majority of public members and a minority of professional members is best suited to balance that promotion with the primary objective of consumer protection.

Finally, Brode provided the statistical information requested by the Committee covering 1988–89 through 1990–91. For example, Brode reported that in 1990–91, there were 3,533 licensed landscape architects in the state; the Board received 81 complaints; and BLA took a total of five disciplinary actions.

LEGISLATION:

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including BLA, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. SB 2044 would also provide that if, upon investigation, BLA has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by the Board to offer or perform those services, the Board may issue a citation containing an order of correction which requires the violator to cease the unlawful advertising and notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising. *[A. CPGE&ED]*

AB 2743 (Lancaster), as amended April 9, would require that a landscape architect's certificate number and renewal date of the certificate appear on plans, specifications, and other instruments of service and contracts therefor, prepared for others, as specified. Additionally, this bill would enable BLA to create a "cost recovery program"—in disciplinary proceedings, the Board would be authorized to request the administrative law judge to direct the licentiate, in certain circumstances, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. *[A. Floor]*

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 have specified that these provisions also apply to actions arising out of the professional negligence of landscape architects. This bill died in committee.

RECENT MEETINGS:

At its May 8 meeting, BLA agreed to seek legislation to amend Business and Professions Code section 5680.2(c), which currently provides that a certificate which is not renewed within five years of its expiration may not be renewed, restored, reissued, or reinstated, but that the holder of the certificate may apply for and obtain a new certificate if he/she, among other things, takes and passes the examination which would be required of the applicant if he/she were then applying for the certificate for the first time, or otherwise establishes to the satisfaction of BLA that he/she is qualified to practice landscape architecture. The Board agreed to seek legislation to delete the provision allowing an applicant to otherwise establish to BLA's satisfaction that he/she is qualified to practice landscape architecture.

FUTURE MEETINGS:

October 18 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 non-physicians appointed to four-year terms, is divided into three autonomous divisions: Licensing, Medical Quality, and Allied Health Professions.

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

The functions of the individual divisions are as follows:

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

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

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

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

MBC's three divisions meet together approximately four times per year, in Los Angeles, San Diego, San Francisco, and Sacramento. Individual divisions and subcommittees also hold additional separate meetings as the need arises.

MAJOR PROJECTS:

MBC Increases Licensing Fees Again to Finance Enforcement System. Backing away from a November 1991 decision to increase physician licensing fees to $500 biennially as of April 1992, the Division of Licensing voted at its January meeting to instead raise MBC's initial and biennial renewal fees to only $480 for licensing periods beginning on and after July 1, 1992. *[12:1 CRLR 69]*

The Medical Board has found it necessary to raise its historically low licensing fees twice during the last year, in response to legislative and public pressure to enhance its physician discipline system. As of January 1, 1991, physicians paid only $180 per year to finance the licensing and enforcement activities of the Medical Board (whereas attorneys paid $478 per year and podiatrists paid $400 per year to support their regulatory agencies). However, the provisions of SB 2375 (Presley) (Chapter 1597, Statutes of 1990) became effective on that date, requiring the Medical Board to drastically improve its disciplinary performance and, among other things, dispose of consumer complaints against physicians within six months of receipt through dismissal, warning, or transferral to the Attorney General's Office for preparation of formal charges. These and other requirements of SB 2375 forced the Board to hire additional investigators during 1991, financed by a $20-per-year increase in physician licensure fees effective August 1, 1991.

SB 2375 also created the Health Quality Enforcement Section (HQES) within the Attorney General's Office. HQES is a statewide unit of attorneys who specialize in prosecuting medical discipline cases on behalf of MBC and its allied health committees. While the specialization concept is sound, HQES' ability to carry out its charge has been hampered from its inception. Whereas HQES' initial staffing of attorneys and paralegals should have been based upon the average number of hours required to prosecute medical discipline cases within recent years (102 hours), it was instead based on the average number of hours required to prosecute all administrative cases for the Department of Consumer Affairs (only 36.6 hours). This miscalculation led to severe HQES understaffing during 1991, which was compounded when DMQ added investigators who began to clear out the Division's huge backlog of pending investigations. HQES Chief Al Korobkin now estimates that his unit requires at least double the number of attorney and support staff positions it was originally allocated in order to handle its projected caseload. To finance the new positions, DOL approved a fee increase to $500 biennially (MBC's current statutory maximum) in November 1991, to become effective in April 1992.

However, at the Division's January meeting, staff advised DOL members that an increase to $480 biennially ($240 per year, still one-half of the dues paid by attorneys and podiatrists), effective on July 1, 1992, would be sufficient to support MBC's existing enforcement budget and the addition of prosecutors to HQES, and maintain two months' worth of operating expenses as required by law. This fee increase requires amendments to sections 1351.5 and 1352, Division 13, Title 16 of the CCR. After discussion, DOL approved the regulatory changes; the Office of Administrative Law (OAL) approved the fee increases on May 20. Additionally, MBC is now sponsoring SB 1119 (Presley) (*see infra* LEGISLATION), which would increase physician licensing and renewal fees to $275 annually effective January 1, 1993, and enable MBC to raise fees to $300 per year if necessary.

At its May 8 meeting, DMQ received a report from HQES Chief Al Korobkin concerning efforts to recruit new deputy attorneys general to HQES. Korobkin announced that HQES has been authorized 22 new attorney positions and is seeking to fill 20 of those 22 as soon as possible. Because medical discipline cases are among the most complex, Korobkin is attempting to fill the new positions with highly skilled prosecutors. Korobkin reported that since March 23, eight attorneys had been hired. Four more attorneys were expected to be hired during May and June, for a total of 12. In addition, 8.5 attorneys in the AG's Office have been temporarily transferred to HQES until July 1 in order to reduce the huge backlog of fully investigated MBC cases awaiting prosecution.

However, Korobkin admitted that HQES continues to fall behind in its efforts to reduce the backlog of investigated cases. The process of filling the new staff positions has been slow, and existing staff is unable to keep up with the 40–60 new cases it receives from MBC investigators each month. Moreover, HQES has experienced a large increase in the number of serious cases requiring temporary restraining orders (TROs) or interim suspension orders (ISOs). Since January 1, HQES has obtained seven TROs/ISOs, which is three to four times the number expected. These cases hamper efforts to reduce the backlog because they demand the immediate and full-time attention of HQES attorneys to obtain a temporary suspension of a physician's license pending a full hearing on the charges. As a result, of the 1,112 active cases in HQES, 466 are now backlogged (*i.e.*, they are fully investigated and await the preparation and filing of an accusation, which triggers the disciplinary process). The average length of time it takes HQES attorneys to file an accusation has grown to 486 days, up substantially from the 200-day figure found by the Office of the Auditor General when it reviewed MBC cases resolved from December 1989 through November 1990. *[11:3 CRLR 47–48, 82–84]* Korobkin further noted that each HQES attorney carries a heavy caseload of about 30 cases. He expressed concern over DMQ Enforcement Chief Vern Leeper's prediction that HQES may receive 600 cases from MBC investigators in fiscal year 1992–93, about 100 more cases than projected.

In a related matter, at its January 30 meeting, DMQ reviewed a report filed by a subcommittee consisting of Division members Dr. John Kassabian and Dr. Clarence Avery on several staff-proposed options to raise revenue for DMQ's enforcement program other than increasing licensing fees. Specifically, staff has again suggested that the Medical Board implement its existing authority to assess fines against physicians 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 and president Frank Albino is usually the sole supporter of the concept. *[12:1 CRLR 69–70; 11:3 CRLR 84]*

At the January 30 meeting, the subcommittee again recommended against implementation of either a fine or cost recovery system at this time, citing three primary reasons for its recommendation. First, the physicians opined that any system of fines or cost recovery would have little impact on the Division's total enforcement budget, while diluting DMQ's ability to pursue effective forms of discipline which protect the public, including license revocations, suspensions, and strict terms of probation. Second, the report stated that "[s]ome physicians may not be able to pay and would then be punished for pure economic reasons." Third, without new legal authority, any funds collected in excess of a two-month operating reserve would be placed in the

Board's surplus account and might be subject to seizure by the state general fund.

The full Division adopted the subcommittee's recommendation.

Further Reforms to Physician Discipline System Urged. At the invitation of DMQ, Center for Public Interest Law (CPIL) Director Robert C. Fellmeth presented an outline of further structural reforms to MBC's physician discipline system at a special session of the Division's May meeting. Under Fellmeth's direction, CPIL previously drafted and sponsored SB 2375 (Presley), a 37-part physician discipline reform bill enacted by the legislature in 1990. In addition to creating HQES and requiring DMQ to investigate and dispose of complaints concerning physicians within an average of six months from their receipt (*see supra*), SB 2375:

–enhanced the flow of information on physician misconduct into the Medical Board by requiring coroners to report evidence of a physician's gross negligence, district attorneys to report felony charges against physicians, court clerks to transmit conviction records and certain felony preliminary hearing transcripts, and probation officers to submit probation reports;

–increased the maximum penalty against hospitals and medical facilities for failure to report adverse peer review actions to the Medical Board under section 805 of the Business and Professions Code;

–authorized DMQ to issue interim orders imposing drug testing, continuing education, supervision of procedures, or other license restrictions pending the final conclusion of the discipline case; and

–provided for the designation and training of certain administrative law judges (ALJs) within the Office of Administrative Hearings (OAH), who are given preference in cases involving discipline of health care professionals.

