proposals, BLA made minor modifications to the some of the language. For example, new section 2614 attempts to provide a transition program for candidates who have passed part(s) of the LARE and are now required to take the PELA. Proposed section 2614(c) would have provided that a candidate who has received credit for sections 1–7 of the 1992 or 1993 LARE from the Board or another state licensing authority and who has passed either section 6 of the 1988 through 1991 UNE (CLARB's previous licensing exam) or section 8 of the 1992 LARE is deemed to have met the Board's examination requirements and is eligible for licensure. BLA decided to omit this subsection, instead simply requiring that a candidate who is transferring credit from the UNE or LARE to the PELA and has not previously received BLA credit for section 8 (California) of the LARE shall be required to take and pass either section 1 (objective) or section 4 (California) of the PELA; however, a candidate who has been granted transfer credit from the LARE to section 1 of the PELA may not apply such transfer credit to also fulfill his/her requirement to have passed the California section of the PELA.

BLA also modified its proposed amendments to section 2623, regarding the procedure candidates must follow in inspecting their exam and appealing a failing score. As modified, proposed new section 2623(c)(2) would provide that an examinee may appeal a failing score on a graphic performance section of the examination only if he/she has obtained a score which is within two standard errors of measurement below the passing score on that graphic performance section; the standard error of measurement shall be based upon the standard deviation and reliability coefficient obtained from a statistical analysis of the graphic performance section.

BLA adopted the entire rulemaking package, subject to the modifications noted above. On February 24, the Board released the modified language for an additional fifteen-day public comment period. At this writing, the action awaits review and approval by the Office of Administrative Law.

Board Reports on Florida Presentation. At its February 19 meeting, BLA noted that the Florida Board of Landscape Architecture has followed California's lead and voted to release a request for proposals for development of a new Florida exam to be administered commencing in 1994. Because of Florida's increasing dissatisfaction with the content, format, and grading of the LARE, the Florida Board invited BLA representatives to make a presentation concerning the PELA at its January meeting; the California panel consisted of Executive Officer Jeanne Brode, Board President Larry Chimbole, and Anita Kamouri and Mark Blankenship, Project Manager and Director, respectively, of H.R. Strategies, BLA's PELA vendor.

According to Brode, the Florida Board voiced many of the same concerns BLA had in the last few years concerning the LARE; for example, the Florida Board believes CLARB's exam is inherently unfair when the seven sections are graded on a non-compensatory basis. In addition, Florida had received letters from other states also indicating similar concerns.

At BLA's February meeting, former Board member Rae Price inquired whether the Florida trip was financed from BLA funds; Brode confirmed that the Board's out-of-state travel budget was partially used for the trip, and noted that BLA was invited to Florida by the Florida Board for the purpose of explaining BLA's break with the LARE. Brode also justified the use of BLA funds insofar as the Board had decided not to attend CLARB's 1992 annual conference in Pittsburgh.

LAO Proposes To Eliminate BLA. In its *Analysis of the 1993–94 Budget Bill*, one of the recommendations made by the Legislative Analyst's Office (LAO) for streamlining state government proposed that the legislature eliminate the state's regulatory role in thirteen currently-regulated areas. Particularly relevant to BLA is LAO's recommendation that the state stop regulating several consumer-related business activities. In determining whether the state should continue to regulate a particular area, LAO recommended that the state consider whether the board or bureau protects the public from a potential health or safety risk that could result in death or serious injury; whether the board or bureau protects the consumer from severe financial harm; and whether there are federal mandates that require the state to regulate certain activities. Based on these criteria, LAO recommended that the state remove its regulatory authority over activities currently regulated by BLA, among other DCA bureaus and agencies. At this writing, LAO's recommendation has not been amended into any pending legislation.

LEGISLATION

AB 1848 (Cortese). Under existing law, a design professional is entitled to a specified design professional's lien on real property for which a work of improvement is planned and for which governmental approval is obtained, as specified; existing law defines the term "design professional" to include architects, engineers, and land surveyors. As introduced March 5, this bill would expand that definition to include licensed landscape architects for purposes of that provision. *[A. Jud]*

AB 1807 (Bronshvag), as amended May 3, would reduce the time within which a landscape architect may renew his/her expired license from five to three years. *[A. W&M]*

SB 842 (Presley), as amended April 13, would permit BLA to issue interim orders of suspension and other license restrictions, as specified, against its licensees. *[A. CPGE&ED]*

RECENT MEETINGS

At its February meeting, BLA noted that the initial overall pass rate on the 1992 LARE was 24.6%. *[13:1 CRLR 42–43]* After BLA reviewed appeals and conducted a grading workshop, the overall pass rate was 34.5%; staff noted that once the transition plan is adopted as part of the Board's regulations (*see* MAJOR PROJECTS), the overall pass rate will increase to 36.6%.

Also at its February meeting, BLA reviewed the availability and cost of its recently-released *Candidates Handbook.* Executive Officer Jeanne Brode reported that all candidates, Board members, staff, and review course providers in California received a handbook free of charge; all others requesting a copy were charged $50.

At its May 7 meeting, the Board tentatively agreed to offer the PELA twice per year; at this writing, the Board is expected to finalize that decision at its July meeting after reviewing a cost summary. BLA also agreed to extend its current contract with H.R. Strategies, its exam vendor, for two additional years.

FUTURE MEETINGS

October 15 in Sacramento.

MEDICAL BOARD OF CALIFORNIA

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

The Medical Board of California (MBC) is an administrative agency within the state Department of Consumer Affairs (DCA). The Board, which consists of twelve physicians and seven non-phy-

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

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

The functions of the individual divisions are as follows:

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

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

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

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

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

MAJOR PROJECTS

Stung by CHP Report, Overhauled Medical Board Finally Takes Steps to Reform Physician Discipline System. The first five months of 1993 have been a time of momentous change for MBC. New upper staff and new Board members, prodded by an insistent Wilson administration and a harshly critical audit of the Board's enforcement practices, have taken the lead in pursuing long overdue changes to the Board's physician discipline system. Following is a chronicle of the somewhat dizzying events of the first five months of 1993 at the Medical Board.

• ***CHP Report Reveals Destruction of Complaints and Corruption.*** On January 20, the Department of Consumer Affairs (DCA) released the results of the California Highway Patrol's (CHP) six-month investigation of allegations of serious misconduct by upper MBC enforcement staff. *[12:4 CRLR 89]* In a report that became front-page headlines in the *Los Angeles Times* and *Sacramento Bee* and feature stories throughout the state, the CHP found that top MBC officials had ordered the destruction of up to 300 complaints against physicians without investigation, including complaints involving patients who had subsequently died or become permanently disabled. Although these cases had been screened by the intake unit, found to be facially meritorious, and referred for formal investigation, the three-member team simply ordered them closed without any investigation and without the usual letter to the complainant informing him/her that the case had been dismissed. The complaint destruction occurred in 1990, when the Board was under legislative pressure to reduce its growing backlog of uninvestigated complaints; the legislature had even refused to appropriate the MBC Executive Director's salary until the Board cut its complaint backlog.

The CHP report confirmed several other allegations of serious problems in the Board's enforcement system, including the following:

–MBC Assistant Executive Officer Tom Heerhartz lied to the legislature about the extent of the Board's case backlog on March 31, 1990;

–MBC's medical consultants (physicians assigned to review complaints to determine whether they rise to the level of a disciplinary violation and medical records gathered by MBC investigators) have "some degree of reluctance...to give unfavorable opinions with regard to applied medical procedures, including instances wherein there is a clear departure from acceptable standards";

–MBC makes little or no use of required reports of medical malpractice judgments and settlements exceeding $30,000; CHP found over 120 such reports sitting on the desks of intake unit personnel, and approximately 2,000 other reports of malpractice judgments and settlements against California physicians unprocessed, unreviewed, and not even entered into the Board's computer system;

–on occasion, the Attorney General's office has failed to ensure that disciplinary cases are filed against physicians; the reluctance is apparently due to the fact that accused physicians can readily secure the testimony of another medical professional to counter the testimony of the Medical Board's expert witnesses;

–MBC's Diversion Program (a non-disciplinary track for substance-abusing or otherwise mentally/physically impaired physicians who refer themselves to the Program or are required to participate in lieu of discipline) is fraught with structural problems and corruption;

–upper staff of the Medical Board engaged in numerous hiring and promotion improprieties, including lying on their own applications for promotion, hiring and/or promoting favored employees, inappropriately failing to promote other employees, failing to advertise MBC vacancies to all MBC staff, and failing to properly document disciplinary problems which were later used to justify the denial of a promotion;

–MBC employees misused state time by being tardy, leaving early, sleeping at their desks, and failing to report time off so it can be subtracted from compensation time earned;

–MBC employees misused state vehicles, state credit cards, and undercover driver's licenses;

–MBC employees misused frequent flyer mileage credits earned while on state business by using them for personal travel; and

–MBC employees misused state telephones, including expensive cellular telephones, for personal matters.

Within one week after the release of the CHP report, Senator Robert Presley and the Center for Public Interest Law (CPIL) announced they would introduce another physician discipline system reform bill, following up on their 1990 efforts in SB 2375 (Presley) (Chapter 1597, Statutes of 1990). *[10:4 CRLR 79, 84]*

• ***Board and Staff Members Replaced.*** Meanwhile, both the Medical Board itself and its top staff were being shaken up. Even before the results of the CHP investigation were released, the Wilson administration replaced a majority of the nineteen Medical Board members with its own appointees, and the "new" Board had ousted former MBC Executive Director Ken Wagstaff in November 1992. *[13:1 CRLR 44–45]* In December, the Board hired Dixon Arnett as its new Executive Director, and John Lancara as its new Enforcement Chief. These individuals assumed their posts in early January, shortly before the release of the CHP report.

Upon release of the report, Arnett, Lancara, Board President Dr. Jacquelin Trestrail, and DCA Director Jim Conran promised major reform, and announced an eight-point plan to address the problems identified by the CHP. Among other things, Arnett stated MBC would reopen six cases which had been improperly closed in 1990; tighten investigative policies and procedures by revising its enforcement manuals; enhance consumer access to MBC by expanding the staffing of its toll-free 800 complaint line; audit the Diversion Program's records to determine whether the diversion function should be contracted to an outside entity rather than remain in-house, and "clean house" by suspending three MBC Diversion Program employees; and convene a statewide "summit" of consumer, community, and medical profession leaders to "focus on what actions the MBC and the Department of Consumer Affairs ought to take to protect consumers and remove unqualified or incompetent doctors from the marketplace."

Sandra Smoley, Secretary of the cabinet-level State and Consumer Services Agency, paid a visit to MBC at its February 5 meeting to convey her outrage about the CHP's findings and stress the Wilson administration's desire for major improvement in the Board's discipline system. She urged MBC to focus on several issues at the "summit," including its investigatory procedures, its overall discipline system (including the Diversion Program), and its policies regarding disclosure of information on physician misconduct to inquiring consumers. In a stern warning to several MBC members who persisted in defending the Board's record, Smoley noted, "Twice since 1988, the MBC's enforcement policies, procedures, and outcomes have been weighed in the balance and found wanting. The some 31 million Californians who depend on the MBC to insure the quality of their medical care deserve better. The MBC must clean up its act."

• ***Board Convenes March "Medical Summit" and Adopts Reform Measures at May Meeting.*** Stung by the impact of the CHP report and concerned about CPIL's new reform legislation, the Board convened a "Medical Summit" on March 18–19. Prodded by DCA, MBC invited over 70 physicians and other health care practitioners, community and consumer group leaders, law enforcement representatives, and Medical Board members and staff to engage in a two-day structured discussion of proposed improvements to the Board's discipline system in four major areas: (1) the complaint process; (2) the enforcement process; (3) disciplinary options; and (4) information disclosure to the public. In each of the four areas, two or three participants were chosen to make five-minute presentations identifying major concerns and suggested resolutions.

After an overview presentation by MBC Enforcement Chief John Lancara, DMQ President Dr. Michael Weisman focused on improvements in the complaint intake process. He noted that MBC's Central Complaint and Investigation Control Unit (CCICU) must be friendly, accountable, and "widely sensitive" to consumer concerns and complaints about physicians. Other participants made specific recommendations in this regard: CCICU should improve its consumer outreach efforts to educate consumers about the kinds of complaints over which MBC has jurisdiction, and enhance its ability to communicate with the many California populations which do not speak English; CCICU should identify reliable sources of information on physician misconduct, and focus its outreach efforts on those sources; bearing in mind that a physician discipline decision is a legal proceeding, CCICU should be supervised by prosecutors who would screen incoming complaints and identify patterns of misconduct and cases which should immediately be referred for concurrent criminal investigation and/or interim suspension treatment; and MBC should establish performance standards for its CCICU personnel and ensure that all complainants are informed in writing of the outcome of their complaint.

Al Korobkin, Chief of the Health Quality Enforcement Section in the Attorney General's Office, spoke on the enforcement process, noting primarily that HQES has been severely understaffed since its inception to handle the flood of physician discipline cases now being processed by MBC investigators. Korobkin stated that in the first half of fiscal year 1992–93, HQES filed 250 accusations against physicians' licenses, which is a 100% increase over MBC's historical rate. In addition to this effort and in spite of its understaffing, HQES has filed over 50 requests for interim suspension or temporary restraining orders in the past two years. Based on current case flow, Korobkin projected that HQES will be faced with 27% more cases than it is currently budgeted to handle in 1993–94, and urged MBC to consider a licensing fee increase so he can properly staff HQES to handle the Board's caseload.

Also in the area of enforcement, DCA Director Jim Conran urged the Board to review the role and performance standards of its medical consultants, the quality of its investigations and enhanced use of technology (*e.g.*, laptop computers, cellular phones) to improve and expedite investigations, and the Board's need to recognize and be more sensitive to California's changing demographics.

CPIL Director Robert C. Fellmeth addressed the participants on disciplinary options. With considerable experience in overhauling a professional discipline system at the State Bar *[11:4 CRLR 1]*, Professor Fellmeth encouraged the Board to adopt the use of mid-level sanctions—something between the Board's current draconian and expensive option of license revocation (which is rarely used) and its meaningless private letter of concern. The Board has considered but rejected a wider range of disciplinary options many times in the past few years. In the area of physician competence, Fellmeth also urged the Board to improve its licensing system, under which physicians are currently given a general license to practice in any specialty they want without testing or required medical education in that specialty. Fellmeth argued that physicians (as well as attorneys) should be licensed and retested in their area of specialty, which would help to prevent incompetence.

Two speakers commented on the Board's information disclosure policies. CPIL Supervising Attorney Julianne D'Angelo criticized the Board's practice of refusing to disclose to the public numerous categories of information which the Board routinely collects and much of which is public information, including criminal convictions and charges against physicians, medical malpractice judgments and settlements, discipline in other

states, and the revocation or restriction of a physician's admitting privileges by hospitals and other health care facilities. She urged the Board—as the public agency charged with consumer protection—to make more information on physician misconduct available to inquiring consumers. D'Angelo also argued that the Board should disclose its own completed investigations of physician misconduct at an earlier point than it currently does.

DOL member Dr. Alan Shumacher agreed with much of D'Angelo's presentation, stating that MBC should disclose to inquiring consumers information on the status of the license; prior discipline—either in California or in another jurisdiction; felony convictions, charges, and other criminal matters which relate to a physician's character or competence; the involuntary reduction of health facility privileges reported to MBC under Business and Professions Code section 805; and completed MBC investigations which have been referred to HQES for the preparation and filing of an accusation. Dr. Shumacher, who is also Chair of the Professional Conduct Committee of the San Diego County Medical Society, stated his opinion that "physicians should be held to a higher standard of conduct because of the nature of what they do."

Following the Summit, the Board created task forces to pursue recommendations made in each of the areas under discussion, including a task force to focus exclusively on the Diversion Program. The Task Forces met throughout March and April, and released recommendations in the following areas for division and Board approval at MBC's May meeting.

On May 6, DMQ reviewed the report of the Enforcement Task Force, chaired by Dr. Lawrence Dorr, which adopted Professor Fellmeth's recommendation to create several intermediate sanctions for physician misconduct, including a public letter of reprimand, a public citation and fine system, a public criminal infraction sanction primarily for unlicensed practice, and a private letter of warning to be utilized in minor cases which do not constitute a violation of the Medical Practice Act. DMQ approved the Task Force report with the exception of the public letter of reprimand, which it referred back to committee for further discussion at the urging of the California Medical Association (CMA). On May 7, the full Board ratified DMQ's decision.

The Enforcement Task Force also addressed two changes to MBC's current interim suspension order (ISO) procedure under Government Code section 11529. The Task Force recommended that MBC pursue two legislative changes: (1) a provision specifying that MBC's burden of proof in petitioning for an ISO is preponderance of the evidence, which would expressly overrule the *Silva* decision (*see* LITIGATION); and (2) an amendment providing that ISO hearings shall be based on affidavits, similar to the procedure utilized by civil courts in entertaining motions for temporary restraining orders. The current provisions of section 11529 require HQES to put on and defend two lengthy evidentiary hearings—one to obtain the ISO, and a second, almost identical hearing on the underlying disciplinary issue. At its May 6 meeting, DMQ approved the Task Force's ISO recommendations, and the full Board ratified that decision at its meeting on May 7.

Also on May 6, DMQ reviewed the report of the Diversion Task Force, chaired by Dr. John Kassabian. Although the CHP report described practices which appear to have compromised the integrity of the program and the protection of consumers from substance-abusing physicians (including profiteering by group facilitators, failure to ensure timely urine collection sampling, alleged mistreatment of program participants, and the acceptance of gifts from program participants by the Diversion Program Manager), the Task Force made no major recommendations for structural change. Other than recommendations to replace top Diversion Program staff, the Task Force recommended that the program remain intact within the Medical Board. One issue which captured the Task Force's attention was the actual nature of the Diversion Program—that is, whether it is simply a monitoring program or whether it is also therapeutic. If it is determined to be therapeutic, the Task Force identified a potential liability problem in that the Program contracts with unlicensed persons to provide "therapy." The notion that the Medical Board may be authorizing unlicensed practice and utilizing unlicensed practitioners to treat substance-abusing physicians resulted in an extended life for the Diversion Task Force, which will look into this issue further.

After discussion, DMQ approved the Diversion Task Force's report, but—at the suggestion of CPIL Supervising Attorney Julie D'Angelo—directed staff to look into alternative ways of compensating the Program's "group facilitators"—independent contractors who conduct group meetings of diversioners (physician participants). The CHP noted that although the Diversion Program characterizes these facilitators as "volunteers," they are actually paid up to $235 per month directly by each participant; some argue this may impact their objectivity. For example, the CHP found that one such "volunteer" has thirty participants and thus could make over $7,000 per month.

Finally, DMQ reviewed the recommendation of the Complaint Processing and Information Disclosure Task Force, co-chaired by DOL member Dr. Alan Shumacher and DMQ public member Gayle Nathanson. After a grueling day-long hearing on April 29, the Task Force adopted much of CPIL's Summit proposal on information disclosure, agreeing to disclose to inquiring consumers medical malpractice judgments in excess of $30,000, felony convictions, prior discipline in California or in another state or jurisdiction, and involuntary revocation or restriction of hospital privileges. The Task Force also agreed to recommend that the Board disclose its own completed investigations at the time the investigation is referred to the Attorney General's Office for preparation and filing of formal charges (instead of after the filing of formal charges); this decision will enable consumers to learn of a completed investigation and impending disciplinary action over one year sooner than they currently can.

At DMQ's meeting, CMA registered strong opposition to the Task Force's public disclosure proposal, particularly the disclosure of medical malpractice judgments and hospital privilege revocations. After a lively debate and an attempt by DMQ's physician members to sever the components which CMA found objectionable, the entire proposal squeaked through by a 4–3 vote, with three of the Division's four physician members (Dr. John Kassabian, Dr. Lawrence Dorr, and Dr. Clarence Avery) voting against it at the behest of CMA. DMQ President Dr. Michael Weisman was the only physician member to vote in favor of the proposal; Weisman was joined by DMQ public members Gayle Nathanson, Theresa Claassen, and Karen McElliott.

At the full Board's May 7 meeting, the public disclosure policy again met with CMA's strong opposition. CMA lobbyist Tim Shannon argued that public disclosure of peer review results would fundamentally change the peer review process, which CMA believes must be preserved at all costs. Calling it "the first proposal with a shred of true consumer protection this Board has considered in seven years," CPIL's D'Angelo urged the Board to adopt it, even though—from her organization's standpoint—it is a compromise because it does not permit the disclosure of some public information which may be relevant to a physician's perfor-

mance (*e.g.*, malpractice settlements and criminal charges). In a dramatic roll-call vote in which several proposal supporters were absent, the Board approved the proposal by a 9–4 vote. The four "no" votes all came from physicians (Dr. John Kassabian, Dr. Madison Richardson, Dr. Camille Williams, and Dr. Clarence Avery).

Public approval of the Medical Board's decision came fast and furious. Among others, the *Los Angeles Times* and the *Sacramento Bee* again carried front-page stories on the Board's "stunning reversal of a long-standing policy against public disclosure." The *Times* and the *Bee* also published important editorial support for the Board's new direction, and called on the legislature to resist CMA's opposition and further reform the Board's physician discipline through passage of the pending Presley legislation.

• ***CPIL Presses for Further Legislative Reform***. Meanwhile, on March 4, Senator Presley and CPIL released SB 916 (Presley), and amended it on May 18 to incorporate many of the changes discussed at the Summit (including the public disclosure proposal) and other structural reforms to the disciplinary decisionmaking process. Throughout the spring and summer, the bill has been the subject of numerous and lengthy negotiation sessions among CPIL, MBC, CMA, DCA, the Attorney General's Office, the Judicial Council, and representatives of Senators Presley and Boatwright to secure agreement on major provisions in the bill. At this writing, the key provisions of SB 916 (as amended May 18) would:

–establish a Medical Quality Hearing Panel of specialized administrative law judges (ALJs) in the Office of Administrative Hearings; these judges, who would be given medical training, would exclusively preside over medical discipline cases;

–transform the Board's Division of Medical Quality, which currently reviews each and every ALJ decision and is authorized to change the findings of fact, conclusions of law, and disciplinary sanction recommended by the ALJ, into an appellate body with a prescribed standard of review limiting its ability to change the facts as found by the ALJ;

–change the existing process of judicial review of Medical Board disciplinary decisions. Currently, a physician who disagrees with an MBC decision may petition the superior court, the court of appeal, and then the California Supreme Court for reversal or modification; this process can take anywhere from three to five years (after a two- to four-year administrative proceeding) and, on many occasions, the physician is successful in seeking a stay of the underlying decision—meaning that he or she may remain in unrestricted practice during the entire period. Because the Medical Quality Hearing Panel and streamlined DMQ review would afford the physician a higher-quality hearing at the agency level, SB 916 would omit the superior court step in the judicial review process. Appeals of MBC disciplinary decisions would go directly to the court of appeal, and the state Judicial Council would be permitted to transfer all medical discipline cases to a single court of appeal or panel thereof, thereby allowing those judges to "specialize" in these complex cases;

–require the Attorney General's Office to place two deputy attorneys general in charge of the Medical Board's complaint intake unit, to better screen incoming complaints for immediate investigation and/or interim suspension treatment and referral to law enforcement for simultaneous criminal investigation;

–require the Medical Board to disclose to inquiring members of the public medical malpractice judgments in excess of $30,000 and hospital privilege revocations or restrictions;

–authorize the Board to issue a letter of reprimand to a physician, and to disclose the issuance of that letter to an inquiring consumer;

–expand Medical Board investigators' access to medical records of complaining patients and business records of physicians under investigation, and establish severe penalties (disciplinary action and a $1,000 per day fine) for physicians who refuse to comply with MBC subpoenas for records;

–create a Medical Board Discipline Monitor to investigate the entire system and monitor the Board's implementation of and compliance with SB 916 and SB 2375; and a Complainants' Grievance Panel to review, at the request of a complaining patient, cases closed at an early stage by MBC; and

–increase physician licensing fees by $50 per year (from $250 to $300 per year).

At this writing, SB 916 (Presley) is scheduled for its first major hearing in the legislature on June 14, before the Senate Business and Professions Committee.

Summit Prompts DMQ Review of Other Disciplinary Matters. Comments made at the March 18–19 Medical Summit have prompted top MBC staff and DMQ to initiate a review of other components of the Board's physician discipline system.

• ***Linkage Between MBC Enforcement Program and HQES***. The investigators in MBC's Enforcement Program are structurally and physically separated from the HQES prosecutors who try physician discipline cases. The first attempt to bridge this gap was accomplished in SB 2375 (Presley), which created HQES, permitted its attorneys to specialize in medical discipline cases, and established a partnership between MBC and HQES. At the Board's May 7 meeting, MBC Enforcement Chief John Lancara and HQES Chief Al Korobkin described measures taken to improve communication between the investigators and prosecutors of physician discipline cases, including monthly visits to MBC regional offices by HQES Supervising Deputy Attorneys General and HQES' review of cases closed by CCICU. Further, HQES and DMQ staffs have reviewed the use of medical consultants and expert witnesses to ensure that they are used only as the needs of the cases dictate, rather than routinely. Communication between MBC investigators and HQES attorneys is also being improved through the implementation of voice mail and computer linkages between the two offices. Finally, Lancara noted that he has instituted a "Ten Oldest Cases" list to assist MBC investigators in identifying and expediting investigation of older cases; the same list may be compiled in HQES.

• ***Enforcement Operations Manual***. In response to the CHP's finding that the Enforcement Program's policy and procedure manual for investigators was inadequate to ensure high-quality, timely, cost-effective, and consistent investigations, Lancara is in the process of developing a professional manual of policy and procedures tailored to the needs of Enforcement Program personnel.

• ***Priority System and Profile***. At the urging of Summit participants, DMQ is also in the process of establishing a priority system for use in efficient complaint processing and subsequent investigations, and for relating discipline sanctions to the level of wrongdoing. Development of the priority system, which may be accomplished with the assistance of an outside medical quality review firm, will likely involve a review of all accusations filed during a two-year period, a classification of all accusations into one of five categories, and formulation of a point system to enable MBC to appropriately prioritize incoming complaints. MBC also intends to develop a classic law enforcement profile of "bad doctors," which might eventually be used to identify and proactively address high-risk licensees.

• ***Use of Medical Consultants and Expert Reviewers***. DMQ is also reviewing its use of medical consultants and expert reviewers. The Division uses both in-house

medical consultants (staff physicians, primarily located at MBC's regional offices, who provide medical advice and evaluate patient/hospital records and evidence gathered by investigative staff) and contract physicians (practicing physicians who review cases at the CCICU stage to identify possible violations of the Medical Practice Act for further investigation). Because its in-house medical consultants frequently lack specialty expertise in matters going to trial, DMQ must also contract with physicians to serve as expert witnesses at evidentiary hearings. In the past, DMQ has relied on MQRC members to provide expert testimony, but as the cases have become more complex and the trials have become longer, MQRC members were unable or unwilling to divert the time necessary from their private practices.

At a special April 7 meeting, a DMQ subcommittee reviewed several options to maximize its use of consultants, reviewers, and experts presented by Enforcement Chief Lancara. The options include use of fewer consultants in cases where the contribution of these consultants is marginal (*e.g.*, sexual misconduct, fraud and embezzlement, and narcotics violations); contracting with commercial expert medical review providers who specialize in medical case work and may be able to offer such services at a lower cost; utilizing as few experts as possible; ensuring that supervisors and investigators provide experts with clear guidelines and instructions as to case review expectations and timeframes for return; paying more for experts but ensuring they are the most respected and credentialed; and utilizing only practicing expert consultants who can demonstrate current, mainstream medical knowledge and experience. DMQ intends to revisit this issue—and the related issue of the future of MBC's MQRCs—at its July meeting.

MBC Votes to Abolish Division of Allied Health Professions. In a key vote on another issue which has been debated since 1989, MBC at its May 7 meeting voted to seek legislation to abolish DAHP and transfer its five member positions to DMQ to assist in the physician discipline process. *[13:1 CRLR 48–49; 12:2&3 CRLR 103]*

DAHP's role, function, and responsibilities have become increasingly unclear as allied health licensing programs (AHLPs) under its jurisdiction have sought and obtained statutory independence from the Division over the past decade. As observed by DAHP President Dr. Madison Richardson, the "captain of the ship" doctrine—that is, the notion that physicians should be captains of the health care team—may have limited validity in the regulatory context. At its February and May meetings, DAHP reviewed a policy paper authored by DAHP Program Manager Tony Arjil which described the history of the Division, identified its remaining duties with respect to the AHLPs, and set forth four options for DAHP's future: (1) continue DAHP in its present form; (2) dissolve the Division and eliminate five MBC positions; (3) increase DAHP's authority over the AHLPs; and (4) abolish the Division, transfer its five members to DMQ, and create a "Committee on Allied Health Professions" to assist AHLPs which have limited statutory authority and monitor unlicensed medical caregivers such as medical assistants.

As the events described above unfolded throughout the spring, it became increasingly apparent that structural changes were necessary to improve and expedite MBC's disciplinary performance. Thus, at its May 7 meeting, and at the urging of Dr. Richardson, the full Board finally voted to pursue legislation to implement option (4) above. The Board plans to merge the five DAHP positions into DMQ, thereby creating a twelve-member DMQ and enabling DMQ to split into two rotating panels of six members each. Statutory amendments to implement this structure, the details of which have yet to be fleshed out at this writing, will probably be incorporated into SB 916 (Presley) during the summer.

MBC Rulemaking. The following is a status update on rulemaking proceedings undertaken by MBC's divisions over the past few months.

• ***SB 2036 Rules Withdrawn.*** After a three-year-long rulemaking proceeding, MBC finally submitted its regulations implementing SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) to the Office of Administrative Law (OAL) on March 8. Section 1363.5, Title 16 of the CCR, would define the terms "specialty board" and "specialty or subspecialty area of medicine," and establish standards for specialty boards whose members may advertise that they are "board certified" in California. *[13:1 CRLR 47; 12:4 CRLR 90–91]* However, MBC withdrew the rulemaking package from OAL in mid-April, after receiving word that OAL had identified several issues requiring clarification or additional information. At this writing, the Board plans to revise the rulemaking file to meet OAL's concerns, reopen the public comment period for a final fifteen days, and resubmit the package to OAL during the summer.

• ***License Fee Increase.*** On February 2, OAL approved DOL's amendments to sections 1351.5 and 1352, Title 16 of the CCR, which increase MBC's licensing fees to their current statutory maximums ($250 per year) effective March 1. *[13:1 CRLR 48]*

• ***Physician Questionnaire.*** On February 19, OAL approved DOL's adoption of section 1304, Title 16 of the CCR, which will make ineligible for license renewal any physician who fails to complete and return MBC's biennial physician questionnaire prior to the time his/her license expires. *[12:4 CRLR 91–92]*

• ***Oral Examinations.*** On March 29, OAL approved DOL's amendments to section 1329, Title 16 of the CCR, regarding its oral examination. *[13:1 CRLR 48]*

• ***Permit Reform Act Regulations.*** On April 5, OAL approved DOL's adoption of new Article 5, Division 13, Title 16 of the CCR, which sets forth processing times for approving clinical training programs. *[12:4 CRLR 91–92]*

• ***Continuing Education Requirements.*** At its May 6 meeting, DOL held a public hearing on proposed amendments to its continuing education regulations, sections 1337 and 1337.5, Title 16 of the CCR. These regulations implement Business and Professions Code section 2190, which authorizes DOL to adopt and administer standards for the continuing medical education (CME) of physicians. Effective January 1, 1993, AB 3635 (Polanco) (Chapter 331, Statutes of 1992) permits DOL's CME requirements to be met by prescribed educational activities, except that educational activities which are not directed toward the practice of medicine or primarily directed toward the business aspects of medical practice no longer qualify as acceptable CME. *[12:4 CRLR 92–93]* Thus, DOL's proposed amendments to sections 1337 and 1337.5 conform these regulations to AB 3635 by expanding acceptable coursework to include classes on the business aspects of the practice of medicine and by specifying that DOL must accept courses relating to preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, and the improvement of the physician-patient relationship as qualifying CME. Following the hearing, DOL adopted the proposed amendments; at this writing, this action is pending at OAL.

DHS Releases HIV Transmission Prevention Guidelines. On April 13, the Department of Health Services (DHS) finally released its Guidelines for Preventing the Transmission of Bloodborne Pathogens in Health Care Settings, which are intended to prevent the transmission of HIV and other bloodborne pathogens in

the health care setting. These Guidelines are required under both state (Health and Safety Code section 1250.11) and federal (Public Law No. 102-141) law, and must be equivalent to HIV transmission prevention guidelines issued by the federal Centers for Disease Control (CDC) in 1991. MBC staff participated in the formulation of these Guidelines. *[13:1 CRLR 46–47; 12:4 CRLR 90]*

The Guidelines are separated into four areas of concern. In the area of infection control and immunization, the Guidelines recommend that health care workers (HCWs) rigorously adhere to the 1987 and 1988 CDC infection control guidelines, including hepatitis vaccinations and the use of universal precautions in all health care settings. All HCWs and health care settings should use the best available method to ensure that each patient is treated with sterile or properly disinfected equipment, devices, and instruments. Adherence to proper infection control procedures, including vaccinations as indicated, is a minimum standard of care; licensed professionals who fail to practice proper infection control should be subject to charges of unprofessional conduct. As part of the accreditation process, professional schools should develop and periodically update guidelines for the infection control curricula. Periodic infection control training should be a condition of HCW certification, licensure, and relicensure.

In the controversial area of testing and practice restrictions where an HCW tests positive, the Guidelines state that "[c]urrent assessment of the risk of transmission of HIV between HCWs and patients does not support a mandatory testing program for either HCWs or patients." HCWs and patients who may have been exposed to bloodborne pathogens through personal risk behaviors, blood products, or occupational accidents are encouraged to seek counseling and testing in order to benefit from medical management. Because of the perceived low risk of transmission, the Guidelines state that "general restriction of the practices of infected HCWs would not offer a significant increase in patient protection and is not recommended." An infected HCW and his/her personal physician should review the HCW's practices and modify any practices that may place a patient or the HCW at risk of infection. The appropriateness of any such restrictions can be reviewed by expert review panels convened by DHS. The Guidelines also recommend that state and professional organizations facilitate job counseling and retraining services for infected HCWs who can no longer work in their field.

In the area of notification to patients of an HCW's infection status and informed consent to further treatment, the Guidelines state: "In accordance with CDC guidelines, HCWs engaging in procedures or practices that place their patients at substantial risk of infection should consult with an expert review panel concerning their responsibility to disclose their serostatus to their patients to performing such procedures." In the absence of a documented exposure incident, DHS "does not recommend routine post-treatment notification of patients treated by infected HCWs." Also in accordance with CDC guidelines, "HCWs should notify patients in a timely manner when the HCW's body fluid comes in contact with the patient parenterally or with their mucous membranes, regardless of the HCW's infection status. Patients and their physicians may then make informed decisions regarding their own testing, prevention, and treatment options."

LEGISLATION

SB 916 (Presley), as amended May 18, is a 40-part bill sponsored by the Center for Public Interest Law to compel further structural reforms to MBC's physician discipline system, in response to the critical CHP audit released in January (*see* MAJOR PROJECTS for related discussion and a description of the bill). At MBC's May 7 meeting, Executive Director Dixon Arnett told the Board that the parties negotiating the terms of the bill "have a very strong desire to agree to structural reform this year." In addition to its May 18 provisions, SB 916 may be amended during the summer to abolish DAHP and the MQRCs (*see* MAJOR PROJECTS). At this writing, MBC has not had an opportunity to take a position on the bill. *[S. B&P]*

AB 2170 (Bornstein), as introduced March 5, would require DMQ to disclose specified information, including—among other things—the number of complaints and criminal complaints filed against a licensee. *[A. Floor]*

SB 366 (Boatwright), as introduced February 19, would permit DMQ to investigate complaints from a member of MBC that a physician may be guilty of unprofessional conduct. *[A. Health]*

SB 971 (Rosenthal), as introduced March 5, would prohibit a health facility from permitting an intern or resident from working in the facility an excessive number of hours in a day or week so as to endanger the health or safety of a patent of the facility. *[S. H&HS]*

AB 720 (Horcher), as introduced February 24, would prohibit any person other than a licensed physician, podiatrist, or dentist from applying laser radiation to any person for therapeutic purposes; any person who violates this provision would be guilty of a misdemeanor. *[A. Health]*

SB 437 (Hart), as amended April 26, would partially authorize, notwithstanding existing provisions of law, supervision of a physical therapy aide by a physical therapist and would authorize a physician to supervise a physical therapy aide who is employed by the physician and who is authorized to provide services by specified provisions of law. *[S. B&P]*

AB 595 (Speier), as amended May 6, would prohibit an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient surgical setting, as defined, without a license issued by DHS or an accreditation agency on the basis of compliance with the requirements of DHS or accreditation agency as approved by DHS. *[A. W&M]*

SB 1048 (Watson), as introduced March 5, and **AB 260 (W. Brown)**, as amended April 12, would each establish the Clean Needle and Syringe Exchange Pilot Project, and would authorize physicians, among others, to furnish hypodermic needles and syringes without a prescription or permit, as prescribed. *[S. H&HS; A. Floor]*

SB 743 (Boatwright). Existing law provides that any act of sexual abuse, misconduct, or relations with a patient, client, or customer that is substantially related to the qualifications, functions, or duties of the occupation for which a license is issued constitutes unprofessional conduct and grounds for disciplinary action for certain healing arts practitioners and social workers. As introduced March 3, this bill would delete the condition that the act be substantially related to the qualifications, functions, or duties of the occupation for which a license was issued. *[12:4 CRLR 94]*

Existing law provides that a psychotherapist who engages in sexual contact, as defined, with a patient or client, or with certain former patients or clients, is guilty of sexual exploitation, with certain exceptions. This bill would also apply that provision to a physician. The bill would specify that each act of sexual contact is a separate violation of the provision and would change the definition of "sexual contact." *[A. Health]*

SB 140 (Kopp), as amended May 5, would establish that providers of medical care are not liable for the release of a patient's non-medical information unless the patient had made a prior written request to the contrary. *[S. B&P]*

AB 891 (Speier), as amended May 5, would require a physician, as a condition of licensure or renewal of licensure, to report a financial interest, as defined, of the physician or his/her immediate family in a health-related facility to MBC; the information so reported would be subject to the Public Records Act. *[A. W&M]*

AB 919 (Speier), as amended May 5, would provide that it is a misdemeanor for a physician to refer persons for certain diagnostic tests and ancillary services, if the physician has a financial interest with the person or in the entity that receives the referral. The bill would also provide that it is unlawful for a physician to enter into certain arrangements or schemes, such as cross-referral arrangements. *[A. W&M]*

AB 1291 (Speier), as amended May 5, is similar to AB 919 (Speier) above, but would apply only to a referral of a person for whom all or part of the costs of the referral are paid pursuant to Medi-Cal, the Public Employees' Retirement Law, or the Public Employees' Medical and Hospital Care Act. *[A. W&M]*

AB 2046 (Margolin), as amended May 4, would require a clinical laboratory to provide to each of its referring providers a schedule of fees for prescribed services by January 1 and July 1 of each year. *[A. W&M]*

AB 179 (Snyder). Existing law provides that it is unlawful for any person licensed by MBC to charge, bill, or otherwise solicit payment from any patient for any clinical laboratory test or service if that test or service was not rendered by the licensee or under his/her direct supervision, unless the patient is notified of the name, address, and charges of the clinical laboratory that performed the service or test. As amended April 20, this bill would require this provision to apply to a clinical laboratory of a health facility or a health facility when billing for a clinical laboratory of the facility only if the standardized billing form used by the facility requires itemization of clinical laboratory charges. *[A. Floor]*

SB 1125 (Calderon), as introduced March 5, would require a physician to provide a patient who requires a clinical laboratory service with a list of clinical laboratories available to perform the service, and the prices charged by the clinical laboratories for the service. *[S. B&P]*

SB 1178 (Kopp), as amended May 6, would require that physicians and dentists refund any amount paid by a patient for services rendered that constitutes a duplicate payment. A violation of the new provision would constitute unprofessional conduct. *[A. Health]*

SB 350 (Killea), as amended April 15, would repeal existing provisions relating to the certification of midwives by DAHP and would enact the Licensed Midwifery Practice Act of 1993; provide that a physician shall not be liable for the acts of negligence by a licensed midwife unless the acts were pursuant to the negligent advice of the physician; and require the Department of Health Services to issue a license to practice midwifery to all applicants who meet certain requirements and who pay a prescribed fee. *[S. B&P]*

AB 1294 (Lee), as introduced March 3, would repeal provisions of law which require that a certificate be obtained prior to engaging in the practice of midwifery. Instead, this bill would enact the Licensed Midwifery Practice Act of 1993, establishing within DAHP a Licensed Midwifery Examining Committee, which would issue licenses to all applicants who meet certain requirements promulgated by the Committee. The bill would also authorize the Committee to adopt regulations to carry out the Act, and would require that a physician be consulted in the event of any significant deviation from normal. *[A. Health]*

AB 1689 (Statham), as amended April 20, would provide a tax credit of $5,000 for a taxpayer who is a qualified health care practitioner with a practice that is certified by the Office of Statewide Health Planning and Development to consist of at least 60% underserved rural patients. *[A. Rev&Tax]*

SB 112 (Roberti), as amended April 21, would require the Department of Health Services to review its written summary which informs patients of alternative methods of treatment for breast cancer no later than January 1, 1995, and every three years thereafter. *[A. Health]*

AB 1446 (Margolin), as introduced March 3, would require 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. *[S. B&P]*

SB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health care professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information. *[S. B&P]*

ACR 34 (O'Connell), as introduced March 5, would request MBC to conduct and complete a survey of existing medical school curricula to determine whether medical students receive adequate training in, and whether physicians understand, pain management and palliative care techniques for the terminally ill; the measure would also request MBC to make recommendations to the legislature on necessary modifications in the medical school curriculum. *[A. Health]*

AB 601 (Speier), as amended April 21, would require every person or entity who owns or operates a health facility or clinic, or who is licensed as a physician, to post a sign or notice with prescribed wording relating to alternative efficacious methods of treatment for breast cancer or prostate cancer, where breast cancer screening or treatment or prostate cancer screening or treatment, respectively, is performed. *[A. W&M]*

AB 890 (B. Friedman), as amended March 31, would add a course providing training and guidelines on how to routinely screen for signs exhibited by abused women to the list of subjects to be considered when determining continuing education requirements for physicians. The bill would also require MBC to periodically develop and disseminate informational and educational material regarding the detection and treatment of spousal or partner abuse, and would add spousal or partner abuse detection and treatment to the subjects required to be included in the curriculum required for license applicants matriculating on or after September 1, 1994. *[S. B&P]*

AB 1392 (Speier), as amended April 14, would require MBC, along with every other agency within DCA, to notify the Department whenever any complaint has gone thirty days without any investigative action, and authorize the DCA Director to review any complaint filed with MBC. *[A. Floor]*

AB 1676 (Margolin), as amended April 20, would provide that the application and rendering by a person of a decision that penalizes a physician for advocating appropriate health care offends public policy, and the application and rendering by a person not licensed as a physician of a decision that penalizes a physician for advocating for appropriate health care constitutes the unlawful practice of medicine. However, the bill would provide that violation of this provision is not a crime pursuant to existing law. This bill would also prohibit specified provisions from being construed to prohibit the enforcement of reasonable utilization review protocols or to preclude a nurse from participating in utilization review activities. *[A. Health]*

AB 1907 (Knight), as amended April 21, would—under specified circumstances—exempt a physician, who in good faith and without compensation renders voluntary medical services at a privately operated shelter, from liability for any injury or death caused by an act or omission of the physician when the act or omission does not constitute gross negligence, recklessness, or willful misconduct. *[A. Jud]*

AB 2036 (Mountjoy), as introduced March 5, would authorize MBC to issue an emergency order suspending a license, but only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions that violate the Medical Practice Act, and that the continued practice by the licensee pursuant to his/her license will endanger the public health, safety, or welfare. This bill would require a hearing to be conducted before an emergency suspension order is issued, unless it appears from the facts shown by affidavit that serious injury would result to a patient or to the public before the matter can be heard on notice. *[A. Health]*

AB 2214 (Lee), as introduced March 5, would require any physician who sells, closes, or transfers his/her medical practice to notify each patient in writing, and require that each patient be given an opportunity to determine where his/her records shall be directed. *[A. Health]*

AB 2316 (V. Brown), as amended April 28, would require any physician who provides primary care to a patient, and who sells, closes, or transfers his/her medical practice, to notify each patient, with certain exceptions, in writing, of the sale, closure, or transfer, and of the intended disposition of the patient's medical records, at least thirty days prior to the intended sale, closure, or transfer of the medical practice, and to advise each patient that they have thirty days to request that their records be directed to another licensee of their choice without any cost to the patient to transfer or direct these records to another licensee. *[A. W&M]*

AB 2156 (Polanco), as introduced March 5, would require 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. *[A. Floor]*

AB 1807 (Bronshvag), as amended May 3, would authorize MBC to establish by regulation a system for an inactive category of licensure. *[A. W&M]*

AB 2241 (Murray), as amended April 14, would create the Naturopathic Physicians Practice Act and establish the Naturopathic Physicians' Examining Committee within DAHP. *[A. Health]*

SB 1166 (Watson), as amended April 14, would define the term "naturopathic physician" and describe the scope of practice of such a physician. *[S. B&P]*

AB 251 (Alpert), as amended May 17, would establish the California Medical Physics Practice Act, which would provide for the licensure of medical physicists, as defined, by DHS; establish a Medical Physicist Advisory Committee in DHS' Radiation Control Branch, with prescribed membership, powers, and duties; and require the Committee to establish fees for the administration of the Act. *[A. Floor]*

LITIGATION

In ***Silva v. Superior Court (Heerhartz)***, No. C014832 (Mar. 23, 1993), the Third District Court of Appeal concluded that an administrative law judge (ALJ) had applied an incorrect standard of proof in issuing an administrative interim order suspending Dr. Enriqueta Silva's medical license. The ALJ applied a "preponderance of the evidence" standard, and had found that the evidence presented justified the order. Government Code section 11529 is silent as to the standard of proof to be applied by the ALJ at a hearing on an application for an interim order. The Third District found that the higher "clear and convincing" standard has been applied in disciplinary proceedings against other professional licensees, such as attorneys, and concluded it would be anomalous to require a higher degree of proof in medical license hearings than in other professions. At its May 7 meeting, MBC decided to seek a statutory change reversing the *Silva* decision and authorizing use of the "preponderance of the evidence" standard in interim order decisions; this change is expected to be amended into SB 916 (Presley) (*see* MAJOR PROJECTS).

In ***Khan v. Division of Medical Quality, Medical Board of California***, No. B061733 (Feb. 5, 1993), the Second District Court of Appeal held that DMQ is not required to prove the element of intent to find that a physician violated certain sections of the Business and Professions Code. The court found that Dr. Hameed A. Khan violated Code sections relating to false advertising, employing a person to practice medicine without a license, and aiding a person in practicing medicine without a license. DMQ disciplined the physician for actions relating to two persons employed in his South Torrance Medical Group: his sister (who was licensed to practice in Pakistan but not in California), and a non-certified physician assistant. Dr. Khan argued that he did not knowingly violate the Code, and that he was misled by the physician assistant. The court emphasized that under the Code a physician has an affirmative obligation to know the law and ascertain the facts. The court relied on the public protection purpose of the statute for its decision. "It is the responsibility of the medical practitioner to contact the licensing agency and ensure the existence of the license of those in his or her employ....Otherwise, practitioners could protect themselves from discipline by the Medical Board by remaining ignorant of the true facts." The court upheld the judgment of the superior court, which had affirmed DMQ's revocation of Dr. Khan's permit to supervise physician assistants and imposition of a three-year probationary period on Khan's license to practice medicine.

On May 6, CMA filed ***California Medical Ass'n v. Hayes***, No. 374372 (Sacramento County Superior Court), its petition for writ of mandate challenging the legislature's transfer of 10% of MBC's special fund to the general fund, which—at this writing—is scheduled to occur on June 30. *[13:1 CRLR 49; 12:4 CRLR 1]* CMA did not request a temporary restraining order or preliminary injunction to stop the transfer before it occurs; instead, it will seek a return of the money—approximately $2.7 million—after it has been transferred. The court has scheduled a hearing on CMA's petition for October 8.

DAHP's medical assistant regulations are being challenged in ***California Optometric Association (COA) v. Division of Allied Health Professions, Medical Board of California***, No. 531542 (filed on January 11 in Sacramento County Superior Court), and ***Engineers and Scientists of California (ESC), et al. v. Division of Allied Health Professions, Medical Board of California***, No. 706751-0 (filed October 8, 1992 in Alameda County Superior Court). Following the enactment of SB 645 (Royce) (Chapter 666, Statutes of 1988), it took DAHP over three years to adopt section 1366, Title 16 of the CCR, its regulation defining the technical support services which unlicensed medical assistants (MAs) may perform and establishing standards for appropriate MA training and supervision. During the lengthy rulemaking process, DCA rejected DAHP's proposed regulations twice and OAL rejected them once before finally approving them in March 1992.

During the rulemaking hearings, COA and the Board of Optometry objected to language in the proposed regulations stating that MAs are permitted to perform "automated visual field testing, tonome-

try, or other simple or automated ophthalmic testing not requiring interpretation in order to obtain test results, using machines or instruments, but are precluded from the exercise of any judgment or interpretation of the data obtained on the part of the operator." *[12:1 CRLR 88–89]* However, DAHP overruled the objections and included this language in its final regulations. COA and ESC claim that section 1366 is invalid because the conduct authorized is beyond the scope of DAHP's authority, and it conflicts with DAHP's enabling statutes, it conflicts with Business and Professions Code sections 3040 and 3041 (which define the practice of optometry and prohibit unlicensed persons from engaging in optometry). At this writing, the Attorney General has filed an answer on behalf of DAHP; no court hearing has been set.

In ***People v. Klvana***, Nos. B048085 and B065578 (Nov. 30, 1992), the Second District Court of Appeal held that there was sufficient evidence to sustain the convictions of Dr. Milos Klvana on over 45 counts, including nine counts of second-degree murder. *[10:2&3 CRLR 21–23; 10:1 CRLR 77–78]* Klvana had argued that his technical incompetence and lack of medical judgment were not sufficient to convict on second-degree murder. Previously, Dr. Klvana's medical privileges had been either denied or revoked at a number of California hospitals. Further, he had been advised that obstetrical deliveries were not permitted at his medical clinic in East Los Angeles. Nevertheless, he continued to practice medicine, resulting in numerous fetal deaths, of which nine were represented by the second-degree murder convictions. The Second District concluded that ample evidence was presented from which the jury could reasonably infer that Klvana was subjectively aware that his methods of home and office deliveries were life-endangering. Further, the court found that Dr. Klvana consciously and deliberately disregarded those risks. The court said that implied malice may be proven by circumstantial evidence and stated that the jury had "overwhelming evidence from which it could conclude beyond a reasonable doubt that implied malice existed when Klvana performed each delivery which formed the basis of a second-degree murder conviction."

FUTURE MEETINGS

November 4–5 in Sacramento.

ACUPUNCTURE COMMITTEE

Executive Officer: Sherry Mehl (916) 263-2680

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

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

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

At its February 3 meeting, AC welcomed new public member Sandra McCubbin, who was appointed by Assembly Speaker Willie Brown to serve the remaining portion of the term vacated by his son last year. McCubbin is the regional director of external affairs for Cellular One. She was instrumental in coordinating the free loan distribution of 2,700 cellular phones to relief organizations and workers following the October 1989 Loma Prieta earthquake. Along with her duties as an AC member, she is on the Board of Directors of the California Institute of Public Affairs.

MAJOR PROJECTS

AC Rulemaking. At its February 3 meeting, AC adopted several proposed changes to its regulations in Division 13.7, Title 16 of the CCR, which had been the subject of a public hearing on January 26. *[13:1 CRLR 50–51]*

Specifically, AC amended sections 1399.417 (grounds for application abandonment), 1399.441 (languages in which AC's exam will be administered), 1399.480 (acceptability of continuing education (CE) courses related to business management and medical ethics), 1399.487 (four hours of CE per year in business management and medical ethics), and 1399.485 (completion of additional CE by inactive licensees seeking to reactivate their licenses). The Committee adopted new sections 1399.486 (required curriculum for additional CE under Business and Professions Code section 4945.5) and 1399.444 (licenses expired for more than five years).

AC modified two of the regulatory proposals and released them for an additional public comment period ending May 7. Specifically, it modified its proposal to amend section 1399.443, which would delete a requirement that an applicant achieve a passing score of 70% on both the written and practical examinations; AC modified the provision to require an applicant to obtain a passing score "as determined by a criterion-referenced method of establishing the passing point on each part of the examination." The Committee also modified its amendment to section 1399.460, which implements AC's authority to establish a license renewal system based on licensee birthdates; AC did not modify the language of the proposed regulation, only the accompanying chart displaying the prorated fee schedule.

Finally, AC tabled two other regulatory proposals: an amendment to section 1399.436 (percentage of transfer credit which may be accepted between AC-approved and non-AC-approved schools and colleges) and an amendment to section 1399.481 (CE course descriptions).

At this writing, the approved changes in the above-described regulatory package are scheduled for review and approval by DAHP at its July 29 meeting; thereafter, they must be approved by the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL).

On April 9, AC published notice of its intent to adopt other changes to its regulations. Specifically, the proposed changes would:

- amend section 1399.413 to provide that all applications for examination shall be received in AC's office at least 120 days prior to the examination date;
- amend section 1399.424(c) to specify that training and experience obtained by a trainee prior to January 1, 1980, and which is consistent with the standards established by AC, may be considered and used to reduce the trainee's theoretical and clin-

ical training in his/her tutorial program;

• amend section 1399.425(e) to define the subjects which must be included in an AC-approved tutorial program;

• amend section 1399.445 to specify that applicants who have failed AC's practical examination may petition AC for reconsideration where they believe they have been significantly disadvantaged due to significant procedural error in or adverse environmental conditions during the test administration;

• amend section 1399.450 to require acupuncturists to provide a bathroom facility in their offices; and

• adopt new sections 1399.463 and 1399.464 to implement AC's authority to issue a citation to an individual for violations of the agency's licensing act, and to specify the mechanism whereby a cited individual may appeal the issuance of a citation.

At this writing, AC is scheduled to hold a public hearing on these proposed regulatory changes at its May 26 meeting.

Finally, AC is still awaiting DCA and OAL approval of its amendments to section 1399.439, which require AC-approved acupuncture schools to submit to AC a course catalog and specified information about the school's curriculum, faculty, and financial condition. *[12:4 CRLR 96; 11:4 CRLR 92]*

LEGISLATION

AB 1807 (Bronshvag), as amended May 3, would provide that if, upon investigation, AC has probable cause to believe a person is advertising in a telephone directory with respect to the offering or performance of acupuncture services without being properly licensed by AC, the Committee may issue a citation containing an order of correction which requires the violator to cease the unlawful advertising. If the unlicensed person to whom a citation and order of correction is issued fails to comply with the order of correction after that order is final, AC shall inform the Public Utilities Commission (PUC) of the violation, and the PUC shall require the telephone corporation furnishing services to that person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

Business and Professions Code section 4935 currently provides that an unlicensed person who holds himself/herself out as engaging in the practice of acupuncture by the use of any title or description of services incorporating specified terms, including the terms "oriental herbalist" or "certified herbalist," is guilty of a misdemeanor; this bill would delete those terms from section 4935.

Existing law provides that nothing in the licensing law for acupuncturists is to be construed as preventing the practice of acupuncture by a dentist or podiatrist within the scope of his/her practice; this bill would also provide that these provisions are not to be construed to prevent the practice of acupuncture by physicians.

Among other things, this bill would also revise the qualifications required of an acupuncturist who may be approved to supervise an acupuncturist trainee, and reduce the time within which an acupuncturist may renew his/her expired license from five to three years. *[A. W&M]*

SB 842 (Presley), as amended April 13, would authorize AC to issue interim orders of suspension and other restrictions, as specified against its licensees. (*See* agency report on DCA for more information.) *[A. CPGE&ED]*

RECENT MEETINGS

At its February 3 meeting, AC discussed the progress of the accusations filed against individual acupuncturists who allegedly purchased AC's licensing exam from former AC member Chae Woo Lew during the late 1980s. *[10:2&3 CRLR 103–04; 9:4 CRLR 65]* Currently, 30–40 cases are awaiting final administrative disposition at the investigative stage. AC has never handled so many cases at once before, and failed to adequately estimate the cost of prosecuting these cases into its budget. In each case, the cost of hiring the investigator(s), deputy attorney general (DAG), administrative law judge, and court reporter must be absorbed by AC. If the respondent acupuncturist and the DAG enter into a stipulated agreement, then AC will not incur hearing costs. However, if a majority of the respondents contest the accusation at a hearing, AC is not in a position to cover the costs.

The only bright spot is that the amount will be reflected in next year's budget. According to AC Executive Officer Sherry Mehl, some money is available in AC's reserve fund, but a budget change proposal would have to be approved in order to access it. Further, AC can attempt to recover the costs of its investigations from the licensees under AB 2743 (Frazee) (Chapter 1289, Statutes of 1992); however, this statute has not yet been tested in the courts and there is some question as to whether it may be applied retroactively.

Also at its February meeting, AC discussed ways to establish a national awareness on the use of acupuncture as a viable medical option. In the course of this discussion, AC decided that acupuncture should be defined as "complementary medicine" *[13:1 CRLR 50]* rather than "alternative medicine." Individuals representing acupuncture schools and the profession agreed that the word "alternative" has a negative connotation. AC passed several motions to write letters to the National Institutes of Health (NIH), U.S. Representative Henry Waxman, and Hillary Rodham Clinton; the letters would seek Waxman's help in urging NIH to include acupuncture in an upcoming study of various medical options and techniques, and endorse acupuncture as a cost-effective form of health care to Mrs. Clinton's national health care task force.

Also in February, staff distributed a copy of an investigation report compiled by DCA's Division of Investigation. The focus of the inquiry was to determine whether AC or any of its members had a conflict of interest with respect to an investigation of National Credential Clearinghouse (NCC), the examination vendor chosen in a controversial 1992 bidding process which resulted in the resignation of four Committee members. *[12:1 CRLR 76–77]* The Division found that any investigation of NCC was initiated by former AC President Lam Kong; AC was not involved in the financing of the investigation and no conflict of interest exists.

Finally, AC reelected acupuncturist David Chen as its Chair and selected public member Jane Barnett as Vice-Chair.

FUTURE MEETINGS

August 3–4 in Sacramento.
November 2–3 in San Diego.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer: Elizabeth Ware (916) 263-2288

Pursuant to Business and Professions Code section 3300 *et seq.*, the Medical Board of California's Hearing Aid Dispensers Examining Committee (HADEC) prepares, approves, conducts, and grades examinations of applicants for a hearing aid dispenser's license. The Committee also reviews qualifications of exam applicants, and is authorized to issue licenses and adopt regulations pursuant to, and hear and prosecute cases involving violations of, the law relating to hearing aid dispensing. HADEC has the authority to issue citations and fines to licensees who have engaged in misconduct. HADEC

recommends proposed regulations to the Medical Board's Division of Allied Health Professions (DAHP), which may adopt them; HADEC's regulations are codified in Division 13.3, Title 16 of the California Code of Regulations (CCR).

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

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

MAJOR PROJECTS

Advertising Guidelines. Last December, HADEC reviewed draft advertising guidelines for hearing aid dispensers; the guidelines were developed as a result of HADEC's recent "call for contracts" and the identification of several hearing aid dispenser advertising problems by the joint Advertising Issues Task Force convened by HADEC and the Speech-Language Pathology and Audiology Examining Committee. *[13:1 CRLR 51–52; 12:4 CRLR 97]* As the result of HADEC's December suggestion that more examples of advertising violations be included in the guidelines, staff added a second sheet entitled "Applying the Law," which HADEC reviewed at its February 19 meeting. The addendum contains examples of "correct" and "incorrect" ways of advertising business names, hearing tests, educational credentials, association memberships, and board certification, among other things. Following its review of the guidelines, HADEC approved them for distribution to its licensees.

Enforcement Report. At HADEC's February meeting, Executive Officer Elizabeth Ware reported that a total of 261 enforcement cases are pending: 151 are being reviewed by a consumer services representative (CSR) at the Medical Board's Central Complaint and Investigation Control Unit (CCICU); 85 are under formal investigation; and 25 are pending at the Attorney General's Office (accusations have been filed in 13 of the cases at the AG's Office). Ware expressed concern about the number of cases pending with CSRs and length of time HADEC's cases spend at CCICU; the average is 140 days. Additionally, eight cases have spent over two years at CCICU. Ware noted she will work to improve this situation and report to the Committee at a future meeting.

LEGISLATION

AB 1807 (Bronshvag), as amended May 3, would authorize HADEC to establish by regulation a system for an inactive category of licensure; delete Business and Professions Code section 3365(g), which requires dispensers to state that any examination made by them must not be regarded as medical or professional advice; reduce the time within which a dispenser may renew his/her expired license from five to three years; and provide that an expired license may be renewed at any time within three years after its expiration on filing of an application for renewal on a form prescribed by the Committee, and payment of all accrued and unpaid renewal fees. *[13:1 CRLR 52] [A. W&M]*

SB 595 (Rogers). Under existing law, the Public Utilities Commission implements programs whereby telecommunications devices are furnished to telephone subscribers who are deaf or hearing impaired and to statewide organizations representing the deaf or hearing impaired, and whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified as deaf or hearing impaired by a licensed physician or audiologist. As amended April 19, this bill would also permit the certification as deaf or hearing impaired to be made by a hearing aid dispenser if a physician has evaluated the hearing impaired individual's hearing. *[S. E&PU]*

RECENT MEETINGS

At HADEC's February meeting, the Committee elected Keld Helmuth as Vice-Chair for the remainder of the year to fill the vacancy created by the expiration of Byron Burton's term of office. The Committee also appointed Helmuth, along with Board member James McCartney, to a subcommittee which will conduct the annual performance review of the Executive Officer.

Also in February, the Committee discussed a letter it received from the California Association of Hearing Instrument Specialists. The Association expressed concern that HADEC has decided to hold all its licensing exams in Sacramento instead of in locations throughout the state, as has been its longstanding practice. Executive Officer Elizabeth Ware reported that the primary issue is budgetary—the Department of Consumer Affairs does not charge for the use of its Sacramento examination rooms and there are no transportation or overtime charges for staff members who participate in administering the examinations. In order to offer the examinations in both Sacramento and Los Angeles, the Committee would only be able to give its examinations twice per year instead of five times per year. The Committee decided to retain the current test dates and study the consequences of making any changes to examination locations.

Jim Conran, Director of the Department of Consumer Affairs, and Dixon Arnett, the new Executive Director of the Medical Board of California (MBC), visited HADEC at its February meeting. Arnett announced that MBC would convene a "Medical Summit" in Burbank on March 18–19, at which public commentary would be welcome. (*See* agency report on MBC for related discussion.) Conran extended the Governor's appreciation to HADEC members for serving on the Committee, and remarked briefly on their responsibility to protect consumers. Conran complimented Executive Officer Ware, explaining that part of the reason he visited HADEC last of all DCA's boards was his knowledge of Ms. Ware's competence and the smooth functioning of the Committee.

FUTURE MEETINGS

November 12 in Sacramento.

PHYSICAL THERAPY EXAMINING COMMITTEE

Executive Officer: Steven Hartzell (916) 263-2550

The Physical Therapy Examining Committee (PTEC) is a six-member board responsible for examining, licensing, and disciplining approximately 14,200 physical therapists and 2,300 physical therapist assistants. The Committee is comprised of three public and three physical therapist members. PTEC is authorized under Business and Professions Code section 2600 *et seq.*; the Committee's regulations are codified in Division 13.2, Title 16 of the California Code of Regulations (CCR). The Committee functions under the general oversight of the Medical Board's Division of Allied Health Professions (DAHP).

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

PTEC also approves physical therapy schools. An exam applicant must have graduated from a Committee-approved

school before being permitted to take the licensing exam. There is at least one school in each of the 50 states and Puerto Rico whose graduates are permitted to apply for licensure in California.

The Committee is currently functioning with only one public member and three PT members. Public member Judith McKinnon resigned before PTEC's February 27 meeting in Burbank. Additionally, the terms of two of the three PT members will expire on June 30. The Committee, therefore, will have only two committee members—one PT and one public member—as of July 1.

MAJOR PROJECTS

Supervision Requirements/PTA Licensure Standards. At both its February 27 and April 23 meetings, PTEC again held regulatory hearings on two rulemaking packages—one pertaining to physical therapists' supervision and use of PTAs and physical therapy aides (proposed amendments to sections 1398.44, 1399, and 1399.1, Division 13.2, Title 16 of the CCR), and the other regarding PTA licensure standards (proposed amendments to section 1398.47). *[13:1 CRLR 53; 12:4 CRLR 100]*

The proposed revisions to 1398.44 establish two supervision standards: one for inpatient/outpatient facilities, and another for the home care setting. 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, and shall be readily available to the assistant at all other times for advice, assistance, and instruction. Additionally, the SPT is required to evaluate each patient, document the evaluation in writing, formulate and record a treatment program based upon the evaluation, indicate which elements of the treatment program can be delegated to the PTA, and identify that PTA prior to the physical therapy treatment by the PTA. The SPT shall provide periodic reevaluation of the treatment program and document any necessary changes in treatment, as well as the patient's progress. The SPT is to assess the patient at least every other week, or more often if necessary. The major area of controversy regarding this section is the requirement that the SPT reassess the patient at least every other week; members of the profession argued that certain patients do not require reassessment that frequently. The consensus is that the need for frequency of reassessments should be left to the PT; otherwise, the treatment program could be more costly to the patient than is necessary.

The revisions to section 1398.44 also eliminate the existing provision authorizing PTEC to waive the 50% supervision requirement. On more than one occasion, Executive Officer Steve Hartzell has stated that PTEC is not sufficiently staffed to handle the number of waiver requests that have been submitted in the past. *[12:2&3 CRLR 114]* He further indicated that measures must be taken to eliminate, as much as possible, the number of waiver requests received by the agency. However, many PTs deem it essential to have a waiver program for these requirements in the inpatient/outpatient facility setting.

In the home care setting, the SPT and PTA are to make joint visits and provide treatment jointly prior to the PTA providing care without the SPT present. Additionally, the SPT and the PTA shall make a joint visit every other week to every patient being seen by the PTA for the purpose of reevaluating the patient's progress and the treatment plan. Here, the main concern is that the requirement of joint visits and frequent reevaluations will discourage the use of PTAs in the home care setting because of the cost of complying with this requirement. The consensus is that verbal and written communication between the PT and the PTA should be effective and sufficient. Additionally, representatives of the California Chapter of the American Physical Therapy Association (CCAPTA) expressed concern that the 50% supervision requirement is not being carried over to the home health care setting, because these patients often have the most serious problems and require special care.

With regard to the use of physical therapy aides, the amendments to section 1399 establish similar requirements on the SPT as to documentation of the SPT's evaluation of a patient prior to the performance of any patient-related task by the aide, establishment of a treatment plan, and specific delegation of patient-related tasks to an aide in that treatment plan. The SPT is required to provide continuous and immediate supervision of the aide and countersign all entries made by the aide in the patient's record on the same day the patient-related tasks are provided by the aide. Some members of the profession stated that documentation of the tasks that have been delegated to the aide is not essential. Many witnesses favored the need to have SPTs review entries made by the aide in the patient's medical record to ensure that the entries are accurate. Other comments, however, took exception to the requirement that PTs be in immediate proximity to the location where the aide is performing patient-related tasks. The consensus among these speakers was that this requirement decreases the efficiency of patient care delivery. If the aide is qualified to perform the task, then requiring the PT to be in immediate proximity is seen as unnecessary and costly to the patient.

The majority of speakers favored PTEC's proposed revisions to section 1399.1, which prohibit a PT from supervising more than one aide at any time.

PTEC's proposed amendments to section 1398.47 describe numerous combinations of training and experience which PTEC believes are equivalent to its educational requirement for PTAs. The amendments to this section would also refine the existing regulation to require a significant portion of any qualifying experience to have been performed under the direct and immediate supervision of a PT in an acute care inpatient facility. The comments on these proposed revisions related to whether an inpatient acute care facility will provide the variety of experiences necessary to render such experience equivalent to that received in an approved PTA school.

Following receipt of these comments, PTEC decided to revise both regulatory packages and hold another hearing at its July meeting.

Ad Hoc Committee on Education. PTEC's Ad Hoc Committee on Education met in September 1992 and drafted proposed legislation amending PT and PTA educational standards. At its April 23 meeting, PTEC reviewed a draft of the proposed changes to numerous sections of the Business and Professions Code.

Among other things, the revised standards would require each applicant for a PT license to be a graduate of an accredited postsecondary institution approved by the Committee, and to have completed a full-time professional education, including academic coursework and clinical internship in physical therapy. Only schools that are recognized by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association (APTA) shall be deemed approved by the Committee, unless the Committee determines otherwise.

The draft cannot be finalized until APTA's Commission on Accreditation submits its final draft on the evaluating criteria for PTA educational programs. Once the Commission's draft is received, then the Ad Hoc Committee will finalize the draft legislation, probably for introduction in 1994.

LEGISLATION

SB 437 (Hart), as amended April 26, would partially authorize, notwithstand-

ing existing provisions of law, supervision of a physical therapy aide by a physical therapist and would authorize a physician to supervise a physical therapy aide who is employed by the physician and who is authorized to provide services by specified provisions of law. *[S. B&P]*

AB 512 (Burton). Existing law establishes the Industrial Medical Council within the Division of Industrial Accidents in the Department of Industrial Relations. The law prescribes the composition and duties of the Council and provides that members in different specialties as required for the evaluation of medical issues related to workers' compensation shall be appointed by the Governor, the Senate Rules Committee, and the Speaker of the Assembly. As introduced February 18, this bill would require that the Council membership include a physical therapist who shall be appointed by the Speaker of the Assembly. The bill would also prohibit a physical therapist from serving as an agreed or qualified medical evaluator or appointing an agreed or qualified medical evaluator. *[A. F&I]*

RECENT MEETINGS

At PTEC's February 27 meeting in Burbank, Executive Officer Steve Hartzell announced that the Committee's investigative expenses for the first six months of the fiscal year have already exceeded its investigation budget for the full year. Consequently, the Committee is unable to afford major equipment purchases or publication of the PTEC newsletter.

Hartzell also announced that the Federation of State Boards of Physical Therapy has increased its examination fee to $185, effective January 1, 1995. The current examination fee is $100 and PTEC adds approximately $40 to cover its administrative costs. Additionally, the Federation is evaluating a change to the examination's structure. The Federation is determining whether separating the physical therapy licensing exam into the four basic physical therapy functions will increase the quality of the exam. Attendant to the structural change will be the creation of four different committees each to draft PT and PTA exam questions. The change will likely result in further exam cost increases. PTEC passed a motion charging staff with developing a proposed regulatory amendment to section 1399.50, Title 16 of the CCR, to increase the examination fee effective January 1, 1995.

At PTEC's April 23 meeting in San Francisco, Steve Hartzell reiterated that the Committee's newsletter probably will not be published until sometime in 1994 because of budget constraints. The goal will be to publish the most current laws and regulations affecting physical therapy practice. The newsletter will also include a list of the 1,000–1,500 licensees who are delinquent in their license fees for two years or more. *[13:1 CRLR 53]*

FUTURE MEETINGS

October 7 in Anaheim.
January 28 in Los Angeles.
April 29 in Sacramento.

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's Division of Allied Health Professions (DAHP).

On March 18, Governor Wilson filled three vacancies on PAEC. He appointed Steven D. Johnson of Pacifica as a PA member of the Committee; Johnson is a PA at the Palo Alto Medical Foundation, specializing in the practice of geriatric and internal medicine. The Governor also appointed PA Robert E. Sachs of Pasadena to the Committee; Sachs is a cardiothoracic surgery PA at the Foothill Surgical Associates Medical Group. Finally, Governor Wilson reappointed Dr. Jacquelin Trestrail to the MBC position on PAEC; Dr. Trestrail is a San Diego radiologist and is currently serving as President of the Medical Board.

MAJOR PROJECTS

Diversion Program. At its April 2 meeting, PAEC noted that its contract with Occupational Health Services (OHS) to administer its diversion program for substance-abusing licensees expires on June 30. Since the program's inception in 1990 *[10:2&3 CRLR 107]*, nine PAs have been referred to the program; seven of these were self-referrals and two were referred by PAEC staff. Of the seven cases which have been closed, six voluntarily withdrew and one was dismissed for noncompliance. None of the nine individuals has successfully completed the program.

PAEC noted that the Department of Consumer Affairs (DCA) is considering the establishment of a collective diversion program for use by all DCA agencies, and has requested proposals for the administration of such a program. PAEC decided to discontinue its contract with OHS and join DCA's program when it is established.

Draft Manual of Disciplinary Guidelines Released. At its April 2 meeting, the Committee reviewed a draft Manual of Disciplinary Guidelines, which is intended to provide those who participate in the PA discipline process with guidance on the Committee's preferred sanction(s) for specified violations of law. The draft Manual outlines most statutory violations which might be committed by a PA and sets forth the Committee's preferred minimum and maximum penalty for each. The Manual also suggests language for several optional terms and conditions which might be included in a disciplinary order. Following review, PAEC approved the manual.

LEGISLATION

AB 1065 (Campbell), as amended May 5, would state the findings and declarations of the legislature regarding the shortage and declining proportion of family practice physicians in the United States, and the growing demand for medical care in California. This bill would

require PAEC to establish a pilot and an ongoing international medical graduate (IMG) PA training program, with the goal of placing as many IMG PAs in medically underserved areas as possible in order to provide greater access to care for the growing population of medically indigent and underserved by training foreign medical graduates to become licensed as PAs at no cost to the participants in return for a commitment from the participants to serve in underserved areas.

This bill would require the Committee, by February 1, 1994, to establish a training program advisory task force to, among other things, develop a recommended curriculum for the training program, and would require the curriculum to be presented to the Committee on Allied Health Education and Accreditation of the American Medical Association for approval by April 1, 1994.

This bill would make any person who has satisfactorily completed the training program eligible for licensure by PAEC as a "Physician Assistant/International Medical Graduate" or "Physician Assistant/IMG" if the person has successfully completed the certification examination of the National Commission on Certification of Physician Assistants, and has successfully completed the Test of English as Foreign Language (TOEFL).

This bill would also provide that the Attorney General may represent the Committee in any litigation necessitated by this measure; if the Attorney General declines, the bill would authorize the Committee to hire the other counsel for this purpose. *[A. W&M]*

At its April 2 meeting, PAEC took an oppose position on AB 1065. In a letter to Assembly Health Committee Chair Burt Margolin, the Committee stated that the bill would create a second licensing track for foreign medical graduates (FMGs), which "is unnecessary, will potentially cost in excess of a half million dollars to implement, will produce few new PA licensees, and will, in medically undeserved [sic] areas, expose California consumers to health care of questionable competency." PAEC noted that its current two-step licensing process—completion of a PAEC-approved training program and passage of a PAEC-approved written examination—may be bypassed by FMGs under existing "challenge mechanisms" if certain conditions are met. PAEC complained that the bill would required it to establish a new application process for this new class of licensee; identify and purchase or create a new PA licensing exam; establish a passing score for the new exam; establish regulations setting standards for foreign health facilities at which FMG PA applicants may have gained experience; require it to monitor every FMG PA for at least three years post-licensure; and require PAEC to revoke the FMG PA's license if the FMG PA fails to work in an underserved area. The Committee further noted that its fund does not have adequate reserves to finance the implementation of AB 1065; the legislature would either have to appropriate the money needed from the general fund or permit PAEC to borrow the needed funds.

SB 633 (Deddeh). The Physician Assistant Practice Act authorizes a PA, as defined, to perform medical services, as set forth by the regulations adopted by the Medical Board's Division of Allied Health Professions (DAHP), when the services are rendered under the supervision of a licensed physician or physicians approved by the Division. As amended May 18, this bill would authorize a PA to perform these medical services when the services are rendered during any state of war emergency, state of emergency, or state of local emergency, as defined, at the request of certain officials or agencies, or pursuant to the terms of a mutual aid operation plan, even if the approved supervising physician is not available, so long as a licensed physician is available to render appropriate supervision. This bill would specify that appropriate supervision does not require the personal or electronic availability of a supervising physician if that availability is not possible or practical due to the emergency. The bill would authorize local health officers to act as supervising physicians during emergencies without being subject to the requirement of approval by DAHP. This bill, which is supported by PAEC, would also exempt physicians supervising PAs under emergency conditions from the limitation on the number of PAs that may be supervised. *[S. Floor]*

AB 2350 (Escutia), as introduced March 5, would require the California Medical Assistance Commission to consider the extent to which a hospital maximizes the delivery of preventive health care services to pregnant mothers and children by appropriately utilizing primary care physicians, primary care nurse practitioners, and PAs, and the demonstrated willingness of a hospital, or university medical school with which the hospital is affiliated, to actively support the recruitment and training of primary care physicians, primary care nurse practitioners, and PAs at that hospital site. *[A. Health]*

AB 2157 (Polanco). Existing law limits the amounts of the various fees PAEC determines will be paid by a physician who seeks approval to supervise a PA; the existing limit for an application fee for a PA supervisor is $50 and the existing limit for an approval fee is $250 to be charged upon approval of an application to supervise a PA. As introduced March 5, this bill would raise the application fee limit for a PA supervisor to $100, and raise the limit of an approval fee for a PA supervisor to $350. *[A. Health]*

AB 1392 (Speier), as amended April 14, would require PAEC to notify DCA whenever any complaint has gone thirty days without any investigative action, and authorize the DCA Director to review any complaint filed with PAEC. *[A. Floor]*

SB 842 (Presley), as amended May 13, would permit PAEC to issue interim orders of suspension and other restrictions as specified, against its licensees. (*See* agency update on DCA for more information.) *[A. CPGE&ED]*

SB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information, and be presented to all legislative committees of the legislature that hear that legislation prior to its enactment. *[S. B&P]*

RECENT MEETINGS

At PAEC's April meeting, staff member Jennifer Barnhart presented a status report on current licensing and enforcement statistics. As of December 31, 1992, there were a total of 2,209 PAs and 5,658 supervising physicians. As of March 1, the Medical Board's Central Complaint and Investigation Control Unit was processing 16 complaints against PAs, and 35 cases against PAs were being actively investigated. Eleven cases against PAs are pending at the Attorney General's Office, nine of which are awaiting the drafting of a formal accusation. From July 1, 1992 to March 1, 1993, PAEC revoked three licenses but stayed the revocation in all three cases, opting for probation instead; one license was denied; and the licenses of seven PAs are on probation.

FUTURE MEETINGS

October 1 in Sacramento.

BOARD OF PODIATRIC MEDICINE

Executive Officer:
James Rathlesberger
(916) 263-2647

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

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

MAJOR PROJECTS

BPM Evaluates Use of State Police For Investigations. At its April 30 meeting, Duane Lowe, Chief of the California State Police, appeared before the Board to discuss the pros and cons of an interagency agreement between BPM and the State Police to utilize the State Police for investigative services. Currently, the Board contracts chiefly with MBC for personnel to investigate reported complaints, though occasionally the Board has sought the services of the Department of Consumer Affairs' (DCA) Division of Investigation (DOI). The primary motivation for the change away from MBC and DOI investigators is economic: MBC investigators cost the Board $76 per hour, while DOI investigators can cost as much as $90 per hour. The services of the State Police investigators are available for $36 per hour, which includes administrative costs. In addition, the officer assigned to the Board will work on BPM investigations exclusively, rather than farming out the work to a number of different officers. At the April meeting, the Board directed staff to further look into the feasibility of such an arrangement.

Drive for BPM Independence From Medical Board Gains Momentum. Efforts continue to transfer BPM out of the Medical Board and make it a separate board within DCA. *[13:1 CRLR 54–55]* At its April 30 meeting, the Board unanimously passed a resolution directing Executive Officer Jim Rathlesberger, in the absence of action by the Medical Board to provide DPMs with satisfactory representation on the Medical Board, to seek enactment of legislation separating BPM from the Medical Board.

In a January 14 letter, Rathlesberger stated that BPM, in seeking to become independent, is not attempting to divorce itself from dialogue and cooperation with the Medical Board. Instead, BPM seeks to maintain a close working relation with MBC, which BPM feels would be improved if the current structure were abolished.

BPM also vowed to monitor ongoing discussions at the Medical Board to do away with its Division of Allied Health Professions (DAHP), the MBC entity which has statutory jurisdiction over BPM. The Board noted that MBC has been discussing the possible abolition of DAHP for several years; its ongoing troubles with its disciplinary system and its need to devote more Board member and staff resources to enforcement will undoubtedly combine to result in the elimination of DAHP (*see* agency report on MBC for related discussion).

Board Modifies Complaint Disclosure Policy. At its April 30 meeting, BPM approved a proposal which will permit inquiring consumers to learn of completed investigations and impending disciplinary actions about one year earlier than they presently can. Specifically, the Board decided to disclose to inquiring individuals the fact that it has completed an investigation against a DPM and is pursuing disciplinary action at the point at which the case is referred to the Attorney General's Office (rather than when the accusation is actually filed, which—due to understaffing and extreme workload in the AG's Office—can be up to one year after the fully investigated case is referred by the Board). Knowing that MBC would be considering a similar proposal at its May 7 meeting, BPM further voted to conform its disclosure policies with regard to other information about podiatrists (*e.g.*, medical malpractice judgments and settlements, criminal charges and convictions) with those approved by the Medical Board on that date. (*See* agency reports on MBC and BOARD OF PSYCHOLOGY for related discussions.)

BPM Fights Back. At its January 29 meeting, BPM adopted a resolution addressing the activities of the American Orthopaedic Foot and Ankle Society (AOFAS), which BPM believes is continuing to engage in an aggressive campaign to discredit DPMs through misinformation. AOFAS produced a "media kit" which suggests that foot and ankle care "should be primarily provided under the auspices" of orthopaedic surgeons rather than "limited-license practitioners," "opponents," or "people known as 'foot doctors' [who] have not attended medical school and aren't MDs." BPM noted that such characterizations distort and denigrate the training received by podiatric doctors, but that those statements are apt to be accepted by consumers. In addition, BPM felt that AOFAS' aggressive efforts are increasingly contributing to unfounded attacks upon licensees of the Board in hospitals and other public and private agencies. In response to those activities, the Board's resolution formally requested AOFAS to discontinue its efforts to defame DPMs in California, and called upon other public and private agencies to pressure AOFAS to redirect its efforts toward open dialogue, professional cooperation, and fair competition.

On February 10, BPM Executive Officer Jim Rathlesberger sent the resolution to AOFAS along with a letter inviting representatives of AOFAS to attend the April 30 meeting and respond. No representative of AOFAS attended the April 30 meeting, nor has AOFAS issued a response to BPM's resolution.

BPM Works Toward A National Written Examination. At its January 29 meeting, BPM agreed to urge the Council on Podiatric Medical Education (CPME) to sponsor development of a national written examination for all residents midway through their first year of postgraduate training. Such an examination has been under discussion for some time, and it is the Board's position that its administration would improve evaluation of both the residents and the programs.

BPM Continues Review of Postgraduate Residency Training Programs. Under section 2475.3 of the Business and Professions Code, BPM is responsible for approving podiatric medical schools and residency programs. Because of the need for national uniformity, BPM—like other state medical/podiatric medical boards—has delegated this authority to CPME, the nationally recognized accrediting agency. In California, at least one year of postgraduate training is required for a license to practice. While the training of podiatrists is uniform through the four years of podiatric medical training, the experiences of residents in postgraduate training programs can vary significantly. In order to impose a degree of consistency on postgraduate training programs, and to establish standards for subject matter, BPM and the Medical Board's Committee on Non-MD Postgraduate Training Programs have been involved in comprehensive review of California podiatric medical residency

programs. *[12:2&3 CRLR 119–20; 12:1 CRLR 83]*

To that end, BPM and MBC's Committee recently retained the services of Dr. Thomas L. Nelson, Professor Emeritus at UC Irvine Medical Center, and Franklin J. Medio, Ph.D., of the CPME to conduct a study focusing on all aspects of medical and podiatric medical graduate training, including training goals and objectives, supervision, evaluation of residents, and the strengths and weaknesses of current training settings. Through this study, the Board hopes to identify what changes, if any, are needed in the training of podiatric medical residents in non-podiatric medical and surgical specialties. The study itself will involve visitations to podiatry schools as well as onsite review of residency programs.

BPM Amends Continuing Education Regulations. On March 12, BPM published notice of its intent to amend its continuing education (CE) requirements in sections 1399.669 and 1399.670, Title 16 of the CCR. Section 1399.669 currently requires a DPM to complete at least 50 hours of CE for each two-year renewal period. However, this regulation does not specify any minimum number of hours to be taken in subjects specifically related to podiatry. Under current regulations, a DPM may conceivably complete his/her CE requirement without having taken a single course specifically related to podiatric medicine.

BPM's proposed regulatory change to section 1399.669 would specify that a minimum of 12 hours of the required 50 CE hours shall be in subjects related to the lower extremity muscular skeletal system. BPM also proposes to amend section 1399.670 to clarify language pertaining to approved CE programs and delete an obsolete reference to preceptorship programs.

BPM held a public hearing on the proposed regulatory changes at its April 30 meeting. No public comments were submitted, and the Board adopted the changes. At this writing, the rulemaking record awaits review an approval by DCA and the Office of Administrative Law.

BPM Enforcement. On February 19, BPM secured a temporary restraining order from the Riverside County Superior Court preventing Mark Ellis, DPM, from practicing podiatric medicine pending the conclusion of his disciplinary proceeding. The court granted the TRO based on declarations from three experts and twenty other colleagues and patients, indicating that Ellis committed numerous acts of gross negligence, incompetence, Medicare and insurance fraud, dishonesty, corruption, and falsification and alteration of medical records. In two cases, patients died after questionable treatment by Ellis. The TRO is in effect pending the outcome of an administrative hearing on the allegations contained in a 140-page accusation and supplemental accusation filed by the Attorney General's Office.

Additionally, BPM plans license revocation proceedings against Brian Douglas Carey, DPM, of Inglewood, who was convicted on April 9 on eighteen felony counts (primarily insurance fraud and grand theft related to unnecessary surgeries). After an eight-week trial, the jury deliberated for six weeks. Deputy District Attorney Al MacKenzie stated that the verdict proves "a doctor can be convicted for performing unnecessary surgeries."

LEGISLATION

SB 916 (Presley), as amended May 18, is a 40-part bill sponsored by the Center for Public Interest Law (CPIL) in response to the critical audit of MBC's enforcement program conducted by the California Highway Patrol and released in January. Throughout the spring and summer, the bill has been the subject of lengthy negotiation sessions involving CPIL, MBC, BPM, DCA, the California Medical Association, the Attorney General's Office, several consumer and patient protection groups, and representatives from the offices of Senator Presley and Senator Boatwright. (*See* agency report on MBC for detailed discussion and description of SB 916.) *[S. B&P]*

At its April 30 meeting, BPM adopted a resolution noting that additional reforms to MBC's enforcement system are necessary and that the failures of the current system are damaging the medical and podiatric professions. The resolution commended CPIL and legislative officials for their leadership role on this issue and directed its Legislative Committee and Executive Officer to assist in the refinement and enactment of SB 916. The Board concluded its resolution by urging "that the necessary dialogue focus not on what is 'acceptable' to the California Medical Association but on what is necessary to achieve a system of public protection satisfactory to the public."

AB 297 (Snyder). Existing law permits a podiatrist to perform surgical treatment of the ankle and tendons at the level of the ankle only in a licensed general acute care hospital, as defined. As amended April 12, this bill would additionally permit a podiatrist to perform this surgical treatment in (1) a licensed surgical clinic if the podiatrist has surgical privileges in a licensed general acute care hospital and meets all the protocols of the clinic, (2) an ambulatory surgical center that is certified to participate in the federal Medicare program if the podiatrist has surgical privileges in a licensed general acute care hospital and meets all the protocols of the center, and (3) a freestanding physical plant housing outpatient services, as defined. *[S. B&P]*

AB 635 (Cortese). The Knox-Keene Health Care Service Plan Act of 1974 prohibits health care service plans that offer podiatry services as a specific podiatric plan benefit from refusing to give reasonable consideration to affiliation with podiatrists for the provision of podiatry services solely on the basis that they are podiatrists. As introduced February 22, this bill would instead prohibit a plan that offers podiatry services within the benefits of a plan that relate to foot care from refusing to give reasonable consideration to affiliation with podiatrists for the provision of podiatry services solely on the basis that they are podiatrists. The bill would also require a plan to consider, as prescribed, a request for affiliation by a podiatrist in relation to services offered by the plan. *[A. Health]*

AB 720 (Horcher), as introduced February 22, would prohibit any person other than a licensed physician, podiatrist, or dentist from applying laser radiation, as defined, to any person for therapeutic purposes, and would provide that any person who violates this provision is guilty of a misdemeanor. *[A. Health]*

AB 1807 (Bronshvag), as amended May 3, would revise the terms that may be used by DPMs for fictitious name permits, and reduce the amount of time within which a DPM may renew his/her expired license from five to three years. *[A. W&M]*

AB 2214 (Lee), as introduced March 5, would require any podiatrist who sells, closes, or transfers his/her practice to notify each patient in writing of the sale, closure, or transfer, and require that each patient be given an opportunity to determine where his/her records shall be directed before the licensee transfers or otherwise disposes of those records. *[A. Health]*

AB 2316 (V. Brown), as amended April 28, would require any podiatrist who sells, closes, or transfers his/her practice to notify each patient, with certain exceptions, in writing, of the sale, closure, or transfer, and of the intended disposition of the patient's medical records, at least thirty days prior to the intended sale, closure, or transfer of his/her practice, and to advise each patient that he/she has thirty days to request this his/her records be directed to another licensee of their choice. *[A. W&M]*

RECENT MEETINGS

At its April 30 meeting, BPM elected Steven J. DeValentine, DPM, and JoAnne M. Watson, DPM, as president and vice-president of the Board, respectively. Their terms begin on June 30. Then-Board President Michael R. Vega, DPM, announced his departure from the Board, effective in June.

FUTURE MEETINGS

November 5 in Los Angeles.
January 25 in Sacramento (tentative).
May 6 in San Francisco (tentative).

BOARD OF PSYCHOLOGY

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

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

BOP is composed of eight members—five psychologists and three public members. Each member of the Board is appointed for a term of four years, and no member may serve for more than two consecutive terms. Currently, Louis Jenkins, Judith Fabian, Linda Hee, Frank Powell, and Bruce Ebert are BOP's psychologist members, and Philip Schlessinger and Linda Lucks are its public members. One BOP public member position is vacant.

MAJOR PROJECTS

BOP Modifies Complaint Disclosure Policy. At its March 20 meeting, BOP became the first occupational licensing agency within the Department of Consumer Affairs (DCA) to liberalize its complaint disclosure policy. The Board decided to disclose to inquiring individuals the fact that it has completed a complaint investigation against a licensee and intends to pursue disciplinary action at the time the case is referred to the Attorney General's Office for drafting of a formal accusation. Inquiring consumers will be told that BOP has forwarded a case to the AG's Office requesting that a formal action be filed, together with a general description of the allegations against the licensee.

Previously, BOP and other DCA agencies released complaint information to inquiring consumers only after the accusation was actually filed. In adopting the more liberal policy, BOP noted that—due to understaffing and an enormous caseload—it takes the AG's Office an average of 250 days after it has received a fully investigated case to file the accusation. At the point of referral to the AG's Office, the case will have been reviewed by BOP's consumer services representative and Executive Officer, fully investigated, and reviewed again by BOP's Executive Officer to ensure that disciplinary action is desired and appropriate. Because of the delay in the AG's Office and possible harm to consumers from incompetent, impaired, or unethical psychologists, BOP decided the public would be better served with earlier factual indication as to whether it has completed an investigation of a licensee and intends to pursue disciplinary action.

Shortly after BOP liberalized its complaint disclosure policy, the Medical Board of California followed suit (*see* agency report on MBC for related discussion).

BOP Rulemaking. On January 29, BOP published notice of its intent to amend several of its regulations in Division 13.1, Title 16 of the CCR. The Board held a public hearing on the proposed regulatory changes on March 20, and adopted all of them. Specifically, the Board decided to:

- amend section 1380.4, to delegate to its Executive Officer the authority to carry out specified investigative and administrative proceedings; in the absence of the Executive Officer, this authority is delegated to the Board Chairperson and then to the Board Vice-Chairperson;
- amend section 1388 to delete a reference to the Examination for Professional Practice in Psychology (EPPP) as the Board's written exam, to give the Board more flexibility with regard to its written exam *[13:1 CRLR 56]*;
- amend section 1392 to increase its biennial renewal fee to $400, in compliance with AB 2743 (Chapter 1289, Statutes of 1992) *[12:4 CRLR 108–09]*, and delete obsolete language relating to the examination fee; and
- in compliance with AB 2743's requirement that its fees for examinations be set at the cost to the Board of developing, purchasing, grading, and administering the exams, amend section 1392 to set the fee for the written exam at $273, and the fee for the oral exam at $78.

The Board submitted the rulemaking record on these regulatory changes to the Office of Administrative Law (OAL) in early May, and expects approval in the near future.

Supervised Professional Experience Regulations. On February 16, BOP released the final modified language of its proposed changes to sections 1387 and 1386(c) and its proposed addition of section 1387.3, Division 13.1, Title 16 of the CCR. Collectively, these regulatory changes would implement the provision in Business and Professions Code section 2914 requiring applicants for psychologist licensure to have engaged for at least two years in "supervised professional experience [SPE] under the direction of a licensed psychologist, the specific requirements of which shall be defined by the Board in its regulations, or such suitable alternative supervision as determined by the Board in regulations duly adopted under this chapter, at least one year of which shall be after being awarded the doctorate in psychology." *[12:4 CRLR 107–80; 12:2&3 CRLR 123]*

Under the modified regulations, a qualified primary supervisor (QPS) overseeing "supervised professional experience" means a psychologist who is engaged in rendering professional services a minimum of one-half time in the same work setting at the same time as the person supervised in obtaining SPE. Effective July 1, 1995, a QPS must have not less than three years of professional post-licensure experience. The QPS may delegate a portion of the supervision for which he/she is responsible to another licensed psychologist or, effective July 1, 1995, to a person who meets the qualifications set forth in new section 1387.3 (*see* below). One year of SPE shall consist of not less than 1,500 hours, which must be completed within 30 consecutive months. Two years of SPE are required, one of which must be completed after being awarded the doctoral degree. After July 1, 1995, each of these two years must be supervised by a different QPS.

Section 1387(o) defines "suitable alternative supervision" as supervision by a psychologist licensed or certified in another state or territory of the United States, a diplomate of the American Board of Professional Psychology, or by a psychologist who holds a doctorate degree in psy-

chology and who has a minimum of three years of professional post-doctoral experience. Section 1387(o)(2) states that a maximum of 750 hours of SPE may be under a primary supervisor who is a licensed professional other than a psychologist, including but not limited to, board-eligible or board-certified psychiatrists, educational psychologists, or clinical social workers. Effective July 1, 1995, the primary supervisor referenced in subsection 1387(o)(2) shall be limited to a board-certified psychiatrist with three years of post-certification experience as a psychiatrist, or other licensed mental health professional who has three years of post-licensure experience as a mental health professional.

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

At this writing, BOP staff is preparing the rulemaking package for submission to DCA and OAL.

LEGISLATION

SB 842 (Presley), as amended May 13, would permit BOP to issue interim orders of suspension and other license restrictions, as specified, against its licensees. (See agency update on DCA for more information.) *[A. CPGE&ED]*

AB 1807 (Bronshvag). Existing law provides for the administration of the Psychology Licensing Law by BOP and the Medical Board's Division of Allied Health Professions (DAHP); as amended May 3, this bill would repeal DAHP's authority to administer the law. This bill would also revise requirements regarding publication of notices of the regular meetings of BOP, and authorize BOP to reduce any of prescribed fees relating to licensing of psychologists as it deems administratively appropriate.

Existing law prohibits a person from holding himself/herself out to be a psychologist unless that person is licensed; the law provides that the use of certain enumerated terms constitute holding oneself out as a psychologist. This bill would delete some of those terms.

Existing law authorizes BOP to order the denial of an application for licensure, issue a license with terms and conditions, or order the suspension or revocation of a license for certain causes. This bill would revise these provisions and would eliminate the use of a fictitious, false, or assumed name by a licensee, alone or in conjunction with a group or partnership, as described, from those causes.

This bill would also authorize BOP to issue citations if, upon investigation, the Board has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services without being properly licensed, and to require the violator to cease the unlawful advertising. This bill would also reduce the time within which a psychologist may renew his/her expired license from five to three years. *[A. W&M]*

AB 179 (Snyder). Existing law provides that it is unlawful for any person licensed by BOP to charge, bill, or otherwise solicit payment from any patient for any clinical laboratory test or service if that test or service was not rendered by the licensee or under his/her direct supervision, unless the patient is notified of the name, address, and charges of the clinical laboratory that performed the service or test. As amended April 20, this bill would require this provision to apply to a clinical laboratory of a health facility or a health facility when billing for a clinical laboratory of the facility only if the standardized billing form used by the facility requires itemization of clinical laboratory charges. *[A. Floor]*

AB 700 (Bowen). The Psychology Licensing Law authorizes BOP to deny an application for a license, issue a license subject to terms and conditions, or order the suspension of a license for a period not exceeding one year, or revoke, or impose probationary conditions upon a licensee for, among other things, using a fictitious name without a permit; the law authorizes the Board to issue fictitious-name permits and authorizes psychologists to practice under a fictitious or false name if the psychologist has a current fictitious-name permit issued by the Board. As amended April 13, this bill would delete the authority to deny an application for a license, issue a license subject to terms and conditions, or order the suspension of, revoke, or impose probationary conditions upon a licensee for using a fictitious name, and would delete the authority to grant the fictitious-name permit. *[A. Floor]*

AB 705 (Alpert). The Lanterman-Petris-Short Act authorizes a person involuntarily detained in a mental health facility to be released if the psychiatrist directly responsible for that person's treatment, or a reviewing psychiatrist, believes that the person no longer requires evaluation or treatment, or is not a danger to others or to himself/herself, subject to certain conditions. The act also exempts the psychiatrist, among others, from civil and criminal liability for any actions of a person so released. As introduced February 23, this bill would also authorize the release of a person involuntarily detained if the psychologist directly responsible for that person's treatment, or a reviewing psychologist, believes that the person no longer requires evaluation or treatment, or is not a danger to others or to himself/herself, and would exempt the psychologist from civil and criminal liability for that person's actions. *[A. Health]*

AB 757 (Polanco). Existing law prohibits the practice of psychology without a license, defines the practice of psychology, and sets forth the requirements for licensure. As introduced February 24, this bill would require that nothing in these provisions relating to licensure of psychologists be construed to limit the scope of practice of a psychologist based on the etiology of a mental disorder, and would provide that a psychologist may provide treatment for mental disorders arising from biological, psychological, or social factors. *[A. Health]*

SB 743 (Boatwright). Existing law provides that any act of sexual abuse, misconduct, or relations with a patient, client, or customer that is substantially related to the qualifications, functions, or duties of the occupation for which a license is issued constitutes unprofessional conduct and grounds for disciplinary action for certain healing arts practitioners and social workers. As introduced March 3, this bill would delete the condition that the act be substantially related to the qualifications, functions, or duties of the occupation for which a license was issued.

Existing law provides that a psychotherapist who engages in sexual contact, as defined, with a patient or client, or with certain former patients or clients, is guilty of sexual exploitation, with certain exceptions. This bill would also apply that provision to a physician. The bill would specify that each act of sexual contact is a separate violation of the provision and would change the definition of "sexual contact." *[A. Health]*

LITIGATION

The Board of Psychology recently prevailed in obtaining an interim suspension of a psychologist's license, against a claim

that it lacks jurisdiction to suspend a license on an interim basis.

In late 1992, BOP filed a petition for interim suspension of Charles Catanese's license, alleging that Catanese—among other things—forcibly raped a female patient. Catanese charged that BOP lacked jurisdiction to seek an interim suspension of his license because of ambiguous language in Government Code section 11529. While that section, added by SB 2375 (Presley) (Chapter 1597, Statutes of 1990) *[10:4 CRLR 84]*, clearly authorizes the Medical Board and the Board of Podiatric Medicine to issue interim suspension orders, respondent claimed it does not so authorize the Board of Psychology or other allied health licensing programs which function under the jurisdiction of the Medical Board's Division of Allied Health Professions. On January 22, Administrative Law Judge (ALJ) Ralph Dash rejected respondent's contention and ruled that BOP is authorized to seek the interim suspension of a license, because section 11529 states that ALJs may issue interim orders "only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act *or the appropriate practice act governing each allied health profession*, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare" (emphasis added).

ALJ Dash's ruling was sustained even upon appeal to the superior court and the court of appeal.

RECENT MEETINGS

The Board elected its 1993 officers at its March 20 meeting. Dr. Bruce Ebert was selected Board Chairperson; Dr. Louis Jenkins was chosen as Vice-Chairperson; and public member Dr. Philip Schlessinger was selected Secretary.

Also on March 20, BOP Enforcement Coordinator Suzanne Taylor presented recent enforcement statistics. From July 1, 1992 to March 1, 1993, BOP had received over 400 complaints; this represents 3.4% of all licensed psychologists. Seventy-eight cases were pending at the complaint stage; 168 were under investigation; 90 were at the Attorney General's Office; and the licenses of 55 psychologists were on probation. Also from July 1, 1992 to March 1, 1993, 48 cases were referred to the AG's Office, compared to 42 during the entire previous fiscal year.

FUTURE MEETINGS

August 27–28 in San Diego.
November 12–13 in Sacramento.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards (916) 263-2666

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

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

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

At this writing, SPAEC is functioning with one audiologist vacancy and one public member vacancy which must be filled by the Assembly Speaker. Further, two Committee members (one audiologist and one public member) are serving in grace periods which expire on June 1. Governor Wilson recently appointed Li-Rong (Lilly) Cheng, Ph.D., as a speech-language pathologist member of SPAEC. Dr. Cheng is assistant dean of student affairs and international development at San Diego State University, and a professor of communicative disorders.

MAJOR PROJECTS

SPAEC Adopts Exam Waiver Criteria Regulation. After a hearing at its January 16 meeting, the Committee adopted proposed amendments to section 1399.159(b), Division 13.4, Title 16 of the CCR, to define the criteria it will apply in deciding whether to grant a request for an exam waiver under Business and Professions Code section 2532.2(e). *[13:1 CRLR 57; 12:4 CRLR 109–10]*

Essentially, the proposed amendment would permit an exam waiver for a candidate who has successfully passed the national exam and who (1) is licensed in another state, or (2) holds a certificate of clinical competence issued by the American Speech-Language-Hearing Association in the field for which licensure is sought, or (3) was previously licensed in California but whose license has lapsed, provided that the applicant can prove continuous employment in the field for which licensure is sought for three years immediately prior to the date on which the application is filed. "Continuous employment in the field for which licensure is sought" is defined as documented employment of not less than fifteen hours per week during the three years specified above, while maintaining a license in the state where the applicant was employed.

During the hearing, SPAEC member Dr. David Alessi again voiced concern about the lack of mandatory continuing education (MCE) requirements in the exam waiver regulation. As SPAEC is not currently authorized to require MCE of its own licensees, legal counsel stated that legislation would probably be necessary if the Committee wishes to require MCE from out-of-state candidates for licensure. Following further discussion, SPAEC approved the proposed regulation as drafted, with Dr. Alessi dissenting.

Upon review of the regulatory package, the Department of Consumer Affairs (DCA) insisted on some minor technical changes. At this writing, SPAEC expects to review and approve the modified language at its June 25 meeting, whereupon the regulatory package will be forwarded to the Office of Administrative Law for approval.

Other SPAEC Rulemaking. On May 7, SPAEC published notice of its intent to adopt other proposed changes to its regulations in Division 13.4, Title 16 of the CCR.

AB 3160 (Conroy) (Chapter 313, Statutes of 1992) amended Business and Professions Code section 2530.2 to specify that hearing screening is within the practice of speech-language pathology. *[12:4 CRLR 110]* Hearing screening involves no speech therapy. To ensure that licensure candidates who are completing their required professional experience (RPE) receive a broad range of experience, SPAEC seeks to amend section 1399.161(b) to specify that a maximum of 5% per week of hearing screening services provided by an RPE applicant in speech-language pathology shall be creditable toward the experience requirement.

SPAEC also seeks to amend section 1399.163 regarding the responsibilities of RPE supervisors, to specify that supervi-

sors must review and evaluate the RPE applicant's performance on a monthly basis for the purpose of improving his/her professional expertise. The RPE supervisor must discuss the evaluations with the applicant and maintain written documentation of these evaluations. The written evaluations shall be signed by both the RPE supervisor and the RPE applicant. If the supervisor determines the applicant is not minimally competent for licensure, the applicant must be so informed orally and in writing. A written statement documenting the basis for the supervisor's determination shall be submitted with the final verification of experience to SPAEC.

Finally, SPAEC seeks to amend section 1399.180, which identifies acts constituting unprofessional conduct. SPAEC plans to repeal subsection (c), which classifies as unprofessional conduct "[d]iagnosing or treating individuals for speech-language or hearing disorders by mail or telephone unless the individual has been previously examined by the licensee and the diagnosis or treatment is related to such examination." In its statement of reasons, the Committee stated that "[m]andating that a licensee personally examines each individual is unnecessarily restrictive and expensive for consumers. Current technology in speech-language pathology and audiology render this regulation as unnecessarily restrictive."

At this writing, the Committee is scheduled to hold a public hearing on these proposed regulatory changes on June 25.

SPAEC Implements Citation and Fine Program. At the Committee's January 16 and March 20 meetings, Executive Officer Carol Richards updated SPAEC on the implementation of the Committee's citation and fine program, which became effective as of March 1 and permits the Executive Officer to assess administrative citations against licensees and nonlicensees for minor violation of the Committee's enabling act and regulations. *[11:1 CRLR 79; 10:1 CRLR 85–86]* Category A violations, which may carry a fine ranging from $1,100–$2,500, include unlicensed practice and unprofessional conduct substantially related to the functions of a licensee. Category B violations, which may carry a fine ranging from $100–$1,000, include false and misleading advertising and failure to register an RPE candidate or aide. Richards issued three citations during March and April, two of which were for unlicensed practice. SPAEC is also pursuing twelve enforcement actions, which are pending at various stages of review and/or investigation.

LEGISLATION

AB 1392 (Speier), as amended April 4, would require SPAEC to notify DCA whenever any complaint has gone thirty days without any investigative action, and would require the DCA Director to determine when a backlog of complaints justifies the use of DCA staff to assist in complaint investigation. *[A. Floor]*

SB 993 (Kelley), as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information, and be presented to all legislative committees hearing the legislation prior to its enactment. *[S. B&P]*

SB 842 (Presley), as amended May 13, would permit SPAEC to issue interim orders of suspension and other license restrictions, as specified, against its licensees. (*See* agency update on DCA for more information.) *[A. CPGE&ED]*

RECENT MEETINGS

SPAEC elected its 1993 officers at its January 16 meeting. Speech-language pathologist Robert E. Hall was reelected Committee Chair, and audiologist Gail Hubbard was elected Vice-Chair.

At its March 20 meeting, SPAEC discussed structural changes taking place within the Medical Board and DCA. Most importantly, the Medical Board appeared on the verge of approving a proposal to abolish its Division of Allied Health Professions (DAHP), of which SPAEC is a constituent allied health licensing program. Uncertainty about the fate of SPAEC if DAHP is eliminated caused members to direct staff to closely monitor these discussions. [*Editor's Note:* At its May meeting, the Medical Board voted to seek legislation abolishing DAHP; *see* agency report on MBC for related discussion.]

Also in March, SPAEC heard a presentation by Dr. Norman Hertz of DCA's Central Testing Unit (CTU) regarding an occupational analysis of speech-language pathology and audiology. Such an analysis would determine the actual scope of practice of speech-language pathologists and audiologists, for the purpose of validating existing licensing examinations and possibly for the purpose of creating a new oral exam for SPAEC. Dr. Hertz explained that an occupational analysis would cost approximately $20,000 and take one year to complete. SPAEC approved a motion to pursue an occupational analysis.

FUTURE MEETINGS

October 8 in Sacramento.
January 7 in San Diego.
April 22 in Sacramento.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

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

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

At its February 9 meeting, BENHA welcomed two new members recently appointed by Governor Wilson. Jon Pynoos, Ph.D., is a professor at the Andrus Gerontology Center at the University of Southern California. Orrin Cook, MD, is a retired plastic surgeon and former medical