must have gained a significant portion of any qualifying work experience under the immediate supervision of a licensed PT in an acute care inpatient facility. *[14:2&3 CRLR 80–81]* On September 8, PTEC submitted the rulemaking file on these changes to OAL, where they are pending at this writing.

• ***ENMG and KEMG Certification Regulations***. On August 29, OAL approved PTEC's amendments to sections 1399.61 through 1399.67, its requirements for specialty certification in electroneuromyography (ENMG) and kinesiological electromyography (KEMG). The amendments establish ENMG and KEMG as two distinct specialties with separate certification requirements and examinations. *[14:2&3 CRLR 81; 14:1 CRLR 61–62]*

• ***Consistent Standards for Credential Evaluation Services Reports***. On September 9, OAL approved PTEC's amendment to section 1398.25, which set standards for the review of the licensure applications and documents of foreign-trained PTs by approved credential evaluation services. *[14:2&3 CRLR 81; 14:1 CRLR 62]*

At PTEC's August meeting, Department of Consumer Affairs (DCA) Supervising Counsel Dan Buntjer recommended further amendments to section 1398.25. Specifically, Buntjer suggested that PTEC adopt both a standardized format for reporting by credential evaluation services and criteria for the approval and disapproval of such services. PTEC directed staff to draft regulatory language to implement Buntjer's suggestions for review at its October 13 meeting.

LEGISLATION

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 81–82:

AB 2836 (Snyder), as amended August 24, requires PTEC to adopt regulations setting forth standards and requirements regarding a PT's supervision of an aide and a PTA, and authorizes a PT to utilize the services of one aide engaged in patient-related tasks, as defined. This bill requires that the maximum number of PTAs that may be supervised by a PT is two, but authorizes PTEC—under certain circumstances—to permit the supervision of a greater number of PTAs, not to exceed twice the number of PTs employed by a facility at any one time. This bill prescribes the manner in which a PT is required to supervise an aide performing patient-related tasks, and requires that the PT provide direct service to a patient for whom an aide is performing patient-related tasks.

This PTEC-sponsored bill also revises the standards for licensure as a PT or for

approval as a PTA, and revises the requirements for practice while an applicant for licensure is a "physical therapist license applicant" or while an applicant for approval is a "physical therapist assistant applicant." The bill provides that upon the failure of an applicant for licensure as a PT or a PTA to satisfy subsequent licensure requirements, when the applicant is temporarily performing the duties of a physical therapist or assistant as authorized by existing law, the privilege to perform those duties terminates upon notice by certified mail, return receipt requested.

Existing law authorizes an applicant for licensure who fails to pass the examination to, in certain circumstances, be reexamined three times before paying an additional reexamination fee. This bill instead authorizes applicants who fail to pass the examination to take another examination, and requires that they pay the reexamination fee.

Existing law requires PTEC to approve certain schools of physical therapy and schools for PTAs in accordance with specified standards. This bill revises the standards for approval of physical therapy education programs and PTA education programs. This bill was signed by the Governor on September 27 (Chapter 956, Statutes of 1994).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for PTEC; creates a Joint Legislative Sunset Review Committee which will review PTEC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which PTEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether PTEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case PTEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

SB 437 (Hart), as amended August 22, would have authorized a physician practicing in certain specialties or having certain medical training, and who provides physical therapy as part of his/her practice, to use one unlicensed aide to perform patient-related tasks at any given time to assist with physical therapy, as long as, when performing these functions, the aide is at all times under the orders, direction, and immediate supervision of the physician. This bill died in committee.

RECENT MEETINGS

At its August 5 meeting, PTEC reviewed a memorandum of understanding between DCA and PTEC regarding PTEC's use of DCA's Division of Investigation (DOI) to handle complaint intake and investigative services for PTEC; the new arrangement represents a transfer of these responsibilities from MBC to DOI. Under the new arrangement, DCA will provide toll-free complaint intake services, triage of jurisdictional and nonjurisdictional inquiries and complaints through the use of an expert reference system and according to guidelines establishes by PTEC, and investigative services for certain types of cases specified by PTEC. DCA will also handle specified duties related to the mailing and tracking of licensure applications, but PTEC will retain responsibility for screening applications for licensure. The agreement became effective on July 1.

Also on August 5, PTEC reviewed its enforcement statistics for fiscal year 1993–94. PTEC received a total of 176 complaints against its licensees, filed 13 accusations, and took a total of 12 disciplinary actions (including six revocations plus four suspensions).

PTEC devoted its August 6 meeting to a strategic planning session during which it discussed its goals, objectives, and mission and vision statements. Several of the goals proposed include the enhancement of PTEC's autonomy, including control over its complaint investigation and discipline functions; completion of the investigative process within 90 days of receipt of a complaint and of the disciplinary process within six months from receipt of a complaint; improvement of its policy and procedure manuals; education of the public and licensees about PTEC's function; continual upgrading of its licensing exams relative to the changing educational environment; and improving its relationship with other health care licensing boards. Following considerable discussion, the Committee decided to defer adoption of its goals, objectives, mission statement, and vision statement to its October 13 meeting.

FUTURE MEETINGS

October 13 in Santa Clara.
February 3, 1995 (location undecided).
May 23, 1995 (location undecided).
August 4, 1995 (location undecided).
October 26, 1995 in San Diego.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale
(916) 263-2670

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

PAEC 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.

MAJOR PROJECTS

Fee Reduction for Supervising Physicians Approved. On June 3, the Office of Administrative Law approved PAEC's proposed amendments to section 1399.553, Division 13.8, Title 16 of the CCR. These revisions, which became effective on July 3, reduce PAEC's supervising physician (SP) fees to a $25 application fee (previously $50), a $75 approval fee (previously $100), and a $100 biennial renewal fee (previously $150). *[14:2&3 CRLR 82; 14:1 CRLR 63]* Since July 3, PAEC has implemented the revisions by changing its application form and advising its cashiering section of the

new fees. PAEC plans to eventually eliminate all SP fees and support the SP program solely from PA licensing fees.

Citation and Fine Regulations. At PAEC's July meeting, staff presented the Committee with draft citation and fine regulations. The proposed regulations are modeled closely after similar rules recently adopted by the Medical Board *[14:2&3 CRLR 69; 14:1 CRLR 63]*, and allow PAEC's Executive Officer to levy citations and/or fines between $100 to $2,500 per infraction for minor violations. Currently, PAEC's options for disciplining minor infractions are a private letter of reprimand to the licensee or a full-blown disciplinary action prosecuted by the Attorney General. PAEC believes that implementation of citation and fine regulations will provide an efficient, cost-effective tool for disciplining minor infractions. PAEC staff will modify the proposed language per Committee direction given at its July meeting, publish the proposed rules for public comment, and hopes to hold a public hearing on the proposed regulatory changes at its January 1995 meeting.

LEGISLATION

SB 1239 (Russell), as amended August 25, authorizes health care providers who experience significant exposure to blood or other potentially infectious materials of a patient to be informed of the HIV status of that patient. In order to allow such information access, this bill authorizes the blood or other tissue or material of a patient to be tested for HIV pursuant to a prescribed procedure, either with or without that patient's consent. This bill does not authorize disclosure of the patient's identity. It does, however, exempt a health care provider from civil or criminal liability and from professional disciplinary action for performing an HIV test on a patient, and for disclosing the HIV status of that patient to prescribed persons so long as the health care provider believes in good faith that his/her actions are consistent with the bill's provisions. This bill was signed by the Governor on September 20 (Chapter 708, Statutes of 1994).

AB 3592 (Umberg), as amended May 27, provides that any person who intentionally harasses another person's child or ward, because of that person's employment, is guilty of a misdemeanor. This bill, supported by the California Medical Association and the California Association of Hospitals and Health Care Systems, responds to increased violence and threats of violence suffered by health care professionals and their families as a result of the debate over reproductive rights. This bill is of particular significance to PAs who work in family planning clinics. The Governor signed this bill on September 11 (Chapter 529, Statutes of 1994).

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at page 83:

SB 1642 (Craven), as amended August 11, authorizes a licensed physician approved to supervise a PA (the supervising physician or "SP") to delegate to a PA under his/her supervision, and in a manner determined by the SP, the authority to administer or provide medication to a patient or transmit a prescription from the SP to a person who may lawfully furnish the medication or medical device to the patient; requires, prior to delegating prescription transmittal authority to a PA, the SP to adopt a written, practice-specific formulary and protocols that specify all criteria to be considered for use of a particular drug or device, and any contraindications for the drug or device; requires any SP's prescription that is transmitted by the PA to be based on either the physician's order for the particular patient or for a drug listed in the formulary; prohibits a PA from administering, providing, or transmitting a prescription for Schedule II through Schedule V controlled substances without an order from the SP; imposes other requirements regarding the content of the prescription transmittal order; and provides that when transmitting a prescription, the PA is acting on behalf of and as an agent for the SP. This bill was signed by the Governor on September 27 (Chapter 968, Statutes of 1994).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within the Department of Consumer Affairs (DCA), requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for PAEC; creates a Joint Legislative Sunset Review Committee which will review PAEC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which PAEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether PAEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case PAEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

AB 1392 (Speier), as amended August 17, is no longer relevant to PAEC.

RECENT MEETINGS

At its July meeting, PAEC discussed the possibility of modifying its SP application form not only to reflect the new fee level (*see* MAJOR PROJECTS) but also to request more information about past offenses of the applicant SP. *[14:2&3 CRLR 83–84]* DCA legal counsel Anita Scuri will research whether a request for information about an applicant's past history of mental illness can be done in compliance with the federal Americans with Disabilities Act and report her findings to the Committee. PAEC also considered requesting a letter of good standing from each state where the applicant SP has been licensed to practice medicine. At this writing, PAEC's Executive and Budget Subcommittee plans to review the viability of these policies at its September 25 meeting in San Diego and subsequently report to the Committee.

Also in July, PAEC evaluated its eleven objectives for 1994. *[14:2&3 CRLR 84]* The Committee believes it meets all but two of the objectives: (1) investigate how to increase utilization of PAs by physicians, and (2) develop educational guidelines for use by SPs and encourage SPs to provide continuing education to PAs. At this writing, PAEC plans to meet with Len Silvey, Inc., a private, state-recommended consulting company, on October 6 in order to articulate its mission statement and its goals and objectives for 1994–95. The results of this consultation will be presented and discussed at the Committee's October 7 meeting.

PAEC Analyst and Enforcement Coordinator Glenn Mitchell reviewed the Committee's enforcement statistics. As of June 30, 10 complaints against PAs were being reviewed by the Medical Board's Central Complaint and Investigation Control Unit, 48 complaints were under active investigation, and 13 cases were pending at the Attorney General's Office at some point in the adjudication stage. In fiscal year 1993–94, PAEC disciplined nine licensees, three of which were outright revocations of the license; 14 PAs are on probation.

Also at the July meeting, PAEC Vice-Chair and public member Ruth Ann Kahlert announced that she has chosen to work on other Committee projects instead of the PAEC newsletter. Committee member Dr. Caroline Lytle will serve as editor of the newsletter, effective October 1, 1994. The Committee discussed the possibility of discontinuing the newsletter,

but decided it plays a useful role as a disciplinary tool.

In the wake of the dissolution of the Medical Board's Division of Allied Health Professions per SB 916 (Presley) *[13:4 CRLR 68]*, PAEC has decided to maintain close alliance with the Medical Board. Prior to the July 1 commencement of fiscal year 1994–95, PAEC negotiated a contract for continued shared services with the Medical Board. PAEC views this alliance as logical, noting the nature of the PA-physician relationship and the parallel investigation procedures undertaken by the two agencies.

FUTURE MEETINGS

October 7 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.

At this writing, BPM is functioning with only five members; one public member position is vacant. As the appointing authority for the vacant position is the Senate Rules Committee, BPM Executive Officer Jim Rathlesberger wrote Senate President pro Tempore Bill Lockyer in February 1994, urging him to expedite the appointment of a public member with no professional, financial, or personal ties to BPM licensees.

MAJOR PROJECTS

Amendments to Citation and Fine Regulations Awaiting Approval. Following a public hearing at its May 6 meeting, BPM adopted proposed amendments to section 1399.698, Division 13.9, Title 16 of the CCR, the Board's citation and fine regulations. The existing regulations permit BPM's Executive Officer to issue citations for specified violations of the Business and Professions Code, the Health and Safety Code, and the California Code of Regulations, and set forth two ranges of fines (from $100 to $1,000, and from $1,100 to $2,500) which may be assessed for the violation of specified sections. BPM's proposed regulatory changes add specific sections of law currently excluded from the regulations, and provide greater latitude in determining the exact amount of the fine to be imposed. The changes extend BPM's cite and fine authority to all appropriate sections of law and conform to the citation and fine program recently adopted by MBC. *[14:2&3 CRLR 84; 14:1 CRLR 51]*

Because it adopted the proposed regulatory changes with minor modifications, BPM released the modified language for an additional 15-day public comment period which ended on June 13. At this writing, the rulemaking record on the proposed regulatory change is being prepared for submission to the Medical Board, the Department of Consumer Affairs (DCA), and the Office of Administrative Law for review and approval.

Public Disclosure Regulations. On September 16, BPM published notice of its intent to adopt new section 1399.700, Title 16 of the CCR, which would establish BPM's public disclosure policy in regulation. *[13:2&3 CRLR 92]*

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

At this writing, BPM is expected to conduct a public hearing on proposed section 1399.700 at its November 4 meeting in Los Angeles.

LEGISLATION

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at page 85:

SB 1775 (Presley), as amended August 25, changes the name of MBC's Committee on Allied Health Professions to the Committee on Affiliated Healing Arts Professions.

Existing law sets forth the requirements for issuance of a certificate to practice podiatric medicine, including one year of postgraduate podiatric surgical training in a general acute care facility; existing law also requires BPM to approve podiatric residency programs. This bill revises the requirements for issuance of a certificate to include one year of postgraduate podiatric medical and podiatric surgical training in a general acute care hospital. This bill also requires BPM, on and after January 1, 1998, to approve only those podiatric residencies approved by the Council on Podiatric Medical Education or other organization designated by BPM, provided that the organization requires entry-level podiatric residencies to include podiatric surgical training. This bill was signed by the Governor on September 30 (Chapter 1206, Statutes of 1994).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for BPM; creates a Joint Legislative Sunset Review Committee which will review BPM's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which BPM's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether BPM should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case BPM would cease to exist and its powers and duties

would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

AB 1339 (Bronshvag), as amended May 9, would have specified that, to the extent permitted by federal law, for purposes of services provided under the Medi-Cal program, DPMs shall receive the same reasonable consideration for participation and inclusion in, and reimbursement for services provided under, the program, to the same extent as any other specialty provider. This bill was vetoed by Governor Wilson on June 24.

FUTURE MEETINGS

November 4 in Los Angeles.
February 10, 1995 in Sacramento.
May 5, 1995 in San Francisco.

BOARD OF PSYCHOLOGY

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

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

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

MAJOR PROJECTS

CPA to Sponsor Prescriptive Privilege Legislation in 1995. At the Board's August meeting in San Diego, Dr. Charles Faltz of the California Psychological Association (CPA) informed BOP that CPA plans to sponsor 1995 legislation to authorize psychologists to prescribe some medications in California. CPA's draft proposal involves a new certification program to be administered by BOP; psychologists who wish to prescribe psychotropic drugs to their patients must complete the requirements of the program and become specially certified by BOP.

The proposal results from the work of CPA's Prescriptive Privilege Task Force, an expert advisory panel which recently studied and released a report on the issue. Currently, the ability of psychologists to obtain psychotropic drugs for their patients is dependent upon the psychologist's collegial relationship with a psychiatrist who is authorized to prescribe drugs; however, the Task Force found that psychiatrists and/or other physicians who are able and willing to prescribe psychotropic drugs are increasingly unavailable (especially in rural, low-income, and underserved areas) and that psychologist/psychiatrist relationships are breaking down. Noting that psychiatrists and other physicians prescribe drugs based upon six weeks of training in medical school, the Task Force unanimously concluded that psychologists could be trained in prescribing in doctoral-level educational level programs, and this training could be enhanced through supervised professional experience. CPA plans to draft a bill which outlines the required curriculum for certification in prescribing, and which authorizes psychologists (like dentists and podiatrists) to prescribe from an unlimited formulary consistent with their scope of practice. As yet, CPA has not secured an author for its legislation.

Executive Officer Tom O'Connor warned CPA that AB 2020 (Isenberg), a similar bill authorizing specially-trained optometrists to prescribe certain therapeutic drugs, was heavily opposed by the physician lobby and defeated in the legislature (*see* agency report on BOARD OF OPTOMETRY for related discussion). He also noted that a certification program is expensive to administer and causes an increase in enforcement costs; he urged that both issues be carefully considered as CPA drafts its legislation.

Continuing Education Regulations Awaiting Approval. At its March 1994 meeting, BOP adopted new Article 10 (commencing with section 1397.60), Division 13.1, Title 16 of the CCR, to implement SB 774 (Boatwright) (Chapter 260, Statutes of 1992). SB 774 added section 2915 to the Business and Professions Code, which requires psychologists, effective January 1, 1996, to satisfy continuing education (CE) requirements prior to license renewal. *[14:2&3 CRLR 86; 14:1 CRLR 65-66; 13:4 CRLR 71]*

At this writing, BOP's continuing education regulations await approval by the Director of the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL).

Citation and Fine Regulations. At BOP's August meeting, staff released draft regulatory language implementing the Board's "citation and fine" authority under Business and Professions Code sections 125.9 and 148. The citation and fine system is intended to provide occupational licensing agencies with intermediate sanctions for violations which do not warrant a full-blown disciplinary proceeding but should not be ignored. Most other DCA agencies have implemented their citation and fine authority, and Senate Business and Professions Committee Chair Senator Dan Boatwright recently expressed his desire that all boards adopt a citation and fine program and use it to address violations by licensees and unauthorized practice by non-licensees.

Under the draft language, the Board's Executive Officer would be authorized to issue a citation and/or fine for specified and relatively minor violations of BOP's enabling act and other enumerated statutes. A cited individual could appeal by requesting an informal conference with the Executive Officer; thereafter, the cited person could request an evidentiary hearing before an administrative law judge to contest the citation.

Following discussion, the Board asked staff to polish the language of the proposed regulations, and deferred this issue to its November meeting.

LEGISLATION

SB 2101 (McCorquodale), as amended July 7, revises the grounds for denial of licensure or discipline of psychologists to include the suspension, revocation, or imposition of probationary conditions on a license by another country, and revises the time period within which a licensee whose license has been suspended, revoked, or made subject to probationary conditions may apply for modification or termination of probation or reinstatement. This bill was signed by the Governor on September 30 (Chapter 1275, Statutes of 1994).

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 86-87:

SB 2039 (McCorquodale), as amended August 25, requires BOP and the Board of Behavioral Science Examiners to revoke the license of any licensee or registrant who is found to have engaged in any act of sexual contact, as defined, with a patient, or with a former patient in described circumstances. This bill is a direct result of the November 1993 oversight hearing by the Senate Subcommittee on Efficiency

and Effectiveness in State Board and Commissions. *[14:1 CRLR 35, 66]* This bill was signed by the Governor on September 30 (Chapter 1274, Statutes of 1994).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within the Department of Consumer Affairs (DCA), requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 for BOP; creates a Joint Legislative Sunset Review Committee which will review BOP's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which BOP's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether BOP should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case BOP would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

SB 1775 (Presley). Existing law regulates patient access to medical records, provides that patients of health care providers are entitled to inspect their medical records and to obtain copies of those records in accordance with certain procedures, and provides that willful violation of these requirements by a health care provider is either unprofessional conduct or an infraction. As amended August 25, this bill includes psychologists within the definition of health care provider for these purposes, and provides that willful violation of the requirements by a psychologist is unprofessional conduct. This bill was signed by the Governor on September 30 (Chapter 1206, Statutes of 1994).

AB 2659 (Morrow). Existing law sets forth the psychotherapist-patient privilege, under which the patient has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between the patient and the psychotherapist; and provides that a professional person rendering mental health treatment has the psychotherapist-patient privilege in situations in which a minor has requested and received mental health treatment or counseling, as specified. As amended August 17, this bill repeals the latter special provision and instead clarifies that the minor who has requested and received mental health treatment or counseling services is the holder of the psychotherapist-patient privilege. This bill was signed by the Governor on September 30 (Chapter 1270, Statutes of 1994).

LITIGATION

In ***Johnson, et al. v. Superior Court of Los Angeles County (Michael Gass, Real Party in Interest)***, 25 Cal. App. 4th 1564 (June 15, 1994), the Second District Court of Appeal held that experts who assist specified occupational licensing boards in disciplinary matters are absolutely immune from civil liability for malicious prosecution.

In 1991, BOP and the Board of Behavioral Science Examiners initiated disciplinary proceedings against Michael Gass, a licensed psychologist. After evidentiary hearings, both boards declined to discipline Gass, who then filed civil actions for malicious prosecution against two licensed psychologists who had served as expert consultants to the boards. In defense of the boards' experts, the Attorney General's Office filed demurrers in both cases, arguing that the experts are absolutely immune from liability under Civil Code section 43.8. Concluding that the immunity afforded by section 43.8 was conditional and not absolute, the trial court overruled the demurrers; the experts appealed.

The Second District reversed. In 1990, the legislature amended section 43.8 as part of SB 2375 (Presley) (Chapter 1597, Statutes of 1990), which the court characterized as "a comprehensive reform of this state's system of discipline against medical practitioners." The 1990 amendment deleted conditional immunity "good faith" language from section 43.8, and the court's review of the bill's legislative history revealed an intent to confer absolute immunity from civil liability on expert practitioners who assist healing arts agencies in reviewing and prosecuting disciplinary actions. Otherwise, according to the court, "the threat of being sued for malicious prosecution would deter all but the most fearless experts from serving as consultants to the Boards. Without those experts, the Boards' disciplinary activities would soon grind to a halt."

On September 8, the California Supreme Court denied Gass' petition for review of the Second District's ruling.

RECENT MEETINGS

At the Board's August 26 meeting in San Diego, a CPA representative informed BOP that the California Medical Association (CMA) plans to petition the state Department of Health Services (DHS) to amend sections 73627, 77103, and 76867, Title 22 of the CCR. These sections currently permit clinical psychologists to order seclusion or the application of restraints in the treatment of patients in, respectively, intermediate care facilities for the developmentally disabled, psychiatric health facilities, and intermediate care facilities for the developmentally disabled-habilitative. CMA's petition seeks to amend these sections to eliminate that authority. CPA noted that it had filed comments in opposition to CMA's petition, and sought assistance from BOP regarding the scope of practice of licensed psychologists, specifically in terms of their authority to order seclusion and/or the application of restraints in the treatment of patients. CPA argued that the use of seclusion and restraint has always been within the scope of practice of licensed psychologists and that, if CMA is successful, the amendments would result in grave consequences in hospitals. BOP noted that DCA Supervising Counsel Dan Buntjer was working on the Board's response to CMA's petition.

Also at its August meeting, BOP continued its review of a recent legal opinion issued by the Attorney General's Office. In Opinion No. 93-706 (Dec. 10, 1993), the AG concluded that the phrase "same work setting" as used in section 1387, Title 16 of the CCR, requires the supervisor of a registered psychological assistant who is seeking licensure to render professional services a minimum of one-half time at the same physical location where the registered psychologist is obtaining experience. *[14:2&3 CRLR 87; 13:2&3 CRLR 94–95]* Although BOP agrees with this interpretation for licensure candidates who are gaining supervised experience in the private practice setting where there are few "checks and balances" and would otherwise be little oversight of those in training, it believes the definition of "same work setting" should be more flexible for candidates gaining supervising experience in governmental or quasi-governmental settings (such as school districts, approved higher educational settings, or nonprofit community agencies), where there tends to be more structure and oversight than in the private practice setting. For example, in some school districts, the primary supervisor of the trainee might work at the district office five miles away from the school which is the practice setting and may not be physically able to be at the placement school during 50% of the time the trainee is working. However, unlike a typical private practice, an intern in a school setting has available to him/her other counselors, teachers, and administrators to assist in any crisis setting. In an effort to enable

interns to earn hours and provide services to those in need in governmental and quasi-governmental settings, the Board decided to interpret the AG's Opinion to permit it to define "same work setting" as meaning "within the same institutional setting" for individuals accruing supervised professional experience in governmental and quasi-governmental settings, and to review these situations on a case-by-case basis.

Also in August, BOP reviewed its enforcement statistics for fiscal year 1993–94. From July 1, 1993 to June 30, 1994, the Board received 561 complaints, opened 169 investigations, and forwarded 67 cases to the Attorney General's Office for disciplinary action and/or to the district attorney's office for criminal action. During that same time period, the Board filed 45 accusations and made a total of 39 disciplinary decisions (including the revocation of 13 licenses). Of the 39 disciplinary decisions, 12 were for sexual misconduct, 10 were for gross negligence or incompetence, and 4 were due to a criminal conviction.

BOP also reviewed recent examination statistics. Of 338 candidates who took the Board's written exam in April, 135 passed (for 40% pass rate). Of 502 candidates who took the oral exam in June, 188 candidates passed (for a 37.5% pass rate). The Board noted that the examiners' ratings on the oral exam were quite consistent; oral exam commissioners agreed 83.4% of the time in their classification of passing and failing candidates.

FUTURE MEETINGS

November 4–5 in Sacramento.
March 17–18, 1995 in San Francisco.
May 19–20, 1995 in Los Angeles.
August 18–19, 1995 in San Diego.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards (916) 263-2666

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

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

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

Governor Wilson recently appointed Stephan Sinclair as the Committee's newest audiology member. Mr. Sinclair is a professor and chair of the communicative disorders program at Cal State Northridge.

MAJOR PROJECTS

McCorquodale Legislation to Merge SPAEC and HADEC Fails. SB 2037 (McCorquodale), an omnibus agency restructuring bill which would have—among other things—merged SPAEC with the Hearing Aid Dispensers Examining Committee (HADEC), was killed on the Senate floor on August 31. The bill, an outgrowth of the Fall 1993 hearings by the Senate Subcommittee on Efficiency and Effectiveness in State Boards and Commissions, called for the merger of the two committees and creation of a new "Speech-Language Pathology, Audiology, and Hearing Aid Dispensers Board" under the jurisdiction of the Medical Board. *[14:2&3 CRLR 87–88; 14:1 CRLR 67]* The bill was killed for reasons unrelated to SPAEC, HADEC, or their proposed merger; it died after the Senate refused to concur in the Assembly's removal of a provision to merge the Cemetery Board with the Board of Funeral Directors and Embalmers (*see* reports on those agencies for related discussion). Thus, SPAEC and HADEC will continue to function as separate committees under the jurisdiction of the Medical Board.

Public Disclosure Policy for Citation and Fine Information. At its July 22 meeting, SPAEC approved a new public disclosure policy regarding information on citations and fines issued to its licensees. *[10:1 CRLR 85–86]* Under the new disclosure policy, SPAEC will disclose information concerning the issuance of a citation, fine, and/or order of abatement once the fine is paid, the action is abated, or upon the expiration of the 30-day period from the date of issuance where no hearing is requested. If the cited person requests an informal conference with the Executive Officer, SPAEC will disclose information on the resulting citation, fine, and/or order of abatement when a final decision has been reached. If the cited person requests a formal hearing before an administrative law judge, SPAEC will disclose information concerning the citation, fine, and/or order of abatement once the accusation is filed. In all instances where SPAEC discloses such information, it will also disclose information concerning the underlying violation of law which led to the citation, fine, order of abatement, and/or accusation.

Occupational Analyses to Commence. At SPAEC's July 22 meeting, Executive Officer Carol Richards announced that the Department of Consumer Affairs' (DCA) Office of Examination Resources (OER) will soon be commencing the occupational analyses of the speech-language pathology and audiology professions which SPAEC approved at its March 1993 meeting. *[13:2&3 CRLR 97]* Richards noted that an OER representative would be present at the Committee's October meeting to unveil OER's specific plan of action.

The purpose of an occupational analysis is to ensure that licensing examinations and other testing procedures accurately test the knowledge and skills required to competently and safely practice the respective professions. With the assistance of SPAEC and outside professionals, OER will compose a questionnaire which will be mailed to a sample of speech-language pathologists and audiologists who work in a variety of settings; the questionnaire will ask the respondents to identify the various tasks which comprise their practice and the knowledge, skills, and abilities (KSAs) necessary to perform them. OER will also conduct follow-up interviews with some of the respondents and compile the resulting information to provide a comprehensive profile of each profession. Thereafter, OER will compare the identified tasks and KSAs to SPAEC's licensing examinations to ensure that the exams are job-related and that they adequately test the KSAs necessary to perform in both professions.

Richards noted that these occupational analyses may be more complex than those of other professions due to the widely varying settings in which SPAEC licensees work, including public schools, universities, rehabilitation centers, skilled nursing facilities, and private hospitals. This factor will require OER to extract information from a large pool of participants in order to obtain an accurate picture of the different settings, services, and types of client disorders addressed by speech-language pathologists and audiologists. Richards also indicated that the

occupational analyses would be useful not only in evaluating SPAEC's licensing exams but also in professional training programs seeking to help students focus on specific areas of practice.

LEGISLATION

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 88–89:

SB 2037 (McCorquodale), as amended August 30, would have (among other things) merged SPAEC and HADEC into a single board under the jurisdiction of MBC. This bill died on the Senate floor on August 31 (*see* MAJOR PROJECTS).

SB 2036 (McCorquodale), as amended August 26, creates a "sunset" review process for occupational licensing boards within DCA, requiring each to be comprehensively reviewed every four years. SB 2036 imposes an initial "sunset" date of July 1, 1999 on SPAEC; creates a Joint Legislative Sunset Review Committee which will review SPAEC's performance approximately one year prior to its sunset date; and specifies 11 categories of criteria under which SPAEC's performance will be evaluated. Following review of the agency and a public hearing, the Committee will make recommendations to the legislature on whether SPAEC should be abolished, restructured, or redirected in terms of its statutory authority and priorities. The legislature may then either allow the sunset date to pass (in which case SPAEC would cease to exist and its powers and duties would transfer to DCA) or pass legislation extending the sunset date for another four years. This bill was signed by the Governor on September 26 (Chapter 908, Statutes of 1994).

SB 2101 (McCorquodale), as amended July 7, states that no provision of the Speech-Language Pathologists and Audiologists Licensure Act may be construed as restricting or preventing the practice of speech-language pathology or audiology by personnel holding the appropriate credential from the Commission on Teacher Credentialing as long as the practice is conducted within the confines of or under the jurisdiction of a public preschool by which they are employed. *[14:2&3 CRLR 89]* This bill was signed by the Governor on September 30 (Chapter 1275, Statutes of 1994).

AB 1392 (Speier), as amended August 17, is no longer relevant to SPAEC.

RECENT MEETINGS

At SPAEC's July 22 meeting, DCA legal counsel Kelly Salter proposed a general policy for retaining Committee meeting records. Specifically, Salter suggested that the Committee erase the audiotapes which are used in drafting Committee meeting minutes after the minutes are prepared; Salter indicated that such a policy is necessary because the approved minutes of each meeting should constitute the final record of resolutions adopted by the Committee. In the absence of a policy, SPAEC has been retaining the tapes for three years before reusing them. The Committee approved a motion permitting the tapes to be reused after the minutes have been approved by the Committee.

Also on July 22, SPAEC discussed a possible 1995 legislative proposal. Business and Professions Code section 2532.2(c) requires speech-language pathologist and audiologist candidates to complete 300 hours of supervised clinical practice in order to be licensed by SPAEC. The American Speech-Language Hearing Association (ASHA), the national accrediting body for training programs, has recently increased its minimum number of supervised clinical practice hours to 400. To bring California into conformity with ASHA's national accreditation standards, SPAEC may sponsor a legislative amendment to section 2532.2(c) to increase the number of required clinical practice hours to 400.

FUTURE MEETINGS

October 28 in San Francisco.
January 20, 1995 in southern California.
April 7, 1995 in northern California.
July 21, 1995 in southern California.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Executive Officer:
Pamela Ramsey
(916) 263-2685

Pursuant to Business and Professions Code section 3901 *et seq.*, the Board of Examiners of Nursing Home Administrators (BENHA) develops, imposes, and enforces standards for individuals desiring to receive and maintain a license as a nursing home administrator (NHA). The Board may revoke or suspend a license after an administrative hearing on findings of gross negligence, incompetence relevant to performance in the trade, fraud or deception in applying for a license, treating any mental or physical condition without a license, or violation of any rules adopted by the Board. BENHA's regulations are codified in Division 31, Title 16 of the California Code of Regulations (CCR). Board committees include the Administrative, Disciplinary, and Education, Training and Examination Committees.

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

On July 21, BENHA welcomed new public member Gloria Sutton-Clark, who was appointed to the Board by Assembly Speaker Willie Brown to fill the remainder of Jack Fenton's term; Sutton-Clark is an Assistant U.S. Attorney with the U.S. Attorney's Office in San Diego. Also at the July meeting, Nancy Campbell announced her resignation from BENHA; Campbell was recently named Deputy Director of Board Relations at the Department of Consumer Affairs (DCA).

MAJOR PROJECTS

Board Begins Improvements to Disciplinary Process. At its July 21 meeting, the Board discussed its ongoing efforts to improve its disciplinary process; the Board began to focus on this issue in October 1993. Currently, the Board is seeking to improve the process through legislative changes, increased interaction with the Attorney General's (AG) Office and the Department of Health Services (DHS), and the development of disciplinary guidelines. *[14:2&3 CRLR 89; 14:1 CRLR 69]*

For example, over the summer BENHA and DCA were successful in adding a provision to SB 2101 (McCorquodale) which amends Business and Professions Code section 3928(a) to allow the AG—which prosecutes enforcement cases on behalf of the Board—24 instead of 12 months to file an accusation against an NHA after a qualifying event; section 3928(a) includes as "qualifying events" DHS' issuance of a temporary suspension order against a facility, service of an accusation to revoke a facility's license, or final decertification of the facility from the Medi-Cal or Medicare program. The Board originally sought an amendment which would provide the AG