However, Professor Fellmeth and CPIL believe that further structural changes in the Medical Board and its disciplinary decisionmaking process are necessary to achieve a defensible system which provides adequate consumer protection. Fellmeth's current proposal, which has been drafted into a preprint bill authored by Senator Robert Presley, derives from similar changes he successfully advocated at the State Bar, where he recently concluded a five-year stint as State Bar Discipline Monitor under Business and Professions Code section 6086.9. The reformed Bar discipline system has achieved a steady and substantial increase in the Bar's disciplinary output since 1987. Public discipline of attorneys at least tripled in 1988–91 over the base level of 1982–87; informal discipline (*e.g.*, reprovals or letters of warning) during 1990–91 was meted out at levels more than twelve times its incidence during 1981–86 (from 40–60 then to a rate of 800 per year in 1991).

Specifically, Professor Fellmeth stressed that the following changes are still needed at the Medical Board:

–the required reporting of the filing of medical malpractice cases to DMQ;

–the transfer of DMQ's investigators to HQES within the Attorney General's Office, to enable them to work directly with and under the supervision of the deputy attorneys general who prosecute medical discipline cases;

–the removal of DMQ's authority to make decisions in disciplinary cases, and the transfer of that authority to a small panel of expert, independent ALJs;

–the removal of the superior court step in the judicial review of medical discipline cases, and the creation of a designated court of appeal to review all appeals of such decisions; and

–the streamlining of the procedure for obtaining interim relief (*e.g.*, suspension of a license pending the conclusion of the disciplinary action).

Fellmeth especially called on DMQ to surrender its decisionmaking role in the adjudication of physician discipline cases, arguing that the composition of the Division—seven volunteers who meet once every two or three months, have not attended the hearing or observed the witnesses in a case, and are not trained in receiving or weighing evidence—does not lend itself to adjudicatory decisionmaking. According to Fellmeth, the Division is more suited to quasi-legislative decisionmaking—that is, making major policy decisions which establish standards of professional competence and conduct for physicians, the violation of which is grounds for discipline. Fellmeth noted that DMQ underutilizes its existing rulemaking authority in favor of policymaking through its disciplinary decisions on a case-by-case basis. He urged DMQ members to "be physicists, not plumbers; instead of concerning yourselves with the individual facts of the very limited number of cases which you can handle, enlarge your impact by establishing rules the entire profession must live by. You can guide the disciplinary process without controlling it."

Fellmeth's presentation, which was attended by Senator Presley, elicited extensive comment and questions from DMQ members. Public member Theresa Claassen expressed her view that a balanced Division, comprised of both physician and public members, should continue to make the final decisions in discipline cases. Fellmeth pointed out that DMQ members have no judicial training; the proposed system would be superior because it would allow ALJs with such training to make the final decision, based on professional standards and disciplinary guidelines established by the Division. Dr. Michael Weisman asked if any other jurisdictions or agencies have implemented Fellmeth's proposal. Fellmeth responded that, thus far, only the State Bar has implemented an adjudicatory decisionmaking process controlled by professional judges instead of members of the regulatory board dominated by members of the very profession being regulated.

DMQ President Frank Albino agreed with Fellmeth's idea that MBC gather information on medical malpractice filings, but disagreed with several other elements of the proposal. Specifically, Albino stressed his views that DMQ is the strongest link in the disciplinary system because ALJs frequently impose insufficient penalties, which must be increased on review by DMQ; that DMQ establishes some of its most important policies through its adjudicatory function; and that HQES prosecutors currently have an appropriate level of interaction with DMQ investigators without transferring the investigators to HQES. Fellmeth responded that professionwide policy is more effectively established through rulemaking than adjudication and that, while prosecutors and investigators should work as a team, prosecutors need to control a case from the beginning. That level of control is not available to HQES prosecutors under the current system, as they usually do not become involved in a case until the investigation is completed.

DMQ member Dr. Clarence Avery was interested in the cost of the proposed system. Fellmeth responded that the system implemented at the State Bar involved a 70% increase in cost (about $110–120 per year increase in licensing fees), but it resulted in a 500% increase in disciplinary case output. Fellmeth suggested that the increased cost would be offset by lower medical malpractice premiums resulting from a more efficient disciplinary system.

In a related matter, at its May 8 meeting the full Board agreed to adopt as its own a letter drafted by Board President Dr. Fredrick Milkie opposing a Department of Consumer Affairs (DCA) restructuring proposal that would essentially abolish the Medical Board and transfer its licensing and enforcement powers to the Department. In its February analysis of the

Governor's proposed 1992–93 budget, the Legislative Analyst's Office (LAO) recommended that all independent boards and bureaus within DCA—including the Medical Board—be eliminated and replaced with, at most, advisory boards, with the Department assuming the licensing and enforcement functions of the agencies on a consolidated basis. LAO contended that abolition of DCA's agencies as independent entities would improve and streamline the state's regulatory framework and eliminate the potential for conflict of interest when members of a particular trade or profession attempt to act as government decisionmakers charged with regulating that trade or profession in the public interest. (*See supra* agency reports on LAO and DCA for related discussion.)

The letter approved by MBC at its May meeting registered its opposition to any proposal which would erode or transfer the authority of the Medical Board to license physicians and enforce the Medical Practice Act. MBC disputed the conflict of interest concept, contending that "there is no way that a doctor on the Board can influence the handling of any complaint against another doctor or an investigation against another doctor," and that "there is no evidence that physicians sitting on the DMQ have ever compromised a case due to conflict of interest." The Board also opposed the proposed transfer of its complaint intake and other administrative functions to DCA, arguing that "it is inconceivable that [a] consolidated complaint unit would have a person so well versed in complex licensing categories of physicians, as well as complaints about auto mechanics and toasters." MBC also complained that while it pays DCA $1.8 million yearly for support services, DCA is unresponsive to the Medical Board's requests for additional staff or an adequate computer tracking system. The Board concluded by stating that MBC members serve to protect the citizens of California; if it is clearly proven that consolidation of enforcement, complaint processing, and administration would be of benefit to the public, the Board would work to achieve improvement.

Public Access to Complaints About Physicians Debated. At its May 8 meeting, DMQ received a report from its recently formed subcommittee charged with the task of studying options to increase public access to information on complaints about physicians. The subcommittee—consisting of DMQ members Gayle Nathanson, Theresa Claassen, Dr. John Kassabian, and Dr. Clarence Avery—reported that it held a March 19 public hearing on the issue. Among those present at the hearing to offer their input were HQES Chief Al Korobkin, DCA Director Jim Conran, California Medical Association (CMA) representative Tim Shannon, Center for Public Interest Law (CPIL) intern Cheryl Forbes, and Board staff including Executive Director Ken Wagstaff and Enforcement Chief Vern Leeper.

At the hearing, the subcommittee described MBC's current complaint disclosure policy, which bars Board staff from releasing any information to inquiring consumers about complaints filed against a physician until ten days after HQES has filed a formal accusation against the physician's license. The Board also declines to disclose any other information about a physician which it has gathered in the course of its disciplinary function, even public information such as criminal convictions and medical malpractice judgments and settlements.

The proposed alternatives to the Board's current complaint disclosure policy discussed at the March 19 meeting include the following:

(1) Release all complaint information immediately upon receipt, giving the public access to information (with an appropriate disclaimer) at the earliest possible date. Board staff expressed concern that since 70% of all complaints are closed without merit, release of this "raw" information could inappropriately cause the public to reject certain qualified physicians based on unfounded allegations. The Board also articulated concern that release of complaint information before an investigation is conducted could compromise the investigative process, especially undercover field operations.

(2) Release complaint information after it has been screened by DMQ's Central Complaint and Investigation Control Unit (CCICU) and sent to a field office for investigation. This would allow consumers to have access to complaints after jurisdiction has been noted and the allegations are deemed serious enough to warrant formal investigation. According to the Board, one out of five of these cases results in the filing of an accusation, and another 25% are "closed with merit." Again, Board staff and physician representatives expressed concern that release of information at this stage might result in the public rejecting certain qualified physicians based on allegations that could not be proven. CPIL's Cheryl Forbes argued that health and safety concerns and the consumer's right to know far outweigh this concern. If complaint information is disclosed at this point, a disclaimer could be given stating that the investigation has not yet been completed and no formal charges have been filed—enabling the consumer to intelligently address the matter with the physician, if deemed appropriate. Also, the Board could consult with the AG's office to screen out those complaints whose disclosure may compromise the investigative process.

(3) Release information on all cases "closed with merit" against a physician, in addition to the information released under present policy. When the Medical Board closes a case with merit, the case has been investigated and the complaint is found to have merit, but there is insufficient evidence to file administrative charges. An investigator who does not have sufficient evidence to file an accusation may close a case with merit and, in the event new evidence becomes available within the next five years, the information contained in the investigation may be incorporated into a new case. Board representatives stated that if this information is released to the public "without any due process," costly legal challenges could result. To solve this "all or nothing" approach, CPIL's Forbes encouraged the Board to create more categories of sanctions. For example, the Board could assess a fine, citation, letter of warning, or other public discipline and then disclose this information, possibly with a disclaimer, to inquiring consumers, allowing them to make more informed choices.

(4) Release information to the public once the Board's investigation is complete and the Attorney General has accepted its request that an accusation be filed. This option would provide the public with relevant information significantly earlier than under the present policy. Most of the Division members appeared to be receptive to this option. CPIL pointed out that, at this stage, the Board has little or no control over the AG's office and the 486-day delay in the preparation of accusations (*see supra*). Consumers should not have to pay this price. The Board has done its job, and consumers should be informed of that fact. By moving the disclosure point up to the point at which the completed investigation is referred to HQES, consumers may learn about very serious misconduct over one year earlier than they can under the current policy.

(5) Release available information on felony filings and convictions against physicians. Felony charges and convictions should invariably lead to an investigation by the Board; and since the Board already receives this information from the courts under SB 2375 (Presley) (*see*

supra), it could easily be disclosed to an inquiring consumer. When Board staff expressed concern about the need to alter DMQ's computer system to accommodate this additional information, DCA Director Conran assured them that he would help find the necessary funding.

(6) Release to the public information about malpractice judgments and settlements of $30,000 or more. Lawsuits are public information, and a pattern of lawsuits may indicate a problem with a physician's practice. Although the precise terms of some malpractice settlements may be sealed, the *fact* of the settlement is public information, and should be disclosed. Release of this information would not compromise MBC investigations.

CPIL's Cheryl Forbes also encouraged the Board to explore the possibility of disclosing the fact of a complaint (or complaints) against a physician even earlier than Option (4) above in certain limited and very serious situations. When complaints come in, they are immediately prioritized based upon the seriousness of the allegation. The Board could adopt a policy permitting immediate disclosure of a Priority One complaint involving imminent irreparable harm (with an appropriate disclaimer). In the alternative, multiple complaints alleging very serious misconduct from different complainants could be disclosed for the protection of the public during the pendency of an investigation. Under this scheme, extremely relevant information could be disclosed at an early point, and no low-priority complaints which are likely to be dismissed would ever be disclosed.

CPIL also urged the Board to consider disclosing reports of adverse peer review decisions made against physicians by hospitals; these reports are required to be forwarded to DMQ under section 805 of the Business and Professions Code. When a section 805 report is made, a health facility has chosen to restrict, deny, or revoke a physician's privileges to admit patients and use the hospital's facilities. These actions are rarely taken, and only in the most extreme circumstances. During the peer review process, the physician enjoys extraordinary due process rights, such that he/she has every opportunity to be heard and to contest the hospital's allegations. CPIL believes that consumers should be told of adverse peer review actions (again, with an appropriate disclaimer) where the cause of the private discipline is medical in nature and is directly relevant to patient care. The consumer should be told that the matter is under review by the Board, if that is the case; if the Board has investigated the matter and determined it to be affirmatively without merit, then its disclosure might be excused.

No formal decisions or recommendations to the Board were made at this hearing. An additional subcommittee hearing was scheduled for April 30; however, due to the civil unrest in Los Angeles, the April 30 hearing was canceled and tentatively rescheduled for May 22 in San Francisco.

MBC Enforcement Matrix Update. At DAHP's May 8 meeting, MBC Assistant Executive Officer 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 the Board's allied health licensing boards and committees. *[12:1 CRLR 70]*

There are 172,480 licensed physicians and allied health professionals in California. The matrix indicates that, as of April 23, a total of 5,088 complaints were pending against physicians and allied health professionals at various stages of the investigative process. The matrix also provides a breakdown of complaint accumulations at each stage of the investigative process: 1,770 were assigned to and pending with a consumer services representative in the CCICU; 2,284 complaints were under investigation; 314 complaints were being reviewed by professional consultants; 144 complaints were pending with the executive officers of the various agencies; and 576 complaints had been forwarded to and were pending at HQES for preparation of an accusation and prosecution.

The April 23 version of the matrix includes information regarding the average number of days complaints stay at the various levels of investigation. According to the matrix, physician and surgeon complaints spend an average of 104 days at the CCICU stage, another 274 days under investigation, and another 21 days on the Executive Director's desk—for a total of 399 days from receipt of the complaint. This delay would appear to violate SB 2375 (Presley), which requires DMQ to investigate and dispose of complaints concerning physicians within an average of 180 days from receipt—either by dismissal, warning, or forwarding to HQES for preparation of an accusation. However, Heerhartz warned that the data in the matrix are not averages; they reflect current time in process for *open* cases only. DMQ has yet to establish a relevant time period for the matrix and factor in cases closed during that period to achieve accurate averages. Heerhartz noted that the next printing of the matrix will include descriptions of the data to avoid misunderstanding.

Because they reflect only the age of open cases, the enforcement matrix figures also fail to support Enforcement Chief Leeper's May 8 announcement that DMQ is in compliance with the six-month goal established by SB 2375 (Presley). Leeper offered no other statistics to support his statement.

Legislature Demands Detailed Enforcement Data. On April 10, Senate Business and Professions Committee Chair Dan Boatwright ordered MBC to produce—within five working days—detailed enforcement data on disciplinary complaints received, investigated, and forwarded for enforcement action within the past 36 months. Specifically, Senator Boatwright requested, for each case forwarded to HQES or a local district attorney, the following information:

–the date the initial complaint was received by MBC;

–the date the case was sent to investigation;

–the date the investigation was completed and the report received by MBC;

–the date the case was forwarded to the Attorney General's Office or a local prosecutor;

–the date of the filing of an accusation by the AG, if any, or other action taken by the AG or a local prosecutor;

–the name of the respondent licensee and information regarding the nature of the charges against him/her; and

–the current status of the case, including the specific nature of any discipline or penalty that has been imposed on, or agreed to by, the respondent.

In an April 15 letter to Senator Boatwright, MBC Executive Director Ken Wagstaff requested an extension of time in which to gather the information, promising to make it available by May 1. In his letter, Wagstaff said he would also attempt to provide information on the number of cases under appeal in superior court after discipline is ordered. "There are some egregious cases that have been on appeal for as long as three years, with our discipline stayed by the court. We consider this kind of delay in the judicial process to be a significant defect in consumer protection."

MBC Committee to Draft HIV/HBV Transmission Prevention Policy. At the full Board's January 31 meeting, MBC continued its November 1991 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. *[12:1 CRLR 75]*

In its policy statement, FSMB urged 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 recommended that state laws (1) require that physicians who perform "exposure-prone invasive" procedures (*e.g.*, surgery) to 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. Following expressions of outrage from CMA representatives and physician members of MBC at the November meeting, the Board decided to appoint an HIV committee to meet with other state officials on the issue, and to invite a representative of the Department of Health Services (DHS) to its January meeting.

In January, Dr. Mary Jess Wilson, Medical Officer for DHS' Office of AIDS, updated the full Board on recent developments in the controversy:

–Universal infection control procedures to prevent HIV transmission to health care workers (HCWs) and patients were established by CDC early in the epidemic; although CDC recently considered establishing a list of invasive procedures considered too risky for AIDS-infected HCWs to perform, it has apparently abandoned that plan in favor of a case-by-case approach.

–DHS' existing guidelines call for ongoing training of HCWs in universal infection control practices, with periodic review of the practices by health care facilities.

–SB 1070 (Thompson) (Chapter 1180, Statutes of 1991) requires DHS to develop guidelines and regulations to prevent the transmission of bloodborne infectious disease between HCWs and patients; DHS is working with professional organizations and community groups, and hopes to release its recommendations by July. This bill also requires MBC (among other occupational licensing agencies) to ensure that its licentiates are informed of DHS' regulations, and makes a knowing violation of the guidelines unprofessional conduct and grounds for discipline.

–In December 1991, the federal Occupational Safety and Health Administration announced mandatory standards to protect HCWs from exposure to bloodborne pathogens. The guidelines require employers to establish infection control plans including training, engineering and work practice controls, and recordkeeping. Use of protective clothing and equipment is mandated.

–Cal-OSHA is working on its own standards which will meet or exceed the federal standards and be consistent with existing regulations for worker safety and medical waste (*see infra* agency report on Cal-OSHA for related discussion).

At MBC's May 8 meeting, Board President Dr. Fredrick Milkie announced that the state Office of AIDS agrees with MBC that FSMB's policy is "premature and incomplete." However, Milkie warned that MBC's failure to adopt a policy of its own is "detrimental" and might subject the Board to public criticism. Therefore, Dr. Milkie appointed the following members to serve with him on MBC's HIV Committee: Dr. Clarence Avery, Gayle Nathanson, Dr. Jacquelin Trestrail, and Frank Albino (contingent upon his reappointment to the Board in July 1992). Milkie advised Committee members that FSMB had since revised the language of its policy and that Frank Albino had drafted suggested alternative language, both of which should be considered by the Committee. Albino's draft language calls for legislation requiring that any diagnosis of HIV positive (of any person or, in the alternative, of any health care worker) be reported to the Department of Health Services (DHS) as a communicable disease. DHS would be required to report HIV positive reports on physicians to MBC, which would then be authorized to investigate the practice circumstances of the reported physician and, if appropriate, enter into a voluntary agreement with the physician limiting or supervising his/her practice to the extent determined necessary in consultation with DHS. Although the draft language characterizes the agreement as voluntary, it also states that refusal to enter into, or breach of, such a voluntary agreement is grounds for discipline. The Committee scheduled a May 29 hearing to discuss the parameters of an HIV/HBV transmission prevention policy.

Use of the Term "Board Certified" in Physician Advertising. SB (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 only if that board or association is (1) a member of the American Board of Medical Specialties (ABMS), (2) a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training (PGT) program that provides complete training in that specialty or subspecialty, or (3) a board or association with equivalent requirements approved by DOL (the so-called "equivalency option"). For over one year, DMQ has been attempting to draft regulations to flesh out the equivalency option; public hearings held on January 13, January 30, and February 25 resulted in the release of proposed section 1363.5, Division 13, Title 16 of the CCR, for a public comment period ending on March 24. *[12:1 CRLR 70–71; 11:4 CRLR 85–86]*

The major provisions of the February 25 version of section 1363.5 are as follows. The term "specialty board" means a board or association which certifies only physicians in a specialty or subspecialty area of medicine. The regulation sets forth detailed standards as to size, purpose, governance, activities, and revenue sources of acceptable specialty boards. Non-ABMS specialty boards may be approved as "equivalent" by DOL for purposes of physician advertising in one of three ways:

(A) the board shall require applicants seeking certification to have satisfactorily completed a PGT program accredited by the AMA's ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC) that includes identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification;

(B) if the training required of applicants seeking certification is other than ACGME- or RCPSC-accredited PGT, then the specialty board shall have training standards that include identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification and that have been determined by DOL to be equivalent in scope, content, and duration to those of an ACGME- or RCPSC-accredited program in a related specialty or subspecialty; or

(C) in lieu of the PGT required in (A) or (B), the specialty board shall require applicants seeking certification to have completed (1) a minimum of six years of full-time teaching or practice in the specialty/subspecialty area of medicine in which the physician is seeking certification, and (2) a minimum of 300 hours of continuing education in the specialty/subspecialty area and which is approved under sections 1337 and 1337.5 of DOL's

regulations. Teaching experience acceptable under this option must be in a PGT program accredited by the ACGME or RCPSC or an equivalent program approved by DOL. Teaching or practice experience accepted under this option must be evaluated by and acceptable to the credentials committee of the specialty board pursuant to standards that are both specified in the board's bylaws and approved by DOL. Physicians applying for certification under this option shall be required by the specialty board to have satisfactorily completed an ACGME- or RCPSC-accredited residency training program.

Specialty boards in existence on the effective date of these regulations may certify physicians based upon teaching or practice and continuing medical education for eight years; thereafter, these specialty boards must demonstrate to DOL that there is in existence one or more PGT programs that include identifiable training in the specialty/subspecialty area of medicine to be certified. Similarly, specialty boards which are incorporated or organized after the effective date of these regulations may certify qualified physicians for eight years from the date of their incorporation or organization; thereafter, the board must demonstrate to DOL that there is in existence one or more PGT programs that include identifiable training in the specialty/subspecialty area of medicine to be certified.

On April 1, DMQ held another public hearing in Torrance to consider comments on the February 25 revisions. Before testimony was heard regarding these changes, SB 2036 Committee Chair Dr. Fredrick Milkie introduced several additional changes for consideration, all of which dealt with the standards for approval under the "equivalency option." First, the bylaws of the specialty board must provide for an independent and stable governing body whose members are internally appointed or selected by the members and serve staggered, limited terms of not more than six years. A member shall not serve more than one term on a governing body. Second, the "identifiable training" specified in subsections (A), (B), and (C) above should be evaluated by DOL to ensure that its scope, content, and duration are equivalent to those of an ACGME- or RCPSC-accredited program and adequate for training in a specialty area of medicine. Third, specialty boards should be required to submit a plan that estimates the number of physicians to be certified through subsection (C) above; specifies the number and location of PGT programs the specialty board has developed and plans to develop and the number of trainees completing the training annually; demonstrates the equivalency of those programs, as provided in subsection (B) above; provides for monitoring to evaluate the quality of existing programs; and allows for upgrading of the parameters of the specialty to accommodate new developments. Every year, specialty boards must report to DOL their progress in implementing their plan for PGT in the specialty or subspecialty area of medicine in which physicians are seeking certification. Failure to so report by a specialty board, to establish that it is in compliance with its plan, or to provide evidence that its PGT programs are equivalent to ACGME- or RCPSC-accredited programs, would be grounds for withdrawal of the Division's approval of the specialty board. Fourth, the ACGME- or RCPSC-accredited residency program required under subsection (C) above must have provided training in the conditions and disease processes that are included in the new specialty.

The April 1 hearing elicited comment from physicians and DMQ members alike. Some physicians and DMQ member Dr. Michael Weisman requested clarification of language under the equivalency option. Some physicians argued that language in the equivalency option would effect a lower standard than desired or prove too difficult and cumbersome for DOL to determine whether the standards are met. One physician expressed concern that the regulation would be too costly to administer and enforce. Another expressed approval of Dr. Milkie's proposed requirement that the "identifiable training" required for equivalency option approval be evaluated by DOL to ensure that it is adequate for training in a specialty area of medicine. DMQ member Dr. John Kassabian also approved this requirement. DMQ voted to approve the February 25 regulation as amended by Dr. Milkie's revisions with several minor modifications in language. The modified text was released for an additional 15-day public comment ending April 29. MBC's SB 2036 Committee was scheduled to meet on May 28 in Torrance to review the comments received and determine whether DMQ should schedule another public hearing in June. At this writing, it appears that another public hearing will be necessary. If so, MBC will probably be unable to complete the entire rulemaking process (including OAL approval) by the time SB 2036 takes effect on January 1, 1993. It is anticipated that MBC will seek legislation to delay implementation of SB 2036 until January 1, 1994.

Public Hearings on Improving Patient Protection in Outpatient Surgery Centers. MBC is receiving an increasing number of complaints that indicate inadequate protection for consumers who undergo significant surgeries in unregulated outpatient clinic settings. These settings are not licensed or accredited by any private agency or Medicare.

At its May 8 meeting, DMQ discussed a proposal presented by MBC Administrative Analyst Rick Wallinder for two public hearings to address this issue. According to Wallinder, unregulated outpatient surgery settings may not provide the quality assurance controls found in hospitals and accredited outpatient facilities. These controls include a credentials review of physicians; physician proctoring if considered appropriate; verification of licensure and disciplinary action with MBC and the National Practitioner Data Bank; regular quality and utilization committee reviews; and organized staff bylaws.

The proposed hearings would provide a means of obtaining information to determine the extent of risk to consumers and the options available to ensure patient protection in outpatient surgery settings. The goal would be to obtain input from consumers, providers, private accrediting organizations, and public regulatory agencies. The hearings were scheduled for June 10 in San Francisco and July 9 in Los Angeles. DMQ formed a subcommittee comprised of public member Frank Albino and Dr. Clarence Avery to address this issue on behalf of DMQ.

DMQ Explores Diversion Program Issues. At its May 8 meeting, DMQ discussed three issues related to its Diversion Program, which is created in Business and Professions Code section 2340. The purpose of the Diversion Program is to enable DMQ to "identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety."

The Division first discussed the criteria for the admission of sexual misconduct cases to the Program. DMQ member Dr. Michael Weisman reported that since January 1, the Division has seen three cases involving sexual misconduct by physicians in which the physician proposed to enter the Diversion Program by stipulation with DMQ. The Division rejected all three stipulations. Weisman

asserted that sexual addiction is not a bona fide mental disease or a diagnosable dysfunction qualifying for admission to the Diversion Program. Because the condition is dangerous, not easily treated, and recidivism is high, Weisman expressed concern that sexual abuse cases admitted to the Diversion Program are being diverted from the discipline process. To explore this problem, DMQ sought specific information from Diversion Program Manager Chet Pelton.

According to Pelton, Business and Professions Code section 2340 authorizes DMQ's Diversion Evaluation Committees to accept mentally ill physicians into the Diversion Program. The DSM III-R contains the commonly accepted categories for diagnosing mental illnesses, including sexual disorders and dysfunctions. Since 1980, 12 persons have been admitted to the Diversion Program for sex problems.

Weisman asserted that DSM III-R does not cover sexual impulsive behavior disorders because they are not listed among the categories enumerated under DSM III-R's list of "Sexual Disorders." He urged DMQ to reassess sexual abusive behavior as a Diversion Program eligibility criterion for two reasons: (1) the mental illness categories do not apply to this disorder; and (2) the protection of the public requires it.

Executive Director Ken Wagstaff explained that despite the name "Diversion Program," DMQ does not completely divert a physician from the discipline track when he/she is accepted into the program. Rather, DMQ goes forward with discipline when there is evidence requiring it. Public member Frank Albino reminded his colleagues that DMQ addressed this issue in 1990, and decided that so long as there is no disruption of the disciplinary process, physicians who could be helped by the Diversion Program without compromising public protection should be admitted. *[11:1 CRLR 67; 10:4 CRLR 81]* Weisman reasserted his desire that DMQ develop specific policies which define who shall evaluate and diagnose alleged sexual misconduct offenders and what steps should be taken to handle them. Staff will work with Dr. Weisman to develop a report for discussion at a future DMQ meeting.

Next, DMQ discussed whether to allow physicians with revoked licenses in the Diversion Program. Under a decision made by DMQ in 1987, physicians whose licenses have been revoked are not allowed in the Program. According to staff, although a change in regulations would best clarify this issue, current regulations might be interpreted to allow such physicians to be monitored and evaluated in the program for a short period of time to assist DMQ in evaluating the physician's rehabilitation prior to reinstatement of the license. This change would enable DMQ to make a more informed decision about reinstatement and give the physician a greater opportunity to deal with his/her problem.

Public member Frank Albino was in favor of the proposed change and would further support expanding it to include full-fledged participation of revoked licensees in the Diversion Program. However, Dr. Michael Weisman and Dr. Clarence Avery expressed their desire for more information before making a decision. DMQ voted to defer a decision until its next meeting and directed staff to prepare a report including the number of physicians whose licenses are revoked per year, with a breakdown by reason (*e.g.*, drug/alcohol abuse, etc.), and the number of physicians reinstated per year.

Finally, Diversion Program Manager Chet Pelton presented a proposal under which DMQ's Diversion Program would administer the diversion program of the Board of Examiners in Veterinary Medicine (BEVM). In January, DMQ assumed the administrative functions of the diversion program of the Board of Podiatric Medicine (BPM). Under the proposal, DMQ would administer the BEVM program the same as it does the BPM program. BEVM would have its own Diversion Evaluation Committee and would reimburse DMQ $2,300 per participant per year for the cost of providing administrative services. Mr. Pelton informed DMQ that there are currently only 11 participants in BEVM's diversion program; the number of participants is anticipated to remain at this level; and monitoring these additional participants would have little impact on DMQ's Diversion Program workload since it has monitored between 245 and 258 active physician participants per year over the past two years. Based on Pelton's recommendation, DMQ unanimously approved MBC's assumption of the administrative functions of BEVM's diversion program.

DMQ Reassesses Size and Role of MQRCs. At its January meeting, DMQ reviewed a proposal submitted by the MQRC Council suggesting an expansion in the role and responsibilities of the MQRCs. MQRCs are currently permitted to conduct disciplinary hearings and confidential physician peer counseling sessions; however, over the past few years, administrative law judges from the Office of Administrative Hearings have presided over the vast majority of disciplinary hearings. The MQRC Council, headed by Dr. Guy Hartman, proposed to expand the role of the MQRCs to strengthen MBC's enforcement program. The proposed MQRC functions included the following:

–Conduct peer counseling interviews with licensees who are the subjects of closed complaints. Sessions would be voluntary but not confidential, and the subject would be so informed. The case may be reopened if something substantially negative is discovered during the interview.

–Assist in finding expert reviewers in various specialties for use in obtaining expert medical opinions.

–Be available by telephone or in person for informal advice needed by DMQ's medical consultants.

–Review closed cases as part of a quality assurance program.

–Participate with medical consultants in interviews with licensees who are the subject of closed investigations. Interviews would focus on ways the physician could improve his/her practice to avoid future complaints.

–Assist medical consultants by doing medical record abstractions.

–Administer voluntary or MBC-ordered professional competency exams, write exam questions, and assist in finding examiners.

–Assist in probation monitoring of certain physician probationers who do not need extensive monitoring.

–Participate in the outreach activities of MBC's speakers bureau, which would include speaking to hospitals, community groups, etc.

–Participate in long-term care quality assurance reviews, commencing in 1992 at the earliest.

CMA representative Dr. Vernon Williams opposed the proposal, arguing that it would move MQRCs into an investigatory and prosecutorial capacity. Williams questioned whether the proposal would preclude MQRC members from hearing cases because, after they have assisted in the investigation or analysis of a case, they would no longer be unbiased. Of particular concern was the proposal regarding interviews of physicians who are the subject of a closed complaint. According to Williams, because information revealed during the interviews could be used against the physician to reopen the case, the physician who feels pressured to participate would become vulnerable in a way that he/she may not realize.

With the exception of the provisions for post-complaint and post-investigation interviews, DMQ adopted the study proposal. The Division formed a subcom-

mittee consisting of Dr. Michael Weisman and Dr. Andrew Lucine to study the need to further modify the proposal and to reassess the entire MQRC program, including size, functions, structure, and manner of appointment to the committees.

At its May 8 meeting, DMQ received a revised proposal from the MQRC Council, which would permit MQRC members to conduct peer counseling interviews with physicians who are the subjects of complaint cases and investigation cases that have been recommended for closure, but which have not yet been closed. DMQ approved the provisions as modified by the Council. DMQ member Dr. Michael Weisman then reported on behalf of the subcommittee charged with assessing the role of the MQRCs. In April, the subcommittee directed MBC staff to conduct a study of MQRC functions, and the number of MQRC members necessary to accomplish them and any expanded duties that would be considered appropriate. Preliminary data indicate that the state and DMQ would be well served by about 100 MQRC members, which is less than half the current number. A final report was expected at DMQ's July meeting.

DMQ also received a report on the results of an interest survey distributed to MQRC members in April. The survey was developed to gather data on the level of member interest in the MQRCs' existing and expanded roles and responsibilities. Members expressed a high level of interest in participating in discipline hearings and petition hearings, and a low level of interest in long-term care quality assurance reviews.

DOL to Appeal OAL Rejection of Training Program Regulation. Over two years ago, DOL proposed amendments to sections 1324 and 1325.5, Division 13, Title 16 of the CCR. Under these sections, DOL may approve alternate training programs, commonly known as "section 1324 programs," for foreign medical graduates (FMGs) who are seeking licensure but having difficulty securing an ACGME-approved PGT program. In amending the regulations, DOL intended to respond to criticisms by CMA and all medical schools in California that section 1324 programs are inferior to those approved by the ACGME, exploitative in that the sponsoring training facility sometimes charges the FMG a significant amount of money (up to $35,000) for the privilege of receiving the training, and unnecessary in that there are sufficient ACGME-accredited residencies in California to accommodate FMGs. *[12:1 CRLR 71; 11:4 CRLR 86–87; 11:1 CRLR 69]*

Both DCA and OAL rejected DOL's regulatory changes during 1991. In November 1991, DOL members Dr. John Lungren and Ray Mallel were appointed to work with DCA on the regulations; following consultation with DCA, DOL resubmitted the package to OAL on December 23—but without securing DCA's approval of the final package as required by law.

On January 21, OAL again rejected the proposed regulatory changes on grounds that the rulemaking record failed to comply with the necessity and consistency standards of Government Code section 11349.1. Specifically, OAL found that DOL failed to sufficiently explain the necessity of requiring the medical director to have an MD degree, and that the requirement is inconsistent with Business and Professions Code section 2453, which provides that it is the policy of the state of California that holders of MD and DO degrees be accorded equal professional status and privileges as licensed physicians and surgeons. OAL also rejected the proposed regulations because they were not submitted for review by the DCA Director; therefore, they are inconsistent with Business and Professions Code section 313.1, which requires submission to DCA as a precondition to the filing of any rule or regulation with OAL.

Following negotiations with DCA and DCA approval, DOL resubmitted the regulations to OAL. On May 7, OAL approved DOL's regulatory amendments to section 1324, but again rejected its proposed amendment to section 1325.5. OAL rejected DOL's arguments that the section does not discriminate against DOs: "As a state agency [subject to section 2453], the [Medical] Board is attempting to prohibit osteopathic physicians from being employed as a medical doctor. To imply that such employment is not part of the physician's professional service is misleading."

At its May meeting, DOL voted to appeal this decision to the Governor. Under section 11349.5 of the Administrative Procedure Act (APA), an agency may initiate a review of an OAL rejection by filing a written request for review with the Governor's Legal Affairs Secretary within ten days of receipt of the written opinion provided by OAL, and must deliver a copy to OAL the same day. OAL has an opportunity to file a written response within ten days of receipt of the agency's request for review. If Governor Wilson overrules OAL's decision, the APA requires that he immediately transfer to the Rules Committee of both houses of the legislature a statement of his/her reasons for doing so, along with copies of the adopting agency's initial statement of reasons and OAL's disapproval statement.

DOL Begins Rulemaking to Implement Physician Questionnaire. Sections 920–925 of the Business and Professions Code concern healing arts licensees and require MBC to issue a report containing certain data every two years. For example, MBC must publish the number of active and inactive licensees; the number of licensees employed full- and part-time; and the number of active licensees who graduated from California medical schools, among other things. MBC also intends to ask whether each respondent is currently in an ACGME-approved PGT residency or clinical fellowship training program; whether respondents perform significant surgeries and in what type of setting; type of practice and/or employment setting; identification of medical specialties and recognized subspecialties in which respondents have achieved certification; whether respondents have admitting privileges at more than one hospital; and whether respondents have participated in any hospital's peer review or ethics committees in the past four years.

To obtain these data, a biennial survey of physicians and surgeons will be implemented. Business and Professions Code section 924 authorizes MBC to take appropriate sanctions against any licensee who fails to complete and return the survey. At its May meeting, DOL approved draft regulatory language and directed staff to begin the rulemaking process to make ineligible for license renewal any physician who fails to complete and return the questionnaire by the time his/her license expires. The proposed regulation will permit DOL to waive submission of the questionnaire by any physician who for reason of retirement, poor health, military service, or undue hardship is exempt from DOL's continuing education requirements or from the payment of a renewal fee. A hearing was scheduled for the Division's July meeting.

Other MBC Rulemaking. Following is an update on several other rulemaking proceedings recently undertaken by the Medical Board:

–Medical Assistants. On March 20, OAL approved DAHP's adoption of new sections 1366, 1366.2, and 1366.4, and amendments to sections 1366.1 and 1366.3. These regulatory changes define the technical supportive services which may be performed by medical assistants (MAs), set forth the training which must be provided to an MA by the supervising physician/podiatrist or in an approved community college/postsecondary in-

stitution, and set forth recordkeeping requirements regarding services provided by MAs. *[11:4 CRLR 87–88; 11:3 CRLR 87]*

–Physician Assistant Scope of Practice. DAHP's 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, were approved by OAL on January 28. (*See infra* agency report on PHYSICIAN ASSISTANT EXAMINING COMMITTEE for related discussion.)

–DOL Approval of Clinical Training Programs. On April 22, OAL approved DOL's proposed amendments to section 1327, Division 13, Title 16 of the CCR. This section requires California hospitals to obtain DOL's approval prior to providing clinical training to foreign medical students or graduates. This amendment exempts from the approval requirement health facilities that have a major affiliation with an approved California medical school and facilities with ACGME-accredited PGT programs. *[12:1 CRLR 71–72]*

DAHP Discusses Its Future. At its May 7 meeting, DAHP held a two-hour roundtable discussion of the need for its continued existence. DAHP President Dr. Madison Richardson called the roundtable to address the Division's legal authority and supervisory role over its allied health licensing programs (AHLPs), both of which have diminished dramatically over the past decade as the legislature has delegated more authority and independence to the individual boards and committees under DAHP's jurisdiction. At this point, DAHP's only legal responsibility is to provide advisory oversight for all the AHLPs and approve all rulemaking for a small number of the programs.

The issue of the need for DAHP's existence has been raised on several previous occasions; no resolution has ever been reached, and none surfaced at the May 7 meeting. The desire of physicians to control the scope of practice of allied health professions, once deemed an adequate policy justification for DAHP's existence, is no longer defensible and has been effectively rejected by the legislature. At this writing, the severe budget crisis of both MBC and the state may become the undoing of DAHP, rather than any formal decision by the Division to disband.

LEGISLATION:

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including MBC, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. SB 2044 would also require the DCA Director to develop guidelines and prescribe components for mandatory continuing education programs administered by any board within the Department. *[A. CPGE&ED]*

AB 2743 (Lancaster), as amended April 9, is another DCA omnibus bill which would, among other things, expressly authorize DCA boards in disciplinary proceedings to request the administrative law judge to direct the licentiate, in certain circumstances, to pay to the board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. The Medical Board has consistently resisted the implementation of the "cost recovery" system to be authorized by this bill, and has also refused to implement its existing authority to create a system of citations and fines for minor violations of the Medical Practice Act (*see supra* MAJOR PROJECTS). AB 2743 would also authorize DCA boards to revoke, suspend, or otherwise restrict a license on the ground that the licensee secured the license by fraud, deceit, or misrepresentation. *[A. Floor]*

AB 3239 (Filante), as amended April 2, is the result of three years of debate within DOL and the medical community over licensure standards for graduates who have not attended medical schools approved by the American Medical Association (AMA). To qualify for physician and surgeon licensure, existing law requires a candidate to complete the curriculum at an approved medical school (or its equivalent), pass specified examinations, and satisfactorily complete one year of approved postgraduate training (PGT). The Division of Licensing does not approve medical schools; it leaves that task to the AMA, which only approves schools in the United States and Canada. Thus, the Division is left to adjudge the equivalency of curricula at foreign medical schools attended by licensure applicants, including the quality of clinical training received during the third and fourth years of medical school.

Over the past few years, the increasing complexity of this task and the litigation it has wrought led DOL to consider other options to ensure competence prior to licensure. After lengthy debate and consideration, the Division settled upon an increase in the number of years of approved PGT training for candidates who have not attended an approved medical school. The rationale, simply speaking, is that an additional year of PGT in an approved setting would remediate any actual or perceived deficiencies in the candidate's undergraduate basic sciences or clinical training. *[12:1 CRLR 72; 11:4 CRLR 86; 11:3 CRLR 85]*

As amended April 2, AB 3239 would add section 2097 to the Business and Professions Code; this provision specifies that "each applicant...who is licensed as a physician and surgeon after December 31, 1993, shall show by evidence satisfactory to the Division of Licensing that he or she has satisfactorily completed at least one year of postgraduate training in addition to that postgraduate training required for licensure under sections 2096, 2101, 2102, or 2103...[of the Business and Professions Code]." Applicants subject to this provision must complete the extra year of PGT within 24 months after initial licensure; if not, the license will not be renewed. Although the bill technically applies to all candidates for licensure (including those who have attended a U.S. or Canadian medical school), its last provision permits applicants who have attended an approved school to substitute two academic years or 72 weeks of clinical instruction in such a school for the required additional year of PGT.

This bill would also amend Business and Professions Code section 2107 to provide that the completion of the PGT on or before the date that the initial license expires would reduce the physician's biennial renewal fee by 50% of the biennial renewal fee established by MBC. The bill would also prohibit MBC from renewing the license at the time of its expiration if this PGT is not completed as prescribed. *[A. Floor]*

AB 3134 (Hunter). Existing law requires instruction in clinical courses as a condition of licensure for physicians and includes instruction in a hospital that is formally affiliated with an approved medical school located in the United States or Canada. As introduced February 20, this bill would give credit only for instruction in the subject areas covered by the affiliation agreement, if the affiliation is limited in nature. This bill would also clarify existing law to authorize a licensure candidate whose undergraduate education and clinical instruction is adjudged deficient by DOL to engage in the practice of medicine in any setting approved by DOL.

Existing law sets forth licensure requirements for a licensure candidate who is a graduate of a medical school located

outside the United States or Canada; those candidates must complete one year of prescribed PGT. This bill would instead require those applicants to satisfactorily complete the same PGT that is required of other applicants.

Existing law requires MBC licensure applicants to pass an examination in the basic sciences and clinical sciences, as determined by DOL, and to pass an examination designed to test their clinical competency; existing law requires applicants to achieve a passing score established by DOL on each part of the examination. This bill would amend these provisions to pave the way for the administration of the new United States Medical Licensing Examination (USMLE) in California. The USMLE will be given to all medical graduates, eliminating the different exams for those graduating from domestic and foreign schools. *[S. B&P]*

AB 3309 (Moore), as amended May 12, would—notwithstanding any other provision of law—require a physician requesting a clinical laboratory test to, upon request of a patient who is the subject to the test, provide the patient with the results of the test in plain language conveyed in the manner deemed most appropriate by the health care professional who requested the test. AB 3309 would require that these test results be recorded in the patient's medical record and be reported to the patient within one week after the test results are received at the office of the physician who requested the test. A willful violation of this requirement would constitute unprofessional conduct under existing provisions of law. *[A. Floor]*

AB 828 (Hansen), as amended January 8, would exempt a physician from liability for any injury or death caused by a negligent act or omission of the physician, when he/she is in good faith and without compensation or consideration rendering voluntary medical assistance at a shelter, as defined, that is privately operated. The immunity provided by this bill would apply only to physicians who comply with applicable licensing requirements and do not possess medical malpractice liability insurance. Under the bill, the immunity would attach only if the shelter posts a sign that fully informs all persons who seek medical care at the shelter that they may be unable to seek compensation for injuries received; physicians would be required to make a similar disclosure. *[S. Jud]*

AB 3279 (Polanco), as amended May 7, would have provided immunity from liability for civil damages for licensed physicians who voluntarily and without compensation render free medical care to any patient at any clinic which is organized in whole or in part for the delivery of primary health care services without charge, if prescribed notice requirements are complied with, unless the act or omission is the result of the licensee's gross negligence or willful misconduct. The bill would have limited the scope of the immunity to licensed physicians including, but not limited to, retired physicians, who fully comply with all applicable licensing requirements and do not possess medical malpractice insurance for the medical assistance to which the immunity provided by the bill applies. This bill was rejected by the Assembly Judiciary Committee on May 12.

SB 1813 (Russell), as amended April 2, is a follow-up bill to SB 1070 (Thompson) (Chapter 1180, Statutes of 1991). SB 1070 requires the Department of Health Services (DHS) to promulgate guidelines and regulations to minimize the risk of transmission of bloodborne infectious diseases in the health care setting by January 1993. It requires MBC and other health profession regulatory agencies to ensure that their licentiates are informed of their responsibility to minimize the risk of transmission of bloodborne infectious diseases in the health care setting, and makes it unprofessional conduct for a licentiate to knowingly fail to protect patients by failing to follow DHS' infection control guidelines (*see supra* MAJOR PROJECTS).

SB 1813 would provide that, in investigating and disciplining physicians for knowing failure to protect patients from transmission of bloodborne infectious diseases in the health care setting, MBC shall consider referencing DHS' guidelines; it would also require MBC to consult with the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nurse and Psychiatric Technician Examiners to encourage consistency in the implementation of this provision. *[A. Health]*

AB 3426 (Filante), as introduced February 21, would require DOL to charge an additional $25 fee to applicants and licensees at the time of initial issuance and biennial renewal of a license. The bill would provide that payment of the $25 fee is voluntary, and would require that physicians be given the opportunity to expressly refuse to contribute. The bill would also require MBC to transfer the fees collected pursuant to this bill, on a monthly basis, to the Office of Statewide Health Planning and Development for support of the Song-Brown Family Physician Training Act (Education Code section 69270 *et seq.*), under which the Office is required to select and contract with accredited medical schools for the purpose of training medical students and residents in the specialty of family practice in order to increase the delivery of primary care health services in areas of the state with unmet needs for providers of those services. *[A. Floor]*

SB 1876 (Deddeh). Existing law provides that a holder of a physician's certificate who, while in actual attendance on patients, is intoxicated to such an extent as to impair his/her ability to conduct the practice of medicine with safety to the public and his/her patients, is guilty of unprofessional conduct. As amended May 5, this bill would also provide that those persons are guilty of a misdemeanor. *[S. Appr]*

AB 3635 (Polanco). Existing law requires DOL to adopt and administer standards for the continuing education of physicians. As introduced February 20, this bill would require DOL to include courses on risk management among the approved courses for continuing education. *[S. B&P]*

AB 3077 (Katz), as amended April 21, would, notwithstanding any other provision of the Medical Practice Act, require DOL to deny licensure renewal to any person who fails to provide service as a general practitioner or surgeon as required pursuant to a grant agreement entered into between the physician and the National Health Services Corps program or the federal loan insurance program, unless the physician has filed with DOL a repayment plan accepted by the federal government in accordance with the terms of the grant or loan insurance program. The bill would require DOL annually to determine if repayments are current and to deny license renewal if a licensee's repayments are not current. *[A. Floor]*

The following is a status update on bills reported in detail in CRLR Vol. 12, No. 1 (Winter 1992) at pages 73–74:

SB 1119 (Presley), as amended May 14, would provide that on or after January 1, 1993, the initial physician's license fee and the biennial renewal fee shall each be $550, or a higher amount fixed by MBC not to exceed $600.

Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify MBC of any filings of felony charges against a licensee. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC, and to transmit any felony preliminary hearing transcripts to MBC. This bill would ex-

pand these requirements to also require notification to other applicable allied health professional program committees or boards of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

AB 1199 (Speier), as amended January 23, would prohibit, on or after January 1, 1993, a private 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 would also prohibit a private health facility operating a PGT program from routinely relying on resident physicians to perform ancillary services, as defined. *[S. B&P]*

AB 2180 (Felando), as amended April 30, would amend SB 2036 (McCorquodale) (*see supra* MAJOR PROJECTS) by prohibiting an MBC-licensed physician who is certified by an organization other than a board from using the term "board certified" in reference to that certification. This bill would also provide that any MBC-licensed physician who specializes in pain management and who is certified by the American Academy of Pain Management is deemed to have met those requirements and may inform the general public of his/her certified status. *[S. B&P]*

AB 569 (Hunter), as amended February 10, would require that any advertisement of board certification by a physician pursuant to SB 2036 include the full name of the board or association. This bill would also permit MBC to assess a fee for approval of a public or private board or association for advertising purposes. Over the summer, this bill is expected to be amended to override the physician assistant scope of practice regulations recently adopted by DAHP. (*See infra* agency report on PHYSICIAN ASSISTANT EXAMINING COMMITTEE for related discussion.) *[S. B&P]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any physician to assess additional charges for any clinical laboratory service that is not actually rendered by the physician to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and Assembly, and is currently awaiting Senate concurrence in Assembly amendments.

AB 190 (Bronzan), as amended May 5, would require a physician to give each patient a copy of the relevant standardized written summary describing the risks and possible side effects of silicone implants and collagen injections and collagen injections used in plastic, reconstructive, or similar surgery, before the physician performs the surgery. *[S. Appr]*

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 peer review 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. *[S. Jud]*

AB 704 (Speier), as amended July 11, would require DMQ, when reviewing 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. *[S. B&P]*

AB 819 (Speier). Existing law generally provides that it is not unlawful for prescribed licensed health professionals, including physicians, to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or co-ownership in the facility. As amended January 29, this bill would instead provide that it shall be unlawful for these licensed health professionals to refer a person to any diagnostic imaging center, clinical laboratory, physical therapy or rehabilitation facility, or psychometric testing facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest, and would provide that disclosure of the ownership or proprietary interest does not exempt the licensee from the prohibition. It would, however, permit specified licensed health professionals to refer a person to such a facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest if the person referred is the licensee's patient of record, there is no alternative provider or facility available, and to delay or forego the needed health care would pose an immediate health risk to the patient. *[S. B&P]*

The following bills were recently dropped by their authors: ***AB 1084 (Filante)***, which would have enabled the California Medical Association to revive its Medical Practice Opinion Program in such a way as to immunize it—theoretically—from tort and antitrust liability; ***AB 992 (Brulte)***, which would have required medical experts testifying in medical malpractice actions against a physician to have substantial professional experience in the same medical specialty as the defendant; ***AB 112 (Kelley)***, which would have exempted 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 117 (Epple)***, which would have exempted 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; ***AB 1183 (Speier)***, which would have required MBC to develop a California Indigent Obstetric Care Indemnification Program, providing 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; ***AB 2222 (Roybal-Allard)***, which would have provided 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; and ***SB 1190 (Killea)***, which would have enacted the Licensed Midwifery Practice Act of 1991, establishing within DAHP a five-member Licensed Midwifery Examining Committee.

LITIGATION:

In ***Lopez v. Board of Medical Quality Assurance***, No. B061468 (May 13, 1992), the Second District Court of Appeal upheld the Medical Board's refusal to license Dr. Wanda Lopez, who graduated from San Juan Bautista School of Medicine (Bautista) in Puerto Rico in 1981, completed clinical residency studies in accredited New York hospitals from 1981 through 1983, and completed a fellowship in internal medicine in Massachusetts from 1984 through 1986. She is licensed to practice in Puerto Rico, Vermont, Massachusetts, and New York; at the time of her application for California licensure, she was employed by the U.S. Navy as a medical doctor in Long Beach.

In spite of her numerous years of practice, DOL rejected Dr. Lopez' application for licensure because Bautista is not an "approved" medical school. The court described DOL's two-tiered licensing procedure—one for graduates of medical schools in the United States or Canada (Business and Professions Code section 2080 *et seq.*), and one for graduates of foreign medical schools (section 2100 *et seq.*). The Division of Licensing, however, does not "approve" any medical schools. Instead, it relies on the Liaison Committee on Medical Education (LCME) of the American Medical Association; any medical school recognized by the LCME is deemed approved by DOL. The LCME does not evaluate foreign medical schools. However, section 2084 states that DOL "may approve every school which substantially complies with the requirements of this chapter for resident courses of professional instruction."

Dr. Lopez argued that the plain meaning of section 2084 requires DOL to evaluate the curriculum at Bautista and exercise its discretion as to whether it substantially complies with the Medical Practice Act. The court disagreed, and concluded that "section 2084 means the Division of Licensing *may*, but need not, approve a substantially complying school" (emphasis original). The court cited "practicalities" as another justification for its holding: The LCME process is "a tremendously complex process" which takes over two years and at least two site visits, and it is "impractical" to think that such a process could be adequately duplicated in a half-day administrative hearing on the denial of a license, where witnesses are attempting to prove the equivalence of "some distant, unseen school...almost a decade after the fact."

The court also rejected Dr. Lopez' argument that Bautista is not a United States medical school for which LCME approval is required, but a foreign medical school for which its approval is not required. Because Puerto Rico is a commonwealth of the United States, the court concluded that the Board's classification of Bautista as a United States medical school is not unreasonable.

RECENT MEETINGS:

At its January 31 meeting, DAHP was addressed by Board of Podiatric Medicine (BPM) President Karen McElliott and Executive Officer Jim Rathlesberger regarding the possibility of a name change for the Division. *[12:1 CRLR 75]* Although BPM is structurally placed under the jurisdiction of the Medical Board and the Division of Allied Health Professions, podiatrists are physicians and not "allied health professionals." McElliott and Rathlesberger explained that 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 the "Division of Health Professions," and noted that the California Podiatric Medicine Association has endorsed that proposal. The consensus of DAHP was that a name change must be considered in light of public safety and any new name must not be misleading. Division public member Alfred Song pointed out that "Division of Health Professions" would be inadequate because the Division does not include physicians—one of the primary health professions. CMA representatives present also opposed the suggested name on these grounds. Song advised Rathlesberger that the best approach to this problem might be for BPM to seek legislation to remove itself from DAHP. After discussion, the Division directed DAHP Program Manager Tony Arjil to meet with Rathlesberger and representatives of CPMA and CMA to develop alternate names. The Division encouraged the allied health licensing programs under its jurisdiction to participate in this discussion.

Also in January, DAHP revised the procedure it uses to review applications from MBC-licensed physicians to supervise physician assistants. (*See infra* agency report on PHYSICIAN ASSISTANT EXAMINING COMMITTEE for details.)

At DOL's January meeting, staff announced that the Division's Faculty in Exile Committee (FIEC) had sunsetted on December 31, pursuant to Business and Professions Code section 2122. Due to DOL's refusal to license Vietnamese medical graduates in 1986, the legislature created the FIEC in SB 1358 (Royce) (Chapter 1382, Statutes of 1987); the Committee was charged with evaluating the application files of Vietnamese medical graduates who graduated from the University of Saigon Medical School between 1976 and 1980, and making recommendations to DOL on the applicants' eligibility for licensure under California law. Under section 2122, DOL was required to accept the FIEC's recommendation unless the Division found, after notice and an opportunity for hearing, that the Committee's recommendation was not based upon substantial evidence. Between its first meeting in February 1988 and its last meeting in November 1991, the FIEC reviewed a total of 93 application files; it approved 85 applicants to continue in the licensing process, deferred five files pending the receipt of additional information, and referred three files to DOL's Application Review Committee (ARC) with no recommendation. Of the 93 applicants reviewed, 33 have been licensed, 44 are still active in the licensing "pipeline," 11 files were closed for lack of interest on the applicant's part, two files were closed at the applicant's request, and DOL was unable to contact two of the applicants. At the time of the FIEC's retirement, no new applications were pending; if and when such applications are received in the future, they will be forwarded directly to the ARC.

Last November, member Dr. Robert del Junco suggested that the Division create a program to educate potential licensees of the Medical Board on non-competency aspects of the practice of medicine in California. *[12:1 CRLR 75]* At its January meeting, DOL approved a survey to be distributed to candidates for licensure prior to taking the oral exam. Responses to this questionnaire will be used to develop an education seminar for future licensure candidates who are waiting to take the oral exam. At its May meeting, DOL reviewed the responses to the survey, which was distributed to candidates who took the Board's oral exam on March 24 in Los Angeles. DOL obtained a 100% response from all 239 candidates. The survey asked 34 questions taken from MBC's *Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons*, which is mailed to each applicant at the time they are notified of their eligibility to take the oral exam. The questions covered license renewals and fees, the Diversion Program, enforcement, and the practice of medicine in California. According to DOL staff, the results of the survey indicate that few candidates actually read the *Guidebook*, and the manual should not be considered a reliable

method of disseminating important information to potential California licensees. The survey will be distributed at future oral exams to obtain a broader sample prior to further action on the orientation program.

At its May meeting, DOL appointed members Dr. Robert del Junco, Dr. B. Camille Williams, and Ray Mallel to review the basic science curriculum required during the first two years at dental schools. Many dental students transfer to medical school after the first two years, and DOL seeks to ensure that the basic science curriculum at dental school is equivalent to that required in medical schools.

At its May 8 meeting, the Medical Board recognized six members whose terms expire in June or July 1992: Dr. J. Alfred Rider, Frank Albino, Dr. Andrew Lucine, Audrey Melikian, Dr. John Tsao, and Alfred Song. Additionally, the Board applauded several staff members who have served 25 years in state service, including Assistant Executive Director Tom Heerhartz (22 years at DHS and 3 years at MBC); Diversion Program Manager Chet Pelton (18 years at DHS and 7 years at MBC); Enforcement Program Assistant Analyst Pat Parkhardt; Lowell Jibbon, Senior Investigator at MBC's Sacramento regional office; and Ed Raley, Senior Investigator at MBC's San Diego regional office. Finally, the Board honored Enforcement Chief Vern Leeper, who is retiring on June 30 after 15 years at the Medical Board.

FUTURE MEETINGS:

November 5–6 in Los Angeles.

ACUPUNCTURE COMMITTEE

Interim Executive Officer:
Curt Augustine
(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. AC still functions under the jurisdiction and supervision of DAHP.

Formerly the "Acupuncture Examining Committee," the name of the Committee was changed to "Acupuncture Committee" effective January 1, 1990 (Chapter 1249, Statutes of 1989). That statute further provides that 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.

Following the mass resignation of four AC members at the Committee's December 1991 meeting *[12:1 CRLR 76]*, Assembly Speaker Willie Brown appointed his son Michael to fill a public member slot in early February. On February 18, Governor Wilson appointed three new acupuncturist members: Marguerite Mei-Yu Hung, Angela Ying Tu, and Young Park. Park, however, resigned immediately after his appointment (*see infra*). In addition, the Governor reappointed acupuncturist David Chen, who is currently serving as Committee chair, to another term on AC. In late March, Governor Wilson appointed Jeanne Tumanjan, Jane M. Emerson, and Jane Barnett to the Committee.

MAJOR PROJECTS:

AC Terminates Executive Officer. Having barely survived a 1989 scandal in which one of its own members was found to have sold its licensing exam over a five-year period and recent bid-rigging allegations which led to the mass resignation of four members in December 1991, the Acupuncture Committee once again became the center of controversy when it fired Executive Officer Lynn Morris at an April 21 public meeting. Although the executive officer is an "at will" employee and may be fired at any time by the Committee for any reason or for no reason at all, the circumstances surrounding the termination sparked anger within the acupuncture profession and various acupuncture schools.

According to some accounts, the events leading to the termination began last winter, when four of the Committee's nine members resigned at a public meeting after unsuccessfully challenging Morris' actions in hiring a new contractor to draft and administer AC's licensing examination. Morris was one member of the Evaluation Committee which analyzed the various bids on the exam contract, and her voting pattern led to the discontinuation of the contract to Hoffman Research Associates (AC's exam contractor for the past two years) and its award to National Credential Clearinghouse (NCC). The December 1991 resignations resulted from allegations by four AC members that Morris had "rigged" the bid process to favor NCC, was biased during the contract review and selection process, misled AC members about the bidding process, and made derogatory remarks about Asian members of the Committee. When their allegations were challenged by the other five members of AC and the upper staff of the Department of Consumer Affairs (DCA), the four accusers—then-AC Chair Lam Kong, Sophia Peng, Janny Shyr, and Mason Shen—abruptly resigned and left the meeting. DCA staunchly supported Morris throughout the entire controversy. *[12:1 CRLR 76–77]*

Subsequently, the Governor's Office moved to appoint new members to the Committee, including several acupuncturists. DCA contends that, on behalf of the Governor, it asked Morris to perform background checks on three prospective acupuncturist appointees, including Young Park. Morris and/or AC staff allegedly cleared all three, and the Governor appointed them to multi-year terms. Immediately after the appointments, however, DCA discovered that Park had allegedly been involved in the 1989 Chae Woo Lew bribery scandal. To head off an extremely embarrassing situation, DCA demanded Park's resignation and got it. Following this incident, DCA Director Jim Conran met with Morris and AC Chair David Chen on April 6, and told Morris that the Wilson administration had lost confidence in her and gave her the opportunity to resign. If she insisted on staying, Conran warned her that the Committee—a majority of whom are now Wilson appointees—would vote to fire her, and the termination would have to take place at a public meeting under the Bagley-Keene Open Meeting Act.

Later that day, Morris wrote Conran a letter advising him that "it is not my intent at this time to submit my resignation as Executive Officer of the Acupuncture Committee." Morris alleged that her ouster was politically motivated, because for a two-year period she has advised DCA, its legal counsel, the Attorney General's Office, the Los Angeles District Attorney, and former Governor Deukmejian's office of "serious improprieties" on the part of "a Gubernatorial appointee" on the Committee,

which accusations were "ignored by the previous administration." Morris rejected the articulated reason for her termination: "To suggest at this juncture that it was somehow my fault or my staff's responsibility that the Governor's office failed to conduct a thorough and adequate background check of one of the administration's appointees, to a Committee beset with legal scrutiny and alleged improprieties, is unconscionable. I will not be the scapegoat for any such irregularity." Morris also stated her "awareness of the discomfort experienced by certain members of the acupuncture profession as a consequence of the information I have brought forward and their determination to see my resignation," and expressed disappointment that the Governor "would capitulate to such pressure."

Conran responded on April 8, emphasizing the fact that the Executive Officer serves at the pleasure of the Committee. "It is my judgment that the Committee now judges that they should have a new executive officer. As such, they are entitled to replace you." Conran stated that AC would meet on April 21 to vote on Morris' continued employment, and that "[t]hey will have my personal and professional support for their decision to replace you."

All nine AC members attended the April 21 meeting, including three new Wilson appointees who had never been to an AC meeting before. The Committee introduced the newcomers and discussed how the proceeding would be conducted, as there were approximately 80 people in the audience and many wished to address AC. The Committee voted to accept public comment from two acupuncture school representatives, three acupuncture association representatives, and three members of the public; additionally, AC Chair David Chen would have discretion to allow the testimony of five more speakers. This motion carried despite opposition by members Michael Brown, Kathie Klass, and Jeanne Tumanjan, who wanted more public testimony.

Accompanied by legal counsel, Lynn Morris read a prepared statement outlining her lengthy public employment and AC's accomplishments during her tenure (which began immediately after the bribery scandal). She briefly described her version of the events leading to this confrontation, and reiterated her contention that her accusations and requests for investigation of former AC members (including several of those who resigned in December) had caused those members and their supporters to pressure the Governor into firing her. She again blamed the appointment of Young Park on "the lack of diligence" of the Governor's Office, and alleged that AC had never been asked to perform a background check on Park. She stated that she was prepared to accept termination by the Committee but asked for honesty about the reasons, and contended that the real reason was "the political will of the Administration."

Public comment at the hearing included testimony by presidents of various acupuncture schools, Assemblymember Delaine Eastin, representatives of the California Acupuncture Association, Board of Barber Examiners Executive Officer Lorna Hill, AC staff member Mary Howard, and representatives from the Medical Board and its Division of Allied Health Professions. Not one person testified against Morris; additionally, a package of 18 lengthy letters of support were distributed to AC and to those in attendance.

After a short break, the meeting resumed and Jay Allen Eisen, counsel representing Morris, was allowed to make a closing statement. Eisen stressed the support for Morris and the absence of any facts, substantiated charges, or reasons to fire her. He also emphasized that the five members most recently appointed to AC had little or no knowledge of her skills or ability; in other words, the termination was a politically motivated firing.

Don Chang, the DCA attorