tural work shall be entitled to an examination for a certificate to practice landscape architecture." OAL noted that while BLA has the discretion to decide what constitutes "training and experience in actual practice of landscape architectural work," its interpretation of the meaning of that phrase must be a reasonable one which is consistent with existing statutory authority. Based on its finding that several of the provisions of section 2620 require candidates to have more than six years of training and experience in actual practice of landscape architectural work, OAL rejected the proposed section as inconsistent with Business and Professions Code section 5650.

BLA revised section 2620 to address OAL's concerns and released the modified text on November 14 for a 15-day public comment period. Although BLA was scheduled to consider the adoption of the new language at its December 6 meeting, the item was carried over until its January 17 meeting.

Other Regulatory Changes. On October 18, BLA conducted a public hearing on its proposed amendments to sections 2610, 2649, and 2671, Title 16 of the CCR. Proposed amendments to section 2649 would increase specified fees; the amendments to section 2671 would require that a landscape architect include his/her name and the words "landscape architect" in all public presentments; and the amendments to section 2610 would change the deadline for filing an application for the licensing exam from the current requirement of at least ninety days prior to the date of the examination to on or before March 15 of the year in which the application is made. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 83 for background information.)

Following the hearing, the Board adopted the amendments to sections 2610 and 2671; these amendments await review and approval by OAL. BLA postponed adoption of the amendments to section 2649 until its January 17 meeting.

ASLA Request for Determination Still Pending. At this writing, OAL has not released its response to a request for a regulatory determination submitted by the American Society of Landscape Architects (ASLA). Specifically, ASLA questions BLA's policy which allows applicants for its licensing test to qualify for the examination by meeting either education or experience requirements. OAL will determine if this policy is a "regulation" as defined in Government Code section 11342(b), and thus subject to the requirements of the Administrative Procedure Act. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 83 for background information.)

LEGISLATION:

AB 1996 (Campbell). Under existing law, in any action for indemnity or damages arising out of the professional negligence of a person licensed as a professional architect, engineer, or land surveyor, the plaintiff's attorney is required to attempt to obtain consultation with at least one professional architect, engineer, or land surveyor who is not a party to the action; the attorney is then required to file specified certifications. This bill would specify that these provisions also apply to actions arising out of the professional negligence of landscape architects. This bill is pending in the Assembly Judiciary Committee.

SB 173 (Bergeson). Under existing law, state and local agency heads may contract for specified services based on demonstrated competence and professional qualifications rather than competitive bidding. This bill would add landscape architectural services to the list of specified services. SB 173 is pending in the Senate Transportation Committee; however, its provisions were amended into ***SB 805 (Bergeson)***, which was signed by the Governor on August 2 (Chapter 314, Statutes of 1991).

Proposed Legislation. At its October meeting, BLA agreed to seek urgency legislation to eliminate the provision in Business and Professions Code section 5651 which requires its written examination to include testing of an applicant's knowledge of California plants and environmental conditions, irrigation design, and California laws relating to the practice of landscape architecture.

RECENT MEETINGS:

At its October 18 meeting, Executive Officer Jeanne Brode announced that the Department of Consumer Affairs declined to carry a continuing education (CE) bill for the Board during 1992. Thus, the Board created a task force consisting of one professional member, one public member, one Education Committee member, and three representatives from ASLA to formulate recommendations for possible legislation establishing statutory authority to require CE of BLA licensees.

Also at its October meeting, the Board discussed revising the definition of a landscape architect, noting that staff had received several letters from landscape architects urging such a change. As stated in Business and Professions Code section 5615, a person who practices landscape architecture is one who performs professional services for the purpose of landscape preservation, development, and enhancement, such as consultation, investigation, reconnaissance, research, planning, design, preparation of drawings, construction documents and specifications, and responsible construction observation. Section 5615 also provides that the practice of a landscape architect may include investigation, selection, and allocation of land and water resources for appropriate uses; feasibility studies; formulation of graphic and written criteria to govern the planning and design of land construction programs; preparation, review, and analysis of master plans for land use and development; production of overall site plans, landscape grading and drainage plans, irrigation plans, planting plans, and construction details; specifications; cost estimates and reports for land development; collaboration in the design of roads, bridges, and structures with respect to the functional and aesthetic requirements of the areas on which they are to be placed; negotiation and arrangement for execution of land area projects; and field observation and inspection of land area construction, restoration, and maintenance. ASLA lobbyist Dick Ratcliff stated that he participated in the drafting of the current definition and is aware of the potential for turf battles among various professions including contractors, engineers, and architects, should this matter be revisited.

Also at its October 18 meeting, BLA elected Larry Chimbole as Board president and Dan Johnson as vice-president for 1992.

FUTURE MEETINGS:

April 17 in Sacramento.
July 17 in Burbank.
October 16 in Sacramento.

MEDICAL BOARD OF CALIFORNIA

Executive Director: Ken Wagstaff
(916) 920-6393
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 nonphysicians 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, in Los Angeles, San Diego, San Francisco, and Sacramento. Individual divisions and subcommittees also hold additional separate meetings as the need arises.

DOL welcomed new member Dr. B. Camille Williams at its November meeting. Dr. Williams, 42, is a cosmetic surgeon currently in private practice in Orinda. Her appointment, which requires Senate confirmation, expires on June 1, 1994.

MAJOR PROJECTS:

Board Again Increases Licensing Fees to Finance Enhanced Discipline System. At its November 21 meeting, DOL held a public hearing on proposed amendments to sections 1351.5 and 1352, Division 13, Title 16 of the CCR, which would increase initial and biennial renewal licensing fees to $500 effective April 1, 1992. MBC just raised its licensing fees from $360 to $400 biennially in August 1991, but this minimal increase is insufficient to support the needs of MBC's disciplinary system and maintain a two-month reserve as required by law. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 84–85; Vol. 11, No. 3 (Summer 1991) pp. 82–84; and Vol. 11, No. 2 (Spring 1991) pp. 81–82 for extensive background information on SB 2375 (Presley) and MBC's enhanced discipline system.)

The fee increase is necessary primarily to support the new Health Quality Enforcement Section (HQES) of the Attorney General's Office, headed by Senior Assistant Attorney General Al Korobkin of the AG's San Diego office. Created by SB 2375 (Presley) (Chapter 1597, Statutes of 1990), HQES is currently staffed by approximately 22 attorneys statewide who specialize in prosecuting medical discipline cases on behalf of the Board and its allied health committees. However, based upon the number of discipline cases now flooding into the AG's office and the amount of time necessary to process and prosecute each, HQES is severely understaffed; Korobkin has proposed a budget change proposal (BCP) which would approximately double the number of attorneys handling medical enforcement cases.

At the November 21 hearing, Linda Ramsey of the California Medical Association testified that although CMA does not oppose the fee increase, it is concerned that the money generated be used to assist physicians through medical quality assurance activities and licensing. CMA stated that MBC should not use the increased funding on allied health profession discipline or licensing. MBC Executive Director Ken Wagstaff assured Ramsey that the money generated will be limited to physician enforcement and licensing, and will not be shared with the allied health programs. Ramsey also called upon DOL and MBC to inform all licensed physicians in California as to why these back-to-back increases are necessary. Following the public comment period, DOL unanimously approved the proposed fee increase amendments, which now await review and approval by the Office of Administrative Law (OAL).

Later, at the full Board's November 22 meeting, Korobkin and MBC Assistant Executive Director Tom Heerhartz discussed the AG's BCP in more detail. The BCP has been somewhat scaled back since its initial presentation in September; currently, HQES estimates that it needs an additional 27 positions—13 permanent attorney positions, 10 three-year limited-term attorney positions, and 4 paralegal positions—to enable it to handle its caseload. As a result of this adjustment, Executive Director Ken Wagstaff announced that the $500 fee increase may be delayed until July 1992. However, legislation to raise the Board's maximum fee ceiling to $600 biennially is needed, and another fee increase (to $550 biennially) will probably have to be imposed as of January 1, 1993. Following discussion, the full Board approved the fee increases and authorized staff to proceed with legislation to raise MBC's fee ceiling to $600 biennially.

Fines, Cost Recovery System Reconsidered. At its November meeting, DMQ received another report from staff on several revenue options other than increasing licensing fees. Specifically, staff discussed the possibility of implementing the Medical Board's existing authority to assess fines for minor statutory or regulatory violations, and/or creating a "cost recovery system" under which the Board could assess its investigative and other enforcement costs of a particular case against a disciplined licensee as part of his/her disciplinary order. Although staff has previously proposed these options, the majority of DMQ has repeatedly declined to entertain the notion of fining physicians; DMQ public member Frank Albino is usually the sole supporter of the concept. (See CRLR Vol. 11, No. 3

(Summer 1991) p. 84; Vol. 11, No. 2 (Spring 1991) p. 82; and Vol. 11, No. 1 (Winter 1991) p. 67 for background information.)

DMQ Enforcement Chief Vern Leeper presented a survey of the other 49 states and their use of fines and/or cost recovery: 34 states have statutory authority to assess fines or recover costs. The amounts of authorized fines range from $50 to $10,000. States with cost recovery authority usually assess both the costs of their investigation and hearing against a disciplined licensee.

After providing a summary of the advantages and disadvantages of each alternative, Leeper noted that neither fines nor cost recovery would recoup the total cost of the Board's enforcement program. However, public member Frank Albino stressed his view that every dollar recouped is a dollar saved. Dr. Michael Weisman opined that certain types of investigations and violations might be more appropriate for cost recovery than others. Dr. John Kassabian voiced opposition to cost recovery, arguing that a physician who wishes to vigorously defend him/herself may be deterred from exercising that right out of fear that costs may be assessed if he/she loses. Following discussion, DMQ appointed a subcommittee consisting of Drs. Clarence Avery and John Kassabian to study the matter with staff. The subcommittee will report back to DMQ at a future meeting.

MBC Enforcement Matrix Update. At DAHP's November meeting, Assistant Executive Director Tom Heerhartz presented the latest version of MBC's "enforcement matrix"—a computer display of key enforcement statistics of DMQ's physician discipline program and the enforcement programs of all the allied health licensing boards and committees. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 88 for background information.)

The matrix indicates that, as of November 19, a total of 5,603 complaints were pending against physicians and allied health professionals at various stages of the system; the matrix then provides a breakdown of complaint accumulations at each stage of the process. For example, 13 newly-arrived cases awaited assignment to a consumer services representative (CSR) in MBC's Central Complaint and Investigations Control Unit (CCICU); 1,577 complaints were assigned to and pending with a CSR; 2,358 complaints were under investigation; 305 complaints were being reviewed by a medical consultant; 187 complaints were pending with the Executive Officer of the various agencies; and 1,160 complaints had been forwarded to and were pending in the AG's office for preparation of an accusation and prosecution.

At DAHP's September meeting, Drs. Jacquelin Trestrail and John Tsao had requested that the matrix be modified to incorporate the age of pending complaints, or the average time a complaint spends at each of the various steps. Such "aging data" is required for physician complaints, as the Board is under a legislative directive to investigate and dispose of complaints about physicians within six months of their receipt—either by dismissal, warning, or forwarding to the AG's office for preparation of an accusation. The matrix presented at the November meeting failed to include any information as to the length of time complaints spend at any particular stage; Heerhartz expressed confidence that such data will be available and included in the next published enforcement matrix.

Additions to Disciplinary Guidelines Proposed. At its November meeting, DMQ considered three proposed additions to its disciplinary guidelines presented by MBC staff counsel Foone Louie. The first addition would bar a physician whose license is on probation from supervising physician assistants. A subcommittee consisting of Dr. Andrew Lucine and public member Theresa Claassen was formed to communicate with DAHP and investigate the need for such a prohibition. The second addition, authorized by SB 2375 (Presley) (Chapter 1597, Statutes of 1990), would require probationers to inform their patients of any relevant restrictions on their practice when a particular procedure is necessary. According to Louie, this disclosure requirement would preclude a physician who is so restricted from "stringing a patient along" while delaying a procedure rather than telling the patient that he/she cannot do it. DMQ formed another subcommittee, consisting of Dr. Michael Weisman and public member Gayle Nathanson, to study the need for the proposed requirement. The third proposed addition, which would require probationers to inform their treating physicians of any history of drug abuse, was rejected.

Implementation of SB 2036. SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) amended Business and Professions Code section 651 to provide that a physician licensed by MBC may include a statement in his/her advertising that he/she is certified or eligible for certification by a private or public board or parent association if that board or association is a member of the American Board of Medical Specialties (ABMS), a board or association with equivalent requirements approved by MBC, or a board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training (PGT) program that provides complete training in that specialty or subspecialty. After several months of preliminary implementation by DOL, DMQ held a public hearing on November 20 in San Diego to receive comments on the proposed addition of section 1363.5 to Chapter 13, Title 16 of the CCR, to guide DOL's approval of specialty/subspecialty boards for purposes of physician advertising. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 85-86 and Vol. 11, No. 3 (Summer 1991) pp. 86-87 for extensive background information.)

Under the proposed regulation, only physicians who are in fact certified by an acceptable specialty board may so advertise. The regulation sets forth detailed standards as to size, purpose, governance, activities, and revenue sources of acceptable specialty boards. Any non-ABMS member specialty board which does not have a PGT program approved by ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC) shall require all applicants seeking certification to have satisfactorily completed an ACGME- or RCPSC-accredited PGT program which includes identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification. If the training required of applicants seeking certification by the specialty board is other than ACGME- or RCPSC-accredited PGT, then the specialty board shall have training standards equivalent in scope, content, and duration to those of an ACGME- or RCPSC-accredited program in a related specialty or subspecialty. Equivalent standards may include a minimum of six years of full-time practice in the specialty or subspecialty area of medicine which is approved under sections 1337 and 1337.5 of Division 13, Title 16 of the CCR. The specialty board shall also require physicians seeking certification to successfully pass a written and/or oral examination which tests the applicants' knowledge in the specialty or subspecialty area of medicine. All examinations shall be subject to a psychometric evaluation, and shall be a minimum of 16 hours in length. Those specialty boards which require prior passage of an ABMS examination in a related specialty or subspecialty area as a prerequisite for certification may grant

up to eight hours' credit toward the 16-hour testing requirement.

The hearing elicited extensive comment from physicians arguing that the regulation should be modified in two ways. First, several witnesses voiced concern that the regulation would allow continuing education as one source from which acceptable specialty boards must derive 80% of their revenue. They felt that boards responsible for certification should not be involved in continuing education, because overlap in these areas poses a conflict of interest. Second, many witnesses desired a mechanism whereby a board may request approval and recognition as a specialty board whose members would then be authorized to advertise board certification. DMQ agreed and approved the regulation subject to modifications which delete the reference to income from continuing education and add a preapproval mechanism for specialty boards. The modified text was released for an additional 15-day public comment period ending December 23. MBC's SB 2036 Committee was scheduled to meet on January 13 and February 25 in Torrance to accept additional testimony on the proposed regulation; DMQ will hear final testimony and formally adopt the proposed regulation later in the spring.

DOL Resubmits Section 1324 Training Program Regulations. At its November meeting, DOL discussed modifications to its proposed regulatory amendments to sections 1324 and 1325.5, Division 13, Title 16 of the CCR. Section 1324 provides an alternative training route, commonly known as a "section 1324 program," for foreign medical graduates (FMGs) who have difficulty securing an ACGME-approved PGT program. While CMA and all medical schools in California called for repeal of section 1324 and abolition of the alternative PGT programs, DOL instead adopted amendments which purport to improve the programs toward equivalence with ACGME standards and enhance their credibility. The controversial regulatory package was originally adopted in November 1990, but was subsequently rejected by Department of Consumer Affairs (DCA) Director Jim Conran in July 1991 and OAL in August 1991. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 86–87; Vol. 11, No. 1 (Winter 1991) p. 69; and Vol. 10, No. 4 (Fall 1990) p. 83 for extensive background information.)

During the fall, DOL representatives met with DCA staff to iron out changes to the regulations, and DOL forwarded proposed modifications to the regulations to DCA. However, in a November 13 memo, DCA Deputy Director Anne Sheehan concluded that the Division failed to achieve its stated goals of augmenting the criteria for DOL approval of section 1324 programs so that they are equivalent to the standards of the ACGME, and to ensure that all hospitals approved to conduct section 1324 training programs provide a uniform training experience to applicants for licensure. Sheehan noted that "the internal organization of the various new subsections and the new language tends to create unclear or unenforceable standards, or no standards at all, or are internally inconsistent. . . . These problems directly impact public health, safety and welfare." Specifically, Sheehan pointed to the following flaws in the modified language:

-The language regarding staff teacher requirements was made permissive instead of mandatory, as was formerly proposed. This raises equivalency and uniformity issues with regard to the training received by students.

-Numerous terms are undefined. For example, with regard to a health facility sponsoring a section 1324 program, one of the requirements is that the facility "accept responsibility for the medical education and training of trainees. . . ." The term "accept responsibility" could mean legal, financial, or professional responsibility. There is no definition or indication as to how the Board can measure compliance with such standards.

-The modifications fail to amend the provision enabling the health facility to charge the trainee fees for the training, in spite of the fact that OAL raised the issue in its disapproval of the rulemaking file.

-The medical director of the program must meet certain mandatory requirements; however, the language fails to clearly define them and makes compliance difficult, if not impossible, to achieve.

-The regulations appear to give unrestricted discretion to the medical director to select trainees and teaching staff; this absence of standards does not achieve equivalency with ACGME standards or uniformity of training.

-One subdivision specifies mandatory responsibilities for all trainees. However, these responsibilities are unclear, vague, difficult to enforce, and—from an individual rights perspective—perhaps even illegal.

-The certificate of completion is issued after an evaluation of the performance of the trainee; however, no criteria for this evaluation are established.

-Certain subsections are unclear and appear to be misplaced. There are technical inaccuracies with words and verb tenses as well as mislettering of the sections.

At the November meeting, DOL discussed Sheehan's memo and deliberated on resubmittal of the regulations. Ken Wagstaff characterized the memo from Sheehan as "nitpicking," prompting a response from Karen McGagin, Special Assistant to the Director of Consumer Affairs, who was in the audience. McGagin defended the Department's memo as expressing valid concerns, and strongly suggested that the Division work with DCA to alleviate its concerns. Dr. J. Alfred Rider cautioned DOL against appearing insensitive and stated that the Division should look into DCA's concerns. Rider appointed himself and Dr. John Lungren as a subcommittee to work with DCA.

The next day, in a hand-delivered letter, the Center for Public Interest Law asked Dr. Rider to recuse himself from participation on the subcommittee and all DOL discussion and decisionmaking on the section 1324 issue. The Center contended that because Dr. Rider runs a section 1324 program at his facility in San Francisco, he has—at the very least—an apparent conflict of interest. Rider had excused himself from the original decision on the section 1324 regulations in November 1990 at the request of the Center and upon the advice of his attorney.

Rider explained that "it is no secret" that he operates a 1324 program; he asserted that he receives no financial benefit from the program and that he has only discussed the issue at DOL meetings in general terms. Rider then excused himself from the room and turned the meeting over to Dr. Lungren, who appointed himself and public member Ray Mallel to work with DCA on the regulations.

The subcommittee and DOL staff subsequently modified the regulatory package and resubmitted it to OAL on December 23—but without resubmitting it to DCA first for approval, as required by law. This failure makes OAL approval unlikely.

Other DOL Rulemaking. At its November 21 meeting, DOL held a public hearing on a proposed amendment to section 1327, Chapter 13, Title 16 of the CCR. The section currently requires California hospitals to obtain DOL's approval before they provide clinical training to foreign medical students or graduates. The amendment would exempt hospitals which have a major affiliation with an approved California medical school and facilities with ACGME-accredited PGT programs. (See CRLR Vol.

11, No. 4 (Fall 1991) p. 87 for background information.) Following the hearing, DOL approved the amendment, which now awaits review and approval by DCA and OAL.

DOL Adopts Report to Legislature and Plans Legislation to Increase Required Postgraduate Training. For over two years, DOL has been considering whether to seek legislation which increases the PGT required for licensure from the existing one-year requirement to two or more years. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 86; Vol. 11, No. 3 (Summer 1991) p. 85; and Vol. 11, No. 2 (Spring 1991) pp. 82–83 for detailed background information.) Assembly Bill 3272 (Filante) (Chapter 1629, Statutes of 1990) required the Board to submit a report to the Assembly Health Committee by January 1, 1992, setting forth a variety of options which would increase the PGT requirements for applicants for California licensure. At its November meeting, DOL approved the final report to the legislature. The alternative selected by DOL as the most appropriate method to increase the PGT requirement in California is the following:

(1) All applicants applying for a California physician and surgeon certificate must complete three years of approved (U.S./Canadian accredited) clinical training, one of which must be at the postgraduate level.

(2) If an applicant has not completed two years of approved clinical training at the undergraduate level, two years of approved PGT must be satisfactorily completed in order to qualify for a physician and surgeon certificate.

(3) Any applicant attempting to qualify for licensure under (2) above and who has completed a minimum of one year of approved clinical training at the postgraduate level may be considered for a provisional physician and surgeon certificate which will allow him/her to begin the practice of medicine to the extent that it is incident to and a necessary part of the resident's duties as approved by the training program. The provisional certificate would be valid until all the approved clinical training requirements have been met.

The impact of this proposed legislation would appear to require most foreign medical graduates to complete at least two years of approved PGT prior to becoming eligible for full and unconditional licensure in California; it also precludes those who must complete two years of PGT from "moonlighting" during the second year of PGT—that is, becoming fully licensed at the end of the first year and working as a physician at a facility other than the training facility during the second year. Thus, graduates of U.S. and Canadian medical schools with approved undergraduate clinical training programs may become fully licensed after one year of PGT and moonlight during any remaining years of their residency; graduates of foreign medical schools must complete at least two years of approved PGT before being eligible for licensure and may not moonlight until they are fully licensed.

At its November meeting, the Division formally agreed to sponsor this legislation during 1992, a decision that met with resistance from a residency association. Dr. William Lye, a resident at UCLA and the vice-president of the California House Officers Medical Society (CHOMS), stated that residents oppose this legislation. Lye said CHOMS is not against additional training requirements for foreign medical graduates when the need has been shown; however, CHOMS believes the Division has failed to show any need for this legislation, which may affect many residents who will be unable to progress with work that requires licensure. He explained that some people who have had one year of training may be well qualified and others who have had two years may not be; singling out one group in a blanket fashion is not warranted. Lye also noted that DOL's recent revisions to the PGT completion form (the "L3 form") which must be completed by the medical director of the training facility should enable DOL to make informed licensing decisions without subjecting some residents to an additional year of PGT.

The Division responded that the L3 form revision may not effectively address concerns about inadequate training (see below). Ken Wagstaff suggested that the Division wants to be on the safe side, because more and more licensees come out of the international pool where the training standards are often inferior to those in the United States. Public member Ray Mallel added that the Division is not an international monitoring body and this legislation would make the Division more comfortable in licensing certain individuals. The Division agreed to proceed with the legislation.

CMA Survey on L3 Form Indicates Changes May Not Be Effective. In September, DOL adopted guidelines and definitions which are to be followed by the Director of Medical Education at a residency institution in completing the "L3 form" for certifying that an applicant has satisfactorily completed a PGT program. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 86; Vol. 11, No. 3 (Summer 1991) p. 85; and Vol. 11, No. 2 (Spring 1991) pp. 82–83 for background information.) In a letter dated October 31, 1991, Dr. William K. Hamilton, Chair of CMA's Committee on Medical Schools, wrote that "in our view, whether the wording is changed is basically irrelevant." At DOL's November meeting, CMA representatives explained that the results of a survey of medical directors indicate that no matter what the wording of the L3 form is, a medical director still may sign the form when a resident has not in fact satisfactorily completed a residency program because he/she is afraid of being sued by the resident if he/she gives a negative response. CMA suggested that DOL co-sponsor legislation with CMA to expand liability protection for those who provide the Board with negative information on licensure candidates. This would presumably ensure more candid assessments from medical directors. At this writing, the Division has not agreed to co-sponsor such legislation.

Update on DAHP Rulemaking. Following is an update on several rulemaking proceedings recently undertaken by DAHP:

-Medical Assistants. DAHP has been engaged in defining the technical supportive services which may be performed by medical assistants (MAs) since the passage of SB 645 (Royce) (Chapter 666, Statutes of 1988). At this writing, DAHP's MA regulations (proposed sections 1366–1366.3, Chapter 13, Title 16 of the CCR) have been rejected by OAL once and DCA twice—most recently by DCA Director Jim Conran in August 1991. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 87–88; Vol. 11, No. 3 (Summer 1991) p. 87; and Vol. 10, No. 4 (Fall 1990) p. 82 for background information.) At the Division's November 22 meeting, DCA legal counsel Greg Gorges reported that the MA regulations had been modified, released for a 15-day public comment period which ended on October 7, and were then pending on Conran's desk. Gorges noted that Conran may still insist on further modifications, but expressed confidence that most major issues had been resolved.

-Physician Assistant Scope of Practice. DAHP's proposed regulatory changes to sections 1399.541, 1399.543, and 1399.545, Division 13.8, Title 16 of the CCR, which define the scope of practice of physician assistants (PAs), have been rejected by OAL three times. In its most recent September 1991 rejection, OAL instructed the Division to

submit the regulatory changes to DCA Director Jim Conran for approval, as they have been significantly amended since being reviewed by Conran's predecessor, Michael Kelley, who disapproved them in October 1990. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 96; Vol. 11, No. 1 (Winter 1991) p. 75; and Vol. 10, No. 4 (Fall 1990) p. 90 for background information.)

Thus, DAHP modified the proposed regulatory changes and submitted them in late October to Conran, who disapproved them in November. Frustrated at DCA's actions, DAHP overrode Conran's rejection by unanimous vote at its November 22 meeting; the Division submitted its PA regulations to OAL for approval on December 30. (*See infra* agency report on PHYSICIAN ASSISTANT EXAMINING COMMITTEE for related discussion.)

OMD v. DOM Revisited. At its November meeting, DAHP once again addressed the OMD/DOM controversy. Under a 1988 Attorney General's Opinion, acupuncturists are permitted to use the acronym DOM (Doctor of Oriental Medicine), but may use the acronym OMD (Oriental Medical Doctor) only if accompanied by an explanatory amendment. DAHP is aware of numerous violations of this rule, and has threatened to seek legislation forcing compliance. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 88; Vol. 9, No. 2 (Spring 1989) p. 63; and Vol. 9, No. 1 (Winter 1989) p. 53 for background information.)

At its November meeting, DAHP reviewed eight titles suggested by the Acupuncture Committee and intended to clarify the OMD title usage. The Division rejected two of them but approved the following: [name], Lic. Ac., OMD; Licensed Acupuncturist, OMD; Certified Acupuncturist, OMD; OMD, Lic. Ac.; OMD, Licensed Acupuncturist; and OMD, Certified Acupuncturist. DAHP agreed that if the Acupuncture Committee agrees to drop the two unacceptable titles, the other six are automatically approved. If the Committee decides against this option, DAHP will take further action at its January meeting.

LEGISLATION:

AB 1084 (Filante), as amended April 10, is the California Medical Association's (CMA) controversial bill which would enable it to revive its Medical Practice Opinion Program in such a way as to immunize it—theoretically—from tort and antitrust liability. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 87; Vol. 11, No. 2 (Spring 1991) p. 81; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 99 for detailed background information on this issue.) This bill is pending in the Assembly Judiciary Committee.

AB 1691 (Filante), as amended May 8, would require, on or after July 1, 1993, every health facility operating a PGT program to develop and adopt written policies governing the working conditions of resident physicians. AB 1691 was rejected by the Assembly on June 27; it is pending in the Assembly inactive file.

AB 1199 (Speier), as amended May 30, would prohibit, on or after January 1, 1992, a health facility operating a PGT program from allowing any resident physician in that training program to work, either in clinical or didactic duty, in excess of certain prescribed hour limits. This bill is pending in the Assembly Ways and Means Committee.

AB 2180 (Felando), as amended May 30, would amend SB 2036 (McCorquodale) by prohibiting a person certified by an organization other than a board from using the term "board certified" in reference to that certification. This bill is pending in the Business and Professions Committee.

AB 569 (Hunter), which would permit MBC to take action to implement SB 2036 (McCorquodale) on or after January 1, 1992, is pending in the Senate Business and Professions Committee.

SB 664 (Calderon) would prohibit physicians, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

AB 992 (Brulte), which would require medical experts testifying in medical malpractice actions against a physician to have substantial professional experience in the same medical specialty as the defendant, is pending in the Assembly Judiciary Committee.

SB 1119 (Presley). Existing law requires the district attorney, city attorney, or other prosecuting agency to notify MBC of any filings against a physician charging a felony, and the clerk of the court in which an MBC licensee is convicted of a crime is required to transmit a copy of the record of conviction to the Board. As amended April 30, this bill would expressly limit the transmittal duties of the clerk of the court to felony convictions. This bill is pending in the Assembly Health Committee.

AB 14 (Margolin), which, as amended May 14, would enact the Health Insurance Act of 1991 for the purpose of ensuring basic health care coverage for all persons in California, is pending in the Senate Rules Committee.

AB 190 (Bronzan), as amended September 3, would require a physician to give each patient a copy of the relevant standardized written summary describing the advantages, disadvantages, risks, possible side effects of, and the conditions for which the federal government has approved silicone implants and injections and collagen injections used in plastic, reconstructive, or similar surgery, before the physician performs the surgery. This bill is pending in the Senate Business and Professions Committee.

AB 465 (Floyd). Existing law provides general civil immunity to persons who provide information to MBC or the Department of Justice indicating that an MBC licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to certain activities of specified health care organizations. This bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This bill is pending in the Senate Judiciary Committee.

AB 112 (Kelley) would exempt a physician from liability for any negligent injury or death caused by an act or omission of the physician in rendering medical assistance, when the physician in good faith and without compensation or consideration renders voluntary medical assistance at a clinic or long-term health care facility. AB 112 is pending in the Assembly Judiciary Committee.

AB 117 (Epple), as amended April 2, would exempt licensed health care providers from liability for any negligent injury or death caused by an act or omission of the health care provider in rendering the medical assistance, who in good faith and without compensation or consideration renders voluntary medical assistance at a shelter. This bill, which would sunset on January 1, 1997, is pending in the Assembly Judiciary Committee.

AB 566 (Hunter), as amended July 11, would prohibit any person from practicing or offering to practice perfusion for compensation received or expected to be received, or from holding himself/herself out as a perfusionist, unless at the time of doing so the person holds a valid, unexpired, unrevoked perfusionist license. This bill is pend-

ing in the Senate Business and Professions Committee.

AB 704 (Speier), as amended July 11, would require DMQ, when undertaking a review of a physician's practice during any investigation pursuant to the Medical Practice Act, to ensure that the review is accomplished by peers of the subject physician. This bill is pending in the Senate Business and Professions Committee.

AB 1183 (Speier) would require MBC to develop a California Indigent Obstetric Care Indemnification Program, requiring the program to provide prescribed state indemnification for malpractice claims against a physician who provides obstetric or gynecological care to patients at least 10% of whom are enrolled in Medi-Cal or other indigent care programs, and who has at least $100,000 in malpractice coverage. This bill is pending in the Assembly Judiciary Committee.

AB 2222 (Roybal-Allard) would provide that the reviewing of X-rays for the purpose of identifying breast cancer or related medical disorders without being certified as a radiologist qualified to identify breast cancer or related medical disorders by a member board or association of the American Board of Medical Specialties, or a board or association with equivalent requirements approved by MBC, constitutes unprofessional conduct. This bill is pending in the Assembly Health Committee.

SB 1190 (Killea), as amended July 17, would enact the Licensed Midwifery Practice Act of 1991, establishing within DAHP a five-member Licensed Midwifery Examining Committee, which would be required to adopt reasonable rules and regulations to carry out the Act. This bill, which would also provide that a physician shall not be liable for independent acts of negligence by a licensed midwife, is pending in the Senate Appropriations Committee.

AB 819 (Speier) would provide that, effective July 1, 1992 and subject to specified exceptions, it is unlawful for specified licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure of the ownership or proprietary interest would not exempt the licensee from the prohibition. This bill is pending in the Assembly Health Committee.

Future Legislation. At the Medical Board's November meeting, the divisions discussed numerous legislative changes each intends to pursue during 1992. DMQ voted to proceed with a number of proposals to enhance the physician discipline system, including the following:

-an amendment to Business and Professions Code section 2225 to make it unprofessional conduct for a physician to fail to produce copies of patient records within fifteen days of receipt of an investigative subpoena or a request coupled with the patient's authorization;

-an amendment to Health and Safety Code section 1795.10 (the Patient Access to Health Records Act) to entitle the Medical Board to receive copies of medical records from health providers within fifteen days of request;

-an amendment to Business and Professions Code section 2337 to enable a superior court which is reviewing a Medical Board disciplinary action to use the "substantial evidence" test instead of the currently-used "independent judgment" test. This change, originally suggested by the Center for Public Interest Law in SB 2375 (Presley), would expedite court review of DMQ's disciplinary decisions and require courts to affirm the Division if there is substantial evidence to support its decision;

-the addition of section 633.2 to the Penal Code, to permit MBC investigators to use electronic recording equipment during investigations independently and without securing the permission and equipment of specified law enforcement officers, such as a district attorney or the Attorney General;

-an amendment to Business and Professions Code section 2240 to make it (in addition to unprofessional conduct) a criminal offense to treat a patient while intoxicated;

-an amendment to Business and Professions Code section 2052 and the repeal of section 2053, to make the unlawful practice of medicine a "wobbler" offense which may be charged either as a misdemeanor or felony; and

-an amendment to Business and Professions Code section 2307 to enable MQRCs to make final decisions on petitions for reinstatement, modification of probationary terms, or early termination of probation. Presently, these MQRC decisions are proposed decisions subject to review by DMQ.

DMQ deferred until its January meeting discussion of a proposal to add section 730 to the Business and Professions Code, which would enable DMQ to require a licensee to attend a meeting to discuss a complaint or adverse report; failure to attend would constitute unprofessional conduct. At the recommendation of staff, DMQ also voted not to pursue a previously-approved amendment to a disputed provision of SB 2375 (Presley) which requires DMQ to establish a goal of completing its investigation of cases in an average of six months from receipt. DMQ previously decided to seek an amendment to Business and Professions Code section 2319 to clarify that the six-month period does not begin to run until DMQ decides a complaint merits investigation; however, that amendment was dropped at the November meeting. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 84 and Vol. 11, No. 3 (Summer 1991) pp. 82–84 for background information.)

At its November meeting, DOL decided to pursue the following legislative changes during 1992:

-an amendment to require an additional year of approved PGT where the candidate's undergraduate clinical training is unapproved (*see supra* MAJOR PROJECTS);

-a technical amendment to Business and Professions Code section 2089.5 to clarify hospital affiliation requirements for foreign medical school clerkships;

-amendments to Business and Professions Code sections 2176, 2177.5, 2183, and 2184 to enable DOL to accept the new United States Medical Licensing Examination (USMLE) in the future. The USMLE will be a national licensing exam which will replace the existing Federation Licensing Examination (FLEX) and the examinations of the National Board of Medical Examiners (the so-called "national boards");

-an amendment to SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) to preclude physicians from advertising that they are "board certified" unless they state clearly and prominently the name of the specialty they claim. At DOL's November meeting, CMA representative Tim Shannon voiced opposition to this proposal, noting that DMQ is currently in the process of adopting comprehensive regulations to implement SB 2036, which should address this problem (*see supra* MAJOR PROJECTS); and

-another amendment to SB 2036 to permit DOL to charge a fee for specialty board applications, so it might recoup the costs of implementing the SB 2036 specialty board advertising program.

At its November meeting, DAHP approved draft legislation for three of its constituent agencies—the Board of Podiatric Medicine, the Board of Psychology, and the Speech-Language Pathology and Audiology Committee (*see infra* agency reports on these boards for details).

RECENT MEETINGS:

The highlight of the full Board's November 22 meeting was MBC's discussion of the Federation of State Medical Boards' (FSMB) October 4 adoption of a formal policy statement on prevention of the transmission of the human immunodeficiency virus (HIV) and hepatitis B virus (HBV) from health professional to patient. In its policy statement, FSMB urges states to adopt and follow the guidelines established by the federal Centers for Disease Control (CDC) for preventing the transmission of the HIV and HBV virus in the health care setting. Specifically, FSMB recommends that state laws should (1) require that physicians who perform "exposure-prone invasive" procedures (*e.g.*, surgery) know their HIV and HBV status; (2) require infected physicians to so report and register confidentially with their state medical board; (3) establish practice guidelines for HIV- and HBV-infected physicians; (4) require state medical boards to restrict and monitor the practices of infected physicians; and (5) require state medical boards to discipline any physician who violates the statutes or rules implementing CDC's guidelines.

CMA representatives expressed outrage at what they characterized as the "police state approach advocated by the Federation." CMA contends that there is "very little, if any, scientific evidence to support the contention that patients are at risk of contracting HIV from health care professionals," and criticized FSMB and CDC's "unscientific approach to this issue and their recent request that a list of 'exposure-prone' procedures be developed." CMA believes that the identification of such procedures is problematic, and has refused to assist CDC in developing such a list. Dr. Roger Kennedy, a member of CMA's AIDS advisory committee, told MBC that FSMB's policy is "totally based on public opinion and not based on science," and opined that mandatory testing of health professionals is "intrusive, cumbersome, terribly expensive, and confidentiality almost certainly would be lost."

During discussion of the issue, MBC public member Bruce Hasenkamp noted that SB 1070 (Thompson) (Chapter 1180, Statutes of 1991) requires the state Department of Health Services to promulgate guidelines and regulations to minimize the risk of transmitting the HIV and HBV virus in the health care setting by January 1993; it further requires MBC to ensure that its licentiates are informed of DHS' regulations, and makes a knowing violation of the guidelines unprofessional conduct and grounds for discipline. Public member Alfred Song acknowledged the sensitivity of the issue but urged his colleagues not to summarily dismiss the Federation's proposal; he called on the Board to formulate a well-reasoned response to the Federation's stance. Physician member Dr. John Tsao noted that failure to respond to FSMB's policy statement might be interpreted as tacit approval; Dr. Rider suggested the formation of a subcommittee to study the issue.

Following discussion, the Board approved a motion to send a letter thanking the Federation for making its position known and stressing that the Board looks forward to full discussion of the matter at future meetings. The Board also decided to invite DHS Director Dr. Molly Joel Coye to address the Board at its January meeting on DHS' progress toward compliance with SB 1070 (Thompson).

At its November meeting, DAHP held its Quarterly Allied Health Professions Forum, at which Board of Podiatric Medicine (BPM) Executive Officer James Rathlesberger addressed the Division. Rathlesberger explained that because podiatrists are physicians and not "allied health professionals," BPM licensees feel strongly about transferring the Board from DAHP's oversight or changing the name of the Division to reflect the proper status of podiatrists. Rathlesberger suggested that DAHP change its name to the "Division of Health Professionals" or something similar. DAHP decided to put this matter on its January agenda for further discussion.

At DOL's November meeting, Dr. Robert del Junco suggested that DOL create a program to educate potential licensees on the Medical Board and noncompetency aspects of the practice of medicine in California. Del Junco recently attended the Board's oral examination and recognized that most candidates for licensure are unfamiliar with the function of the Board. DOL assigned del Junco and Dr. Fred Milkie to work with staff to develop a questionnaire to survey licensure applicants as to their knowledge of the Medical Board's role.

At its November meeting, DMQ received a report from Diversion Program Manager Chet Pelton. DMQ is authorized to divert alcohol- and drug-abusing physicians into its Diversion Program for rehabilitation and monitoring, as an alternative to disciplinary proceedings. As of October 1, there were 251 active participants in the program. Since the program began in 1980, 326 participants have successfully terminated the program; terminations for other reasons total 161, including 72 for noncompliance. A survey conducted in January 1990 indicated that of the 247 physicians then in the program, 131 (53%) had hospital privileges.

At its November meeting, MBC held its annual election of Board officers. Dr. C. Fredrick Milkie was elected Board president; Frank Albino was voted vice-president; and Bruce Hasenkamp was elected secretary. Each of the divisions also selected 1992 officers. DOL elected Dr. J. Alfred Rider as president, Dr. John Lungren as vice-president, and Audrey Melikian as secretary. DMQ re-elected Frank Albino as president, and selected Dr. John Kassabian as vice-president and Theresa Claassen as secretary. DAHP elected Dr. Madison Richardson as president, Alfred Song as vice-president, and Bruce Hasenkamp as secretary.

FUTURE MEETINGS:

May 7–8 in Sacramento.
July 30–31 in San Francisco.
November 5–6 in Los Angeles.

ACUPUNCTURE COMMITTEE

Executive Officer: Lynn Morris
(916) 924-2642

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.

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 on and after July 1, 1990, and 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 sets standards for acupuncture schools, monitors students in tutorial programs (an alternative training method), and handles complaints against schools and practitioners. 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.

MAJOR PROJECTS:

Four Committee Members Resign During Meeting Over Exam Contractor Controversy. At AC's December 12 meeting, four of the Committee's nine members abruptly resigned during yet another controversy over AC's examination. As a result of the 1989 bribery scandal in which Committee member Dr. Chae Woo Lew sold AC's licensing examination to hundreds of licensure applicants over a five-year period, AC is now precluded from drafting or administering its licensing examination; until 1995, it is required to hire an independent contractor to prepare and administer its examinations. From 1990 until September 1991, Hoffman Research Associates (HRA) was AC's exam contractor.

The chain of events leading to the mass resignation began at a special AC meeting on September 19, when the Committee chose National Credential Clearinghouse (NCC) as its new exam consultant for 1992–93, based upon the recommendation of the Evaluation Committee established to review the bids in response to AC's request for proposals (RFP). The Evaluation Committee consisted of AC Executive Officer Lynn Morris, AC Chair Lam Kong, DCA counsel Don Chang, Dr. Norman Hertz of DCA's Central Testing Unit, and Stan Glaser of DCA's Contracts Unit. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 93 for background information.) The other bidders—including HRA and the Western Institute of Traditional Chinese Medicine—protested the award, alleging irregularities in the bidding process. HRA subsequently withdrew its protest, and the Department of General Services (DGS) scheduled a hearing on the Western Institute's claim.

At AC's October 17 meeting, while awaiting the outcome of DGS' hearing, the Committee noted that the delay in awarding the contract might lead to a delay or cancellation of its 1992 exam. Thus, AC unanimously voted to delegate its authority to approve and sign the contract with NCC to Executive Officer Lynn Morris, AC Chair Lam Kong, and AC member Leona Yeh, in the event of a favorable decision by DGS. The Department subsequently reviewed the protest and AC's response, concluded that the bidding process was properly conducted, and denied the protest.

However, AC held an emergency meeting on November 18. Only five members attended; the others were unable to attend based upon the short notice given. During the emergency meeting, four AC members—Chair Lam Kong, Mason Shen, Sophia Peng, and Janny Shyr—accused Executive Officer Lynn Morris of bias in the contract selection. Their contention was based on the allegations of Frank Garcia, a former AC employee who drafted the request for proposals (RFP) for the exam contract. In statements on November 18 and in a subsequent November 26 memo to Lam Kong, Garcia alleged that Morris had publicly stated that she did not like HRA and wanted the RFP drafted so that HRA could not win. Garcia also questioned the composition of the Evaluation Committee created to review the bids, and contended that Morris attempted to "stack" the Committee to exclude AC members and favor NCC. The AC members present at the meeting voted 4–0, with one abstention, to reject the Evaluation Committee's recommendation. The Committee took no action on awarding the contract, and decided to address the matter at its regularly scheduled December 12 meeting.

On December 3, Lam Kong stirred up the acupuncture community by mailing a memorandum to all acupuncture schools and acupuncturists detailing his reasons for pursuing Garcia's allegations against Morris. He expressed concern that he was the only acupuncturist on the Evaluation Committee, and contended that Morris had "misled" and "misinformed" him and the other AC members about the required composition of the Evaluation Committee. Kong also alleged that NCC is "a firm with no phone listing, no prior experience as a firm, an unlocatable place of business and, by its own admission, only one full-time staff person. . . . This firm has never before administered a state exam!"

The December 12 fireworks began before the meeting started. Lam Kong brought his attorney, Richard Rosen, with him to the meeting, and asked Rosen to sit next to him at the head table reserved for Committee members. The Committee's argument about the propriety of private counsel attending an AC meeting, the capacity in which counsel would be permitted to speak, and where he should sit lasted over an hour. Ultimately, the other Committee members permitted Rosen to speak for Kong only on the issue of the exam contract, and only in the capacity as a translator or interpreter, as Kong's command of English is limited.

After another hour-long argument over the minutes of the October 17 and November 18 meetings—during which many of the 200 spectators interrupted the proceedings with booing, hissing, and catcalling, the Committee finally reached agenda item 4, the Chair's Report. At this point, Rosen took his seat next to Lam Kong and explained that it had been brought to Kong's attention that NCC may have made misrepresentations to the Committee about its qualifications and its ability to handle the examination project. Kong had asked Rosen to investigate these charges. Through Rosen, Kong alleged "inconsistencies" in the documents presented to AC and documents filed by NCC with other state entities. For example, in one document, NCC described itself as a corporation; but the Secretary of State has no record of NCC as a corporation. The address allegedly listed for NCC on some of the documents turned out to be an empty shop with a "for rent" sign in the window, and the phone number provided by NCC was disconnected. Rosen also alleged a connection between Lynn Morris and NCC president Barbara Cole, and reiterated Frank Garcia's contention that Morris is biased against HRA. Rosen stated that, in Kong's opinion, AC should give a one-year extension to HRA and simultaneously issue a new request for proposals.

At this point, Committee member Kathie Klass questioned Lam Kong regarding his source of information and who was paying Rosen to undertake the investigation. Kong stated that he was personally paying Rosen and that others had "volunteered" their services. Klass stated that if Kong is involved in a conflict of interest, the other AC members do not want to be brought into it by considering the allegations made.

When the Chair's Report concluded, AC decided to take agenda item 13—election of 1992 officers—out of order. The Committee elected David Chen as its new chair by a 5–4 vote. Kathie Klass moved that the new Chair conduct the remainder of the meeting. Before the motion was seconded, Lam Kong stated that he was only attempting to bring an important issue to the attention of the Committee. Because the Committee did not appreciate his effort, Kong resigned not only the chairship but the Committee. Kong gathered his papers and left the meeting.

Next, Sophia Peng announced her resignation from the Committee, noting that rushing the exam contractor process without fully checking on the qualifications of the bidders is inappropriate in light of the Committee's previous exam scandal. Peng gathered her papers and left.

Janny Shyr expressed her displeasure at the Committee's constant bickering about insignificant matters and failure to address important issues. She also noted that, during the past few weeks, she had been "pressured" by various constituencies (legislators, the Department of Consumer Affairs, acupuncture schools) to make a particular decision; she opined that such tactics were improper. She resigned, and began to gather her papers. While Shyr was collecting her materials, AC member Mason Shen announced his resignation; Shyr and Shen left together.

Because the five remaining members constituted a quorum, the meeting continued. What was left of AC agreed to move agenda item 10(E)(1) out of order to complete the discussion of the exam consultant. The Committee heard from two non-AC members of the Examination Subcommittee, who stated that they were unimpressed with the quality of HRA's work, and not surprised that Lynn Morris gave it a low score. Dr. Norman Hertz of DCA's Central Testing Unit explained the RFP process at length, including the voting and scoring process. He stated that the composition of the Evaluation Committee was consistent with other such committees used for DCA boards, and noted that members are free to give proposals anywhere from 0–100 points. Hertz admitted that he had concern about the "organizational capabilities" of NCC, but that it is not unusual to award a testing contract to a one-person entity which then subcontracts out portions of the project to other companies. Lynn Morris stated that it was her understanding that she was obligated to rank the bidders based on all the information she had, including her prior experience with HRA; she was not satisfied with HRA's performance, and her scoring reflected that sentiment.

The Committee next asked Barbara Cole of NCC to respond to Lam Kong's accusations. Cole presented examples of her experience in the testing field; stated that NCC has a valid address and telephone number; noted that she has previously subcontracted with McGraw-Hill, a well-known exam consultant; and denied knowing Lynn Morris until she attended the bidder's conference on AC's RFP. After mild cross-examination, the Committee appeared ready to award NCC the contract. However, DCA counsel Don Chang stated that AC should take no action until DCA's Division of Investigation (DOI) had an opportunity to investigate Kong's allegations; he suggested that AC postpone its decision for two weeks to enable DOI to conduct an expedited investigation. AC agreed to postpone its decision until December 20, and requested that DOI also investigate the source of funds used to pay Richard Rosen and Lam Kong's actions (to determine if he had a conflict of interest).

At AC's December 20 meeting, DOI investigator Warren Wolfe presented the findings resulting from DCA's investigation. Wolfe concluded that NCC is a legitimate business entity, but that it must acquire a current business license. Barbara Cole noted that she is in the process of applying for a business license. Following discussion, AC agreed that Lam Kong's allegations were unfounded and that DOI's investigation revealed nothing improper about the bidding process, and nothing that would impair NCC's ability to perform the contract. The Committee voted 4–0 to award its examination contract to NCC.

Implementation of SB 633. At its November 22 meeting, DAHP approved AC's proposed regulatory changes to implement SB 633 (Rosenthal) (Chapter 103, Statutes of 1990). In the aftermath of the Chae Woo Lew bribery scandal, SB 633 requires all acupuncturists licensed prior to 1988 to complete 40 hours of continuing education (CE) in six specified subject areas prior to January 1, 1993. New section 1399.486 established the curriculum to be covered in each of the six areas; and an amendment to section 1399.481 requires CE providers to submit specified course information and the curriculum vitae of instructors to AC at least 30 days before the first day of the scheduled course. These changes await review and approval by DCA and the Office of Administrative Law (OAL). (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 92–93 for background information.)

Other AC Rulemaking. During the fall, AC completed its work on its rulemaking package which amends eleven sections and adds three new sections to its regulations in Division 13.7, Title 16 of the CCR, all of which were the subject of a July 18 public hearing. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 92 and Vol. 11, No. 3 (Summer 1991) p. 90 for background information.)

At its October 17 meeting, AC approved minor modifications to the language of sections 1399.443 (which requires licensure applicants to pass the written exam before they are eligible to sit for the oral and practical exam) and 1399.445 (which establishes an appeals process for applicants who fail the practical examination), as published on August 21. AC declined to adopt a modification to section 1399.425, regarding AC's criteria for approval of tutorial programs, instead referring the section for additional research and review.

On November 22, DAHP approved the entire regulatory package. At this writing, the changes await review and approval by DCA and OAL.

Use of OMD vs. DOM. At AC's October 17 meeting, DAHP Program Manager Tony Arjil addressed the Committee regarding acupuncturists' use of the acronym "OMD." Under an 1988 Attorney General's Opinion, acupuncturists are permitted to use the acronym DOM (Doctor of Oriental Medicine), but may use the acronym OMD (Oriental Medical Doctor) only if accompanied by an explanatory qualifier. DAHP discussed numerous violations of this ruling by acupuncturists at its September meeting, and threatened to seek legislation forcing compliance with the AG's opinion unless AC notifies the acupuncturist profession of the ruling and the profession agrees to abide by it. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 88 for background information.)

At DAHP's November 22 meeting, AC staff presented eight titles for DAHP's review. DAHP rejected two of them as misleading and confusing to the public, but approved the following combinations: [name], Licensed Acupuncturist, OMD; Lic. Ac., OMD; Certified Acupuncturist, OMD; OMD, Lic. Ac.; OMD, Licensed Acupuncturist; and OMD, Certified Acupuncturist. DAHP agreed that if AC agrees to drop the two unacceptable titles, the other six are automatically approved. If the Committee rejects this option, DAHP will revisit the matter at its January meeting.

LEGISLATION:

SB 664 (Calderon) would prohibit acupuncturists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

SB 417 (Royce), as amended April 15, would (among other things) revise existing law regarding the licensure and regulation of acupuncturists to require a person to complete an education and training program approved by the appropriate governmental educational authority to award a professional degree in the field of traditional Oriental medicine approved by the Committee. In the case of an applicant who has completed education and training in schools and

colleges other than those approved by the Committee, this bill would require the applicant's educational training and clinical experience to be approved by the Committee as equivalent to the standards established pursuant to prescribed provisions through an examination administered by one or more qualified, independent consultants with expertise in the professional licensure field, which is based on educational program learning outcomes comparable to those of institutions approved under a certain provision. The bill would also add section 4938.2 to the Business and Professions Code, to require AC to contract with an independent consultant for the purposes of determining the equivalency of educational training and clinical experience. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 86 for background information.) This two-year bill is pending in the Senate Business and Professions Committee.

RECENT MEETINGS:

At its October 17 meeting, AC announced the appointment of new member Kathie Klass, who was unable to attend the meeting.

Also in October, Executive Officer Lynn Morris presented the Committee with a proposal to hire continuing education consultants to help AC staff in its review of CE courses and providers. Morris presented the résumé of Kathleen Deaton, who was interested in serving as a CE consultant. AC voted unanimously to accept the proposal to hire consultants; it agreed to hire Deaton for six months and to notify and solicit the schools and professional associations for interested and qualified acupuncturists to serve as CE consultants.

FUTURE MEETINGS:

April 23 in San Francisco.
July 2 in San Diego.
October 8 in Los Angeles.
December 10 in Sacramento.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Executive Officer: Elizabeth Ware
(916) 920-6377

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. The other three members must be licensed hearing aid dispensers.

MAJOR PROJECTS:

Committee Vacancies. In November, Governor Wilson appointed Dr. Gus Gill to fill the Committee's position for a licensed physician who specializes in treatment of disorders of the ear. This still leaves HADEC with two hearing aid dispenser vacancies. Thus, HADEC now has five members, four of whom must show up at meetings to reach a quorum and enable the Committee to conduct business.

At its June 1991 meeting, HADEC decided to send a letter to Governor Wilson requesting the appointment of a dispensing audiologist to sit in the place of a hearing aid dispenser on the Committee; at this writing, the Governor has not yet responded to HADEC's letter.

LEGISLATION:

SB 664 (Calderon) would prohibit hearing aid dispensers, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

LITIGATION:

Robert Hughes of Long Beach has filed an appeal of the trial court's dismissal of his action against HADEC. Hughes and his wife, both hearing aid dispensers, claim that HADEC applies "underground rules" in regulating the hearing aid industry and, particularly, in approving licensed hearing aid dispensers to train and supervise trainees. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 94 for background information.) Hughes' action is pending in the Second District Court of Appeal.

RECENT MEETINGS:

HADEC's November 16 meeting was cancelled due to lack of a quorum.

FUTURE MEETINGS:

June 27 in San Francisco.
September 26 in Los Angeles.
December 5 in San Diego.

PHYSICAL THERAPY EXAMINING COMMITTEE

Executive Officer: Steven Hartzell
(916) 920-6373

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).

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

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

At this writing, no replacement has been appointed for public member Mary Ann Meyers, who resigned in November 1990. The Committee currently has two public members and three PT members.

MAJOR PROJECTS:

PTEC Newsletter. The first issue of PTEC's newsletter was distributed the week of October 14. The newsletter provided information on the Committee, dates of upcoming examinations and PTEC meetings, a fee schedule, and information concerning PTEC's enforcement program and its ad hoc committee on education.

Education and Examination Subcommittee. Exam development for

electroneuromyography (EEMG) and kinesiological electromyography (KEMG) continues. PTEC's Education and Examination Subcommittee is working with the Department of Consumer Affairs' Central Testing Unit to develop valid, reliable examinations. The exam development project was initiated because Executive Officer Steve Hartzell believes that the agency needs validated exams and more control over the exam process. Neither of the exams has been given in the past three years. It is estimated that 10–20 physical therapists will take the exams when they are completed. The exams previously consisted of a written portion and a practical application where physical therapists penetrate the skin to demonstrate skill. PTEC is weighing the need for the skin penetration requirement, as it raises medical necessity questions. PTEC was scheduled to discuss the practical section of the exams in a closed session at its January 24 meeting.

PTEC's ad hoc committee on education, consisting of Committee member Lida Mooradian and nine outside PTs and PTAs, met in September and finalized draft revisions to PTEC's regulations implementing the physical therapy education standards in sections 2650–2653 of the Business and Professions Code. Section 2653 requires licensure applicants who have graduated from foreign physical therapy schools to complete a period of clinical service unless it is waived by PTEC pursuant to criteria which are to be set forth in the Committee's regulations. The ad hoc committee proposes to amend regulatory section 1398.26 to permit PTEC to waive all or part of the required clinical service if it finds the applicant has completed a period of clinical education or internship equivalent to that required by section 2650 of the Code for licensure. PTEC was scheduled to hold a public hearing on this proposed regulatory change at its January 24 meeting.

Other PTEC Rulemaking. Also on January 24, PTEC was scheduled to hold a regulatory hearing on a proposed amendment to section 1398.4, Division 13.2, Title 16 of the CCR. The amendment would specify that in the absence of PTEC's Executive Officer, the Committee Chair is delegated all the functions necessary to the dispatch of the Committee's business in connection with investigative and administrative proceedings under PTEC's jurisdiction.

Fee Increases Approved. On December 30, the Office of Administrative Law (OAL) approved PTEC's regulatory amendments to section 1399.50, Title 16 of the CCR, which will, effective July 1, 1992, increase fees for initial licensing, biennial renewal, and delinquency charges for PTs. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 95; Vol. 11, No. 3 (Summer 1991) p. 92; and Vol. 11, No. 2 (Spring 1991) p. 88 for background information.)

Citation Program. PTEC continues to gather information for the citation manual which will outline its procedures for issuing citations to physicians who illegally supervise physical therapist assistants, physical therapy, or other unlicensed individuals performing physical therapy. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 95 for background information.) The Committee was scheduled to review a draft of the manual at its January 24 meeting.

LEGISLATION:

SB 664 (Calderon) would prohibit physical therapists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

AB 819 (Speier). Existing law provides that it is not unlawful for prescribed health professionals to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or coownership in the facility. This bill would, effective July 1, 1992, provide that, subject to specified exceptions, it is unlawful for these licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure of the ownership or proprietary interest would not exempt the licensee from the prohibition. This two-year bill is pending in the Assembly Health Committee.

RECENT MEETINGS:

At PTEC's October 17 meeting, Executive Officer Steve Hartzell introduced Karen McGagin, Special Assistant to the Director of the Department of Consumer Affairs (DCA). Ms. McGagin is part of a task force established by DCA Director Jim Conran to improve relations between DCA and the boards and committees of the Division of Allied Health Professions (DAHP).

The Committee also discussed regulatory changes proposed by the Board of Registered Nursing (BRN). Currently, a physical therapist may authorize a nurse to perform certain types of physical therapy. BRN believes nurses should be able to delegate these tasks to a physical therapist assistant, and has proposed amendments to section 1443.5(4), Division 14, Title 16 of the CCR, to enable RNs to assign nursing tasks according to a specific protocol to subordinates, including unlicensed personnel. (*See infra* agency report on BRN; *see also* CRLR Vol. 11, No. 4 (Fall 1991) p. 109 for background information.) PTEC is opposed to this change, and Steve Hartzell has submitted comments and proposed amendments to BRN.

At its October meeting, PTEC held an open forum to receive public comments on four issues:

-The Practice of Physical Therapy by General Law Corporations. Based on a review of relevant statutes by its counsel and the Secretary of State's Office, PTEC has concluded that no statute prohibits the conduct of the practice of physical therapy through a general business corporation (as opposed to a professional corporation). (See CRLR Vol. 11, No. 1 (Winter 1991) pp. 74–75 for background information.) The issue at the October 17 public forum was whether quality of care suffers when the practice of physical therapy is controlled by non-PTs, and whether the law should be changed to require physical therapy to be conducted through a professional corporation (where incorporation is desired). Most witnesses on this issue were generally opposed to the practice of physical therapy through a general business corporation.

-The Licensure of PTAs Based on Equivalent Education and Experience. Currently, section 2655.3 of the Business and Professions Code requires applicants for a PTA license to have graduated from a school for PTAs approved by PTEC "or have training or experience or a combination of training and experience which in the opinion of [PTEC] is equivalent to that obtained in an approved school." Regulatory section 1398.47 fleshes out numerous combinations of training and experience which PTEC believes is equivalent to its educational requirement. The American Physical Therapy Association (APTA) expressed support for equivalency testing (which is not present in section 1398.47), and has also suggested the inclusion of 12–18 months of acute care training for PTAs. Other witnesses expressed concern over the inadequacy of the equivalency requirements and/or circumvention of the educational process.

-Whether Regulatory Changes Are Needed to Refine the Amount and Type of Supervision Which PTAs and Physical Therapy Aides Must Receive. Currently, regulatory section 1398.44 requires a PTA supervisor to be present in the same physical therapy facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty, unless this requirement is waived by PTEC; however, no standards or criteria for the granting of a waiver are established in the regulation. Lately, PTEC is experiencing a huge increase in the number of waivers requested. During this portion of the public forum, PTEC distributed draft criteria for the granting of a waiver of the 50% rule.

-PTEC's Processing of Consumer Complaints Against Licensees. Steve Hartzell described PTEC's complaint handling process, parts of which are actually handled by the Medical Board. Complaints are received, entered onto a computer, and screened by a consumer services representative (CSR) of the Medical Board. Complaints against PTEC licensees are referred to Committee staff, who decide whether they merit formal investigation. Hartzell introduced Lynne Merrifield, a Medical Board investigator, who described the investigation process. Once a complaint is fully investigated and PTEC's Executive Officer decides disciplinary action is warranted, the matter is referred to the Attorney General's Office for the preparation and filing of a formal accusation, and the conduct of an evidentiary hearing before an administrative law judge from the Office of Administrative Hearings. Based upon the evidence, the ALJ makes a proposed decision to PTEC, which then reviews and adopts (or non-adopts) the decision as its own. A licensee who disagrees with a PTEC disciplinary decision may seek judicial review in superior court.

PTEC held elections for the positions of 1992 Committee Chair and Vice-Chair at its October meeting. Norma Shanbour was elected Chair and Carl Anderson was chosen Vice-Chair.

FUTURE MEETINGS:

March 27 in San Francisco.
May 29 in Los Angeles.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale
(916) 924-2626

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

PAEC licenses individuals as PAs, allowing them to perform certain medical procedures under a physician's supervision, including drawing blood, giving injections, ordering routine diagnostic tests, performing pelvic examinations, and assisting in surgery. PAEC's objective is to ensure the public that the incidence and impact of "unqualified, incompetent, fraudulent, negligent and deceptive licensees of the Committee or others who hold themselves out as PAs [are] reduced." PAEC's regulations are codified in Division 13.8, Title 16 of the California Code of Regulations (CCR).

PAEC's nine members include one member of the Medical Board of California (MBC), a physician representative of a California medical school, an educator participating in an approved program for the training of PAs, one physician who is an approved supervising physician of PAs and who is not a member of any division of MBC, three PAs, and two public members.

MAJOR PROJECTS:

Scope of Practice Regulations Forwarded to OAL Over DCA Director's Veto. On November 22, the Medical Board's Division of Allied Health Professions (DAHP), which must formally adopt PAEC's regulations, voted unanimously to override Department of Consumer Affairs Director Jim Conran's rejection of the Committee's proposed regulatory changes to sections 1399.541, 1399.543, and 1399.545, Division 13.8, Title 16 of the CCR, which define the scope of practice of physician assistants.

For three years, PAEC and DAHP have been involved in drafting new scope of practice regulations in response to Attorney General's Opinion 88-303 (Nov. 3, 1988). The proposed regulatory changes would permit a PA's supervising physician (SP) to specify the type and limit of delegated medical services based on the SP's specialty or usual and customary scope of practice. They would also authorize PAs to initiate (or transmit an order to initiate) certain tests and procedures, and to provide necessary treatment in emergency or life-threatening situations. However, the regulatory changes have been rejected by the Office of Administrative Law (OAL) three times. In its most recent September 1991 rejection, OAL instructed the Division to submit the regulatory changes to DCA Director Jim Conran for approval, as they have been significantly amended since being reviewed by Conran's predecessor, Michael Kelley, who disapproved them in October 1990. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 96; Vol. 11, No. 1 (Winter 1991) p. 75; and Vol. 10, No. 4 (Fall 1990) p. 90 for background information.)

Thus, DAHP modified the proposed regulatory changes to satisfy OAL's concerns and submitted them in late October to Conran, who disapproved them on November 20. DAHP disagreed with Conran's perception that the regulations confer to PAs an "unrestricted authorization to perform surgical procedures" in proposed section 1399.541(i), and argued that all activities of a PA (including surgery) are "controlled, guided, and supervised by the supervising physician" through written delegations of authority and protocols. DAHP overrode Conran's rejection by unanimous vote, and PAEC submitted its scope of practice regulations to OAL for approval on December 30.

LEGISLATION:

SB 664 (Calderon) would prohibit physician assistants, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

RECENT MEETINGS:

In his enforcement report during PAEC's October 11 meeting, Executive Officer Ray Dale noted that as of October 1, four accusations were pending against PAs and one licensee has been disciplined during fiscal year 1991–92. Currently, 54% of PAEC's budget is devoted to enforcement. The Committee discussed the possibility of appointing a PAEC member to act as a consultant regarding disciplinary actions, but decided to leave it as a Committee function.

Staff member Jennifer Barnhart presented a status report on current licensing statistics. As of September 13, there

were 4,869 approved supervising physicians and 2,077 licensed physician assistants. Supervising physician applications account for approximately 65% of PAEC's revenue. Ray Dale stated that he submits questionable supervisor applications to DAHP before rejecting them.

At the October meeting, Occupational Health Services (OHS) reported that two PAs have participated in the Committee's Diversion Program during fiscal year 1991–92. The purpose of the program is to identify and rehabilitate PAs whose competence may be impaired due to substance abuse. Since the Program's inception in April 1990, a total of six PAs have participated; all were self-referred.

Also in October, PAEC elected its 1992 officers: Janice Tramel was re-elected PAEC Chair, and Nancy Edwards was reelected Vice-Chair.

FUTURE MEETINGS:

April 3 in San Francisco.
July 24 in Sacramento.
October 2 in Anaheim.

BOARD OF PODIATRIC MEDICINE

Executive Officer: James Rathlesberger
(916) 920-6347

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:

Roundtable on Implementation of SB 2375 (Presley). At its December 6 meeting, BPM sponsored a roundtable discussion of the Medical Board's implementation of SB 2375 (Presley) (Chapter 1597, Statutes of 1990), the Medical Judicial Procedure Improvement Act. SB 2375 was sponsored by the Center for Public Interest Law (CPIL) in its ongoing attempt to enhance and improve the Medical Board's discipline system and infuse it with an appropriate prosecutorial atmosphere. (See CRLR Vol. 10, No. 4 (Fall 1990) pp. 79–80 and 84; Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 74–75; and Vol. 9, No. 2 (Spring 1989) pp. 1 and 60 for extensive background information.) BPM licensees are subject to the Medical Practice Act and, as part of the Medical Board, BPM utilizes many aspects of MBC's discipline system. The purpose of the discussion was to allow for presentation of different points of view on the bill's implementation and to enable BPM to ask questions of the roundtable participants.

Leading off the discussion was CPIL Supervising Attorney Julie D'Angelo, who noted that although SB 2375 has not accomplished as much as SB 1498 (Presley) (Chapter 1159, Statutes of 1988) (the Center's 35-part bill which overhauled the State Bar's attorney discipline system and created the independent State Bar Court), it has resulted in some important first steps toward a better medical discipline system. Specifically, SB 2375 has accomplished the following:

-It has enhanced the flow of information regarding practitioner misconduct into the Medical Board, especially through provisions which require coroners to report gross negligence to MBC, district attorneys to report felony filings against physicians to MBC, and court clerks to transmit criminal convictions, certain preliminary hearing transcripts, and probation reports on physicians to the Board. D'Angelo noted that the Medical Board failed to publicize these new requirements until August 1991.

-SB 2375 has attempted to speed up investigations by imposing a six-month goal; that is, the Medical Board has six months from the date of receipt of a complaint to investigate it and dispose of it, either by way of dismissal, warning letter, or transfer to the Attorney General's Office for the filing of an accusation. D'Angelo noted that MBC spent the better part of 1991 disputing the six-month goal and arguing that it should not begin to run until MBC decides a complaint merits formal investigation. However, at its November meeting, the Board abandoned plans to sponsor a bill seeking "clarification" of this legislative directive. D'Angelo acknowledged that, in fact, the Board has helped itself achieve the six-month goal by centralizing its complaint intake and tracking function, raising physician licensing fees, and hiring over twenty new investigators. (*See supra* agency report on MBC for related discussion.)

-SB 2375 requires the Medical Board to annually publish numerous key enforcement statistics on its physician discipline system. At the instigation of BPM, MBC's Division of Allied Health Professions decided to institute a quarterly "enforcement matrix" to enable it to track similar enforcement statistics for BPM and the allied health committees. Although D'Angelo praised the enforcement matrix concept and its potential ability to detect backlogs at various locations, she noted that the current version of the matrix has several problems. For example, it should reveal quarter-to-quarter change so improvement or backlog at each step of the process may be detected; the matrix should reveal the average age of complaints pending at each stage of the process—otherwise, the Board will never know whether the six-month goal of SB 2375 is being met; and MBC should establish "backlog" periods for each stage of the process. That is, complaints should remain at any one step for a limited time period, after which the complaint should be designated as "backlogged" and entitled to priority treatment.

-SB 2375 also attempted to infuse the medical discipline system with a much-needed prosecutorial influence by establishing the Health Quality Enforcement Section (HQES) in the Attorney General's Office. The attorneys assigned to HQES now specialize in medical discipline cases; previously, deputy attorneys general handled a varied mix of cases which generally precluded them from gaining substantive expertise in any particular area. CPIL considers the creation of HQES one of the most important accomplishments of SB 2375, and believes its prosecutors should "actively interfere" in the Medical Board's processing and handling of consumer complaints by directing and guiding their investigation from the day of receipt. However, D'Angelo noted that HQES is currently laboring under a huge backlog of cases due to a number of factors, and that it desperately needs a staff increase to handle its caseload effectively.

-Another provision of SB 2375 attempted to enable administrative law judges of the Office of Administrative Hearings (OAH) to specialize in medical discipline hearings in the same way as HQES has enabled prosecutors to so specialize. SB 2375 created a special list of ALJs who have training and experience in presiding over medical discipline cases; the early versions of the bill would have limited the list to seven or eight judges who would hear only medical cases. This reform was patterned directly after the Center's SB 1498 reform to the State Bar's adjudi-

cative system; SB 1498 successfully replaced 400 volunteer practicing attorneys who functioned as "hearing referees" with a panel of six hearing judges and a three-judge appellate panel. D'Angelo noted that OAH has instituted a 25-hour medical education program for ALJs and will apparently be requiring continuing education as well. Although CPIL supports this educational component, it does not support the actions of OAH Director Karl Engeman in appointing 27 ALJs to the medical quality list. All of these judges hear medical cases, but they hear many other types of cases as well. CPIL believes this implementation defeats the purpose of the reform, which was to enable a small number of ALJs to increase their familiarity with and expertise in medical cases, render informed and consistent decisions, and issue interim orders suspending a practitioner pending the conclusion of the disciplinary case.

D'Angelo expressed CPIL's view that, in spite of these important first steps, SB 2375 will achieve only marginal improvement in the overall discipline system as it has been implemented thus far by MBC, the AG's Office, and OAH. More important and structural changes are needed, including the following:

-earlier disclosure to inquiring consumers of pending complaints against physicians, especially where multiple or very serious complaints are pending;

-an enhanced flow of information on physician misconduct into the Medical Board for computer entry, tracking, investigation, and disciplinary action as appropriate, including medical malpractice claims, judgments, and settlements;

-an increased number of MBC investigators and HQES attorneys, and improved access to medical records of an accused physician for investigators and prosecutors;

-the Medical Board's Division of Medical Quality, BPM, and the allied health committees should be removed from the disciplinary decisionmaking "loop"; qualified ALJs on a revamped Medical Quality Panel in OAH should be permitted to make the final disciplinary decision which is then appealable to a court;

-the superior court step should be removed from the judicial review process, and appeal of the ALJ's final decision should be made to a single, designated court of appeal panel which—again—would be able to specialize in and become familiar with medical discipline cases;

-MBC should create an entity similar to the Bar's Complainants' Grievance Panel, a seven-member panel which is authorized to review the dismissal of a complaint at an early stage at the request of the complaining consumer; and

-the legislature should create a Medical Discipline Monitor position similar to the State Bar Discipline Monitor position created through the 1986 enactment of Business and Professions Code section 6086.9. The Monitor would be responsible for investigating the Medical Board's discipline system from top to bottom and making further recommendations for legislative and administrative reform. D'Angelo argued that the Monitor position is needed because the Attorney General's Office has not been given supervisory control over all aspects of the Medical Board's enforcement system, and MBC—controlled by physicians and historically moribund in its enforcement efforts—continues to attempt to mislead the legislature and the public about its accomplishments. As an example, D'Angelo cited a disciplinary summary distributed by MBC in May 1991, in which the Medical Board stated that it had disciplined 62 physicians in a five-month period. Although MBC's claim is technically true, 23 of those physicians had been disciplined in another state and 17 were convicted of felonies. Many of the disciplined physicians do not even reside in California. Of the 62 claimed disciplinary actions, only four cases resulting in actual suspension were originated by the Medical Board.

Next to address BPM was HQES Chief Al Korobkin, who explained that HQES is currently staffed by 22 deputy attorneys general in Los Angeles, San Diego, San Francisco, and Sacramento. Korobkin acknowledged that HQES is severely understaffed and backlogged, and noted that he has already begun action on a 1992–93 budget change proposal (BCP) which will add 27 new positions to HQES (including 23 attorneys). In response to CPIL's concern about the need to closely review MBC's processing of cases, Korobkin noted the following changes made by his staff:

-During the summer, Korobkin personally reviewed all cases closed by the Medical Board's Central Complaint and Investigation Control Unit (CCICU) without formal investigation, and those closed after being referred for formal investigation, including all cases "closed with merit." He also reviewed, on a more random basis, cases "closed without merit." Korobkin pledged to continue to make personal visits to CCICU and review case closures.

-The Supervising Deputy Attorney General (SDAG) in each of the AG's HQES units makes bimonthly visits to MBC branch offices, so as to establish a consistent working relationship with MBC regional supervisors and investigators.

-When a case is referred to HQES for the preparation of an accusation and disciplinary action, the SDAG immediately reviews the investigative work-up by the MBC investigator before the case is referred to the line DAG for accusation drafting. If the case has been inadequately investigated by an MBC investigator, it is personally returned to the investigator by the SDAG with instructions and guidance as to its completion.

-Korobkin has established a special coordinator in the San Diego office to review egregious cases which may warrant immediate AG attention and a motion for interim suspension.

Korobkin concluded his presentation with a promise: "Once we get the budget authorization and a sufficient number of attorneys, you will see the most dramatic change in statistics you've ever seen." He noted that the change would impact OAH as well, because even though a large number of cases will probably settle, OAH will be flooded with disciplinary hearings.

OAH Director Karl Engeman also addressed BPM. He began his presentation by noting that he is "a proponent of generalists among the [ALJ] central panel and opposed to a hearing panel of six to eight judges devoted to Medical Board cases or any other type of case." According to Engeman, "If I believed that setting up a panel of six to eight judges would solve the problem, I'd do it tomorrow. But SB 2375 does not require the establishment of a small panel. . . . I have attempted to move as many people as possible onto the list—that's my philosophy. I recognize that there's a major philosophical difference between my office and CPIL." Engeman contended that the Deukmejian administration—"not OAH"—opposed the small-panel concept espoused by CPIL, and had insisted on replacing the "panel" with a "list" of qualified ALJs.

Engeman described the medical training program that OAH has established in consultation with MBC's Division of Medical Quality. All "list" ALJs must take 25 hours of required medical training in specified subjects. New ALJs seeking to qualify for the "list" must take the 25-hour course and observe six hours of expert testimony presented before a "list" judge and discuss it with the judge. Engeman noted

one problem in this area: new ALJs are having trouble meeting this requirement because "62% of MBC's disciplinary cases settled before hearing last year"—thus precluding new ALJs from observing expert testimony. Engeman also noted that "list" ALJs must take at least nine continuing education hours per year. With regard to the "bubble" of cases which has finally moved from the Medical Board and into HQES, Engeman estimated that OAH will eventually need five new ALJs and two support staff positions.

BPM members and staff presented comments and questions to the roundtable participants. Executive Officer Jim Rathlesberger noted that although Medical Board enforcement staff were invited to the roundtable, they failed to attend. He also expressed concern to Judge Engeman that, although BPM had requested to have input into the 25-hour ALJ training syllabus, MBC had ignored this request and had designed the curriculum with OAH by itself. Engeman noted that OAH will eventually schedule sessions on all medical specialties, and that he welcomes BPM's input.

Several BPM members objected to D'Angelo's suggestion that BPM be precluded from making disciplinary decisions. They opined that many ALJs are not capable of making an informed decision on an issue of podiatric competence; thus, review by podiatric experts is necessary. D'Angelo stated that most discipline cases do not involve issues of competence, but rather inappropriate sex, drug/alcohol impairment, or criminal convictions. Additionally, both D'Angelo and Engeman pointed out that ALJs usually must be educated about the medical particulars of a case by expert witnesses who testify at the hearing on behalf of the Board and the respondent podiatrist; thus, the HQES prosecutor must adequately prepare him/herself and his/her expert witness, and the witness must be capable of assisting the prosecutor in impeaching or rebutting the testimony of the respondent's expert.

BPM President Karen McElliott concluded the roundtable discussion with enthusiastic thanks to all participants, and pledged to ensure that such roundtables occur on a regular basis. The roundtable participants noted the conspicuous absence of a Medical Board representative, and suggested that MBC consider sponsoring a similar roundtable at a future meeting.

Board to Examine Podiatric Residencies. At its December meeting, BPM began a preliminary discussion of podiatric residency programs. The Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association approves residency programs based on specified requirements and criteria. CPME recognizes four basic types of postgraduate programs: rotating podiatric residency (RPR), podiatric orthopedic residency (POR), podiatric surgical residency (12 months), and podiatric surgical residency (24 months or more). The Board plans to scrutinize the frequency of CPME review and availability of documentation that residency programs in fact meet CPME requirements, and the criteria for CPME residency approval to ensure they satisfy California licensing statutes, with a special focus on whether RPR and POR programs provide sufficient surgical experience. The Board planned to invite a CPME spokesperson and representatives from the California College of Podiatric Medicine to its March meeting for a wide-ranging forum on podiatric residencies and state licensing requirements.

Continuing Education Policy. At the Board's December meeting, the Committee on Continuing Medical Education (CME) and Postgraduate Education stressed BPM's policy on CME courses. Courses in medicine other than podiatric medicine may be acceptable for CME credit, but only if they are pertinent and relevant to the practice of podiatric medicine. Courses of an administrative nature are not acceptable, but medical ethics courses will be given CME credit.

LEGISLATION:

SB 1004 (McCorquodale), as amended May 7, would prohibit health facilities from denying, restricting, or terminating a podiatrist's staff privileges on the basis of economic criteria unrelated to his/her clinical qualifications or professional responsibilities. This bill would define "economic criteria" as factors related to the economic impact on the health facility of a podiatrist's exercise of staff privileges in that facility, including but not limited to the revenue generated by the podiatrist, the number of Medi-Cal or Medicare patients treated by the podiatrist, and the severity of the patients' illnesses treated by the podiatrist. This two-year bill is pending in the Senate Health and Human Services Committee.

SB 664 (Calderon) would prohibit podiatrists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

SB 1119 (Presley). Existing law requires the district attorney, city attorney, or other prosecuting agency to notify BPM of any filings against a licensee charging a felony, and the clerk of the court in which the licensee is convicted of a crime is required to transmit a copy of the record of conviction to the Board. As amended April 30, this bill would expressly limit the transmittal duties of the clerk of the court to felony convictions. This two-year bill is pending in the Assembly Health Committee.

AB 465 (Floyd). Existing law provides general civil immunity to persons who provide information to MBC/BPM or the Department of Justice indicating that a licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to the certain activities of specified health care organizations. This bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This two-year bill is pending in the Senate Judiciary Committee.

Future Legislation. During 1992, BPM plans to sponsor a bill amending Business and Professions Code section 2475, which currently limits the term of a podiatrist's participation in an orthopedic residency to two years. Because residency programs offering three to four years of comprehensive postgraduate training are becoming increasingly available to residents training in California, BPM proposes to extend the term limitation on podiatric medical and surgical residency programs from two to four years. In addition, the Board will "clean up" sections 2483, 2486, 2487, and 2492 by deleting obsolete provisions.

The California Podiatric Medical Association (CPMA) plans to reintroduce AB 1568 (Klehs), which was vetoed by Governor Wilson last October. The bill would correct the unintended exclusion of podiatrists from various provisions of the Health and Safety Code which specifically mention physicians and surgeons. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 98 for background information on AB 1568.)

RECENT MEETINGS:

At BPM's October 3–4 meeting, Executive Officer Jim Rathlesberger announced that the fee reduction authorized in SB 1195 (Boatwright) (Chapter

983, Statutes of 1991) would take effect on January 1, 1992. SB 1195 authorized BPM to reduce its initial license fee for podiatrists just completing their residencies from $800 biennially to $400.

Following the roundtable discussion at BPM's December 6 meeting, DCA Director Jim Conran addressed the Board. Conran characterized BPM as a "model board" and expressed his wish that other DCA agencies were as consumer-oriented as BPM. Conran urged BPM to continue to keep consumers at the forefront of its activities, and to move aggressively and decisively against incompetent and unscrupulous licensees.

Conran then answered questions from BPM members. Board President Karen McElliott revisited a major issue from the roundtable discussion—the need for more attorneys in HQES, the source of funds to pay for them, and the state legislature's recent action to strip all special-funded agencies (including BPM) of all reserve funds in excess of three months' worth of operating expenses as of June 30, 1992. Conran replied that DCA is "at bat" for its boards in the legislature, but that the state's $14.3 billion budget deficit required everyone to make cuts.

McElliott also stated that BPM is intent on leaving the oversight of the Medical Board's Division of Allied Health Professions, and may seek to become an independent DCA board or a separate agency within the Medical Board. At the very least, BPM believes that the name of DAHP should be changed to remove the word "allied," as podiatrists are physicians and not "allied health professionals." Conran stated that he would support a transfer if BPM can prove its financial ability to operate independently.

FUTURE MEETINGS:

June 26 in San Francisco.
September 25 in Los Angeles.

BOARD OF PSYCHOLOGY

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

The Board of Psychology (BOP) (formerly the "Psychology Examining Committee") is the state regulatory agency for psychologists under Business and Professions Code section 2900 *et seq.* 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, three of whom are public members.

MAJOR PROJECTS:

Board Seeks Enforcement Coordinator Position to Handle Soaring Complaint Caseload. BOP is currently seeking a budget change proposal (BCP) to add an Associate Government Program Analyst position to serve as BOP's Enforcement Coordinator. According to the BCP, the number of complaints against psychologists received by the Board increased 188% from fiscal year 1984–85 to 1990–91. The majority of jurisdictional complaints received by BOP involve serious allegations of sexual misconduct, gross negligence, unprofessional conduct, unlicensed practice, and conviction of a crime. The BCP reveals that the number of consumer complaints sent to formal investigation has increased 215% in the last six years; the number of alleged sexual and gross negligence cases investigated more than tripled during the same time period.

In its BCP, BOP admits that cases involving instances of potentially serious consumer harm are unintentionally being overlooked because its existing staffing situation does not allow for thorough review of the current volume of complaints. "In the past fiscal year, 34 complaints have inappropriately been closed only to be reopened and investigated at a later date after closer scutiny [sic] is demanded by the consumer. These were cases where after careful review, the consumer was harmed and the potential for further consumer harm on the part of the licensee was very real."

BOP has no in-house enforcement staff; all enforcement-related activities are generally handled by Executive Officer Tom O'Connor. BOP notes that its overall staffing level was established two decades ago, and that current staffing is inadequate due to several factors: (1) increased media attention surrounding issues of patient harm by therapists; (2) 1988 legislation which required the Department of Consumer Affairs to publish *Professional Therapy Never Includes Sex!*, a brochure to assist victims of psychotherapist/patient sexual abuse; California law requires therapists to give this brochure to clients who reveal that they were exploited by a previous therapist; and (3) SB 2375 (Presley) (Chapter 1597, Statutes of 1990), which overhauled the Medical Board's discipline system in which BOP participates. Due to SB 2375 and accompanying public and legislative pressure, the Medical Board has doubled the number of its investigators, centralized its complaint intake unit, and expedited the processing and investigation of all complaints against physicians and allied health professions under its jurisdiction—including psychologists. The confluence of these factors has caused the number of complaints against psychologists to skyrocket, and the Board is simply incapable of handling them properly. "The situation is . . . blatantly putting the public at risk."

Thus, BOP proposes the addition of a professional Enforcement Coordinator position to relieve the Executive Officer of most enforcement-related activities. The Enforcement Coordinator would be expected to oversee the coordination of complaint routing and investigation between BOP and the Medical Board; reviewing cases for referral to the Attorney General's Office for disciplinary action; working with the AG on case settlements; communicating with complaining consumers; working with expert witnesses used in disciplinary hearings; and ensuring that BOP's enforcement program is adequately funded.

BOP Rulemaking. On November 22, BOP published notice of its intent to adopt new sections 1397.50–.53, Division 13.1, Title 16 of the CCR, to implement AB 4016 (Filante) (Chapter 800, Statutes of 1988), which prohibits psychologists from practicing under a fictitious name unless that name is approved by BOP. Under the proposed regulations, any fictitious name used must contain either the term "Psychology Group" or "Psychology Clinic." A fictitious name containing the word "medical" shall not be issued to a group practice or clinic containing psychologists only. The regulations also impose a $50 fee for a fictitious name permit and its biennial renewal. BOP was scheduled to hold a public hearing on the proposals on January 10 in Los Angeles.

BOP also hopes to amend section 1387, Division 13.1, Title 16 of the CCR, to further define the criteria for and responsibilities of a "qualified primary supervisor"; specify the length and type of required supervised professional experience; define acceptable group supervision; and delineate the responsibilities of supervisors and supervisees regarding the proper logging of experience to ensure accurate verification of supervised professional experience. (See CRLR Vol. 11, No. 3 (Summer 1991) p.

96; Vol. 10, No. 4 (Fall 1990) p. 93; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 110 for background information.) At its July 27 meeting, BOP decided to add a provision to section 1387 prohibiting a licensee from supervising a former or current patient. At this writing, BOP has prepared a draft of the notice and text of the proposed changes, but will not formally notice these proposed regulatory changes until the spring of 1992.

LEGISLATION:

SB 1004 (McCorquodale), as amended May 7, would prohibit health facilities from denying, restricting, or terminating a clinical psychologist's staff privileges on the basis of economic criteria unrelated to his/her clinical qualifications or professional responsibilities. This bill would define "economic criteria" as factors related to the economic impact on the health facility of the psychologist's exercise of staff privileges in that facility, including but not limited to the revenue generated by the psychologist, the number of Medi-Cal or Medicare patients treated by the psychologist, and the severity of the patients' illnesses treated by the psychologist. This two-year bill is pending in the Senate Health and Human Services Committee.

AB 1106 (Felando) would create the Alcohol and Drug Counselor Examining Committee within the Board of Behavioral Science Examiners (BBSE), and require the Committee to adopt regulations to establish certification standards and requirements relating to education, training, and experience for persons who practice alcohol and drug abuse counseling, and to grant certificates to practice drug and alcohol abuse counseling to applicants who meet the requirements and standards established by BBSE. This two-year bill is pending in the Assembly Health Committee.

SB 664 (Calderon) would prohibit psychologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

SB 774 (Boatwright), as amended July 3, would, commencing January 1, 1995, prohibit BOP from issuing any renewal license unless the applicant submits proof satisfactory to the Board that he/she has completed no less than 48 hours of approved continuing education (CE) in the preceding two years, and require each person renewing his/her license to practice psychology to submit proof satisfactory to the Board that, during the preceding two-year period, he/she has completed CE courses in or relevant to the field of psychology. Although the Board previously opposed SB 774, it decided to approve the bill in principle at its November meeting. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 99 and Vol. 11, No. 1 (Winter 1991) p. 78 for background information.) This two-year bill has passed both the Senate and the Assembly and is pending in the Senate inactive file.

SB 738 (Killea) would require BOP to establish required training or coursework in the area of domestic violence assessment, intervention, and reporting for all persons applying for an initial psychologist's license and the renewal of such a license. This two-year bill is pending in the Senate Business and Professions Committee.

Future Legislation. In cooperation with BBSE, BOP intends to introduce legislation in 1992 to amend section 820 of the Business and Professions Code, to permit BOP to compel psychological examinations of licensure applicants whose competence appears to be affected by mental illness. BOP is currently authorized to compel such examinations for licensees.

BOP also intends to introduce legislation increasing its examination fees, since the costs of the exams themselves have increased. BOP will also seek legislation to double its license renewal fees to cover the costs of an adequate enforcement program.

LITIGATION:

In an unpublished decision released on November 26, the Third District Court of Appeal affirmed the trial court's dismissal of Dr. Frank McGuigan's action against the Board as moot. For six years, Dr. McGuigan sought reciprocity licensure from BOP under Business and Professions Code section 2946; the Board denied his request and then denied his demand for a statement of issues and hearing under the Administrative Procedure Act. In 1990, Dr. McGuigan filed suit, seeking a ruling on his right to a statement of issues and a hearing; upon the advice of the Attorney General, the Board immediately granted Dr. McGuigan a hearing, but denied its general obligation to grant other similarly situated applicants such a hearing. Due to the Board's acquiescence, the trial court dismissed Dr. McGuigan's lawsuit as moot. McGuigan appealed, arguing that because the challenged action is likely to recur and resolution of the issue is in the public interest, he is entitled to a ruling on the underlying legal issue. The Third District disagreed, and affirmed the trial court in *McGuigan v. California Board of Psychology*, No. C010084. (*See supra* COMMENTARY for extensive background information on the *McGuigan* case.)

RECENT MEETINGS:

At its November 2 meeting in Sacramento, BOP discussed a recent Department of Consumer Affairs (DCA) questionnaire regarding the disclosure of information about complaints to inquiring members of the public. BOP discloses the fact that a complaint has been made about a psychologist only if the complaint has resulted in the filing and service of an accusation. DCA is considering a policy of earlier disclosure; recognizing the backlog of completed investigations awaiting preparation and filing of an accusation by the Attorney General's Office, DCA is considering a policy whereby complaint information would be disclosed to an inquiring consumer when the agency refers the completed investigation to the AG's office for disciplinary action.

FUTURE MEETINGS:

May 15–16 in Los Angeles.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards (916) 920-6388

The Medical Board of California's 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).

The Committee registers speech-language pathology and audiology aides and examines applicants for licensure. The Committee hears all matters assigned to it by the Board, including, but not limited to, any contested case or any petition for reinstatement, restoration, or modification of probation. Decisions of the Committee are forwarded to the Board for final adoption.

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

the California Code of Regulations (CCR).

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

MAJOR PROJECTS:

Absence of Criteria for Exam Waivers Causes Controversy. At SPAEC's November 8 meeting, the Committee's failure to adopt standards to guide it in granting waivers from its written examination requirement resulted in another lengthy discussion of the proper criteria for an exam waiver. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97; Vol. 11, No. 2 (Spring 1991) p. 93; and Vol. 11, No. 1 (Winter 1991) p. 79 for background information.)

Business and Professions Code section 2532.2(e) permits SPAEC to waive its written exam requirement if an applicant—usually an out-of-state licensee—"has successfully completed an examination approved by the Committee." Section 1399.159, Division 13.4, Title 16 of the CCR, previously required an applicant to have taken the applicable national examination within the five years preceding application for California licensure in order to qualify for an exam waiver. In 1990, SPAEC amended section 1399.159 to permit an exam waiver when the national exam was taken more than five years prior to application for California licensure, provided that the applicant can demonstrate to SPAEC that he/she has maintained his/her knowledge of speech-language pathology or audiology; SPAEC may require the applicant to appear before it for an "exam waiver interview." Over the past year, these interviews have proven controversial, as members do not agree on the criteria for such a demonstration.

Some members contend that since the exam is being waived, and the exam tests a broad range of knowledge, skills, and abilities, an exam waiver candidate must be able to demonstrate a very broad range of experience and education during the years preceding application for California licensure. Under this standard, an applicant whose clinical or work experience has been limited to a narrow field (*e.g.*, speech development only) or to a relatively narrow sector of the public (*e.g.*, children in the educational setting or industrial audiology) would not qualify for an exam waiver. Other Committee members stress currency of knowledge and experience over breadth, and would grant an exam waiver to an applicant regardless of the specialized nature of clinical or work experience, so long as it is recent.

Over the past year, the Committee has engaged in a case-by-case *ad hoc* balancing approach to exam waiver requests. Interviews have included questions regarding the candidate's continuing education, work experience, scores on previous examinations, and undergraduate program. However, no standards in any of these areas have ever been adopted by the Committee as regulations pursuant to the Administrative Procedure Act, and applicants are not necessarily apprised of the basis upon which the exam waiver decision is made. At SPAEC's November meeting, Committee Chair Robert Hall characterized the process as a "judgment call." Additionally, the Committee expects the candidate to include complete documentation and description of experience and continuing education on the exam waiver interview form, but fails to specify this requirement on the form. If the record is inadequate, the Committee decides against the applicant. Thus, the candidate is penalized by denial of the exam waiver, and significant time and effort of both the candidate and the Committee are wasted.

At this writing, the Center for Public Interest Law is preparing a petition for rulemaking to compel resolution of this issue.

Mandatory Continuing Education. At SPAEC's November 8 meeting, the Mandatory Continuing Education (MCE) Subcommittee presented its draft of a legislative proposal for the implementation of MCE for SPAEC licensees. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 100; Vol. 11, No. 3 (Summer 1991) p. 97; and Vol. 11, No. 1 (Winter 1991) pp. 79–80 for background information.) The draft language sets forth standards for acceptable MCE courses and requires completion of a minimum of 30 hours every two years for licensure renewal; the MCE provider must be approved by SPAEC. The proposal would further implement a periodic auditing process to ensure compliance, and require a report on completion of CE as a requisite for renewal.

The Board of Directors of the California Speech-Language-Hearing Association (CSHA) recently voted to support SPAEC's position requiring professional development as a condition of licensure renewal. The Board action was based in part on the fact that SPAEC, as a regulatory agency, is the only entity that could monitor and enforce ongoing professional development of its licensees. The Board further requested the opportunity to provide input to SPAEC in the implementation of the program. Committee member Dr. Philip Reid reported similar acceptance by other organizations representing members of the profession, despite the negative response of a minority of licensees responding to a questionnaire administered by SPAEC. Of approximately 7,000 questionnaires delivered to licensed speech-language pathologists and audiologists, only 349 (4.6%) completed them to some degree. Overwhelmingly, the responding licensees concluded that the expense and complexity of MCE would impose an onerous burden. Additionally, these licensees voiced concern that the choice of curricula would be inadequate. Dr. Reid countered that the public expects professionals to pursue continuing education and that a fifteen-hour annual requirement is not a burden.

SPAEC identified a logistical problem with the enforcement of MCE due to the large number of licensees in California, which is ten times that of other states. The MCE Subcommittee was directed to continue working on this problem.

Speech-Language Pathology and Audiology Aides. At its November meeting, the Committee continued its discussion of guidelines and criteria for the scope of practice and supervision of aides. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 101; Vol. 11, No. 3 (Summer 1991) p. 97; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.)

Several members expressed concern about the distinction in licensure requirements for aides as between for-profit and nonprofit organizations engaged in the practice of audiology. Specifically, the Committee addressed Business and Professions Code section 3351, which exempts from the Hearing Aid Dispensers Licensing Law's temporary license requirement an aide who is working under the supervision of a licensed audiologist (including the taking of earmold impressions) in a nonprofit organization, so long as the aide is not engaged in the sale of hearing aids. In the past, the Committee has opined that making earmolds is an inappropriate task for an unlicensed audiology aide, and that such an aide is required to have a temporary license under the jurisdiction of the Hearing Aid Dispensers Examining Committee (HADEC). However, in interpreting the relevant statutes, Department of Consumer Affairs (DCA) counsel Greg

Gorges has concluded that no license is required so long as the aide is not engaged in the sale of hearing aids.

In any event, the Committee recognized that, under the statute, a person not qualified to make earmolds in the for-profit setting may be able to perform the same task in a nonprofit setting. If the focus is on consumer protection, there should be no difference in standards based upon the work setting. SPAEC plans to refer this issue to its joint subcommittee with HADEC (once it is created), because the conflict is beyond SPAEC's independent jurisdiction.

LEGISLATION:

SB 664 (Calderon) would prohibit speech-language pathologists and audiologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This two-year bill is pending in the Senate Business and Professions Committee.

Future Legislation. The Department of Consumer Affairs has agreed to include several legislative amendments for SPAEC in its 1992 omnibus bill. The first will change the Committee's licensure expiration and renewal process from a biennial system to a cyclical renewal system. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 97 for background information.) The second change will amend Business and Professions Code section 2534.2(2) to raise the minimum delinquency fee for late payment of fees from $10 to $25, and section 2534.2(5) to increase the fee for the issuance of a duplicate certificate from $10 to $40. Finally, an amendment to section 2530 will correct an oversight in the 1990 legislation which changed the name of SPAEC to the "Speech-Language Pathology and Audiology Committee" and added "-language" to the term "speech" throughout the Act, but failed to change the name of the Act itself.

RECENT MEETINGS:

At the Committee's November 8 meeting, the subcommittee which is developing SPAEC's Fine/Citation/Enforcement Manual reported that the project is still in progress. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 101; Vol. 11, No. 1 (Winter 1991) p. 79; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.) The subcommittee's efforts have revealed the difficulty of drafting an adequate description of the profession's permissible range of involvement without either duplicating existing guidelines or writing a voluminous "novel." At this writing, the subcommittee is awaiting additional input, and tentatively considering a joint committee with CSHA.

Also at its November meeting, the Committee briefly discussed the legality of hearing screenings via telephone. A licensed audiologist has inquired as to the feasibility of setting up a 900 number to offer hearing screenings over the phone in California. Apparently, a number of organizations in other states offer hearing screenings via 800 lines. DCA counsel Greg Gorges prepared a memo identifying section 1399.180(c), Title 16 of the CCR, as the applicable regulation. The section provides that diagnosis or treatment of individuals for speech or hearing disorders by mail or telephone without prior examination by a licensee is unprofessional conduct. The Committee, however, postponed action until its January meeting since Gorges was not present at the November meeting.

Also at the November meeting, SPAEC implored DCA Director Jim Conran to encourage Governor Wilson to fill the vacancies on HADEC, so that SPAEC may initiate a joint subcommittee with HADEC to resolve issues of mutual interest. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 94 and 101 for background information.)

FUTURE MEETINGS:

April 2 in San Francisco.
July 10 in Irvine.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Executive Officer: Ray F. Nikkel
(916) 920-6481

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.

Governor Wilson recently appointed Nancy Campbell to the Board as a public member. Campbell is currently chair of BENHA's Administrative Committee, and also serves on the Board's Disciplinary Committee.

MAJOR PROJECTS:

Nursing Home Reform Act Update. As a result of the recent settlement between the federal Health Care Financing Administration (HCFA) and California's Department of Health Services (DHS) regarding California's implementation of the federal Nursing Home Reform Act passed by Congress in 1987, HCFA is responsible for circulating guidelines implementing the federal reforms and compiling and circulating changes submitted by California and other states. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 101–02; Vol. 11, No. 3 (Summer 1991) p. 98; and Vol. 11, No. 2 (Spring 1991) pp. 94–95 for background information.) At BENHA's December 4 meeting, BENHA Executive Officer Ray Nikkel informed the Board that HCFA has yet to release the proposed guidelines; Mr. Nikkel anticipated the release to be forthcoming and the public comment period to begin forthwith.

Examination and Enforcement Statistics. The pass rate for the October 10 state exam for nursing home administrators (NHA) was 54%; the national exam pass rate was 60%.

From August 1 to November 30, BENHA received three citations from the Department of Health Services (DHS) for "AA" violations, which are violations of standards which lead to a patient's death, and 62 "A" violations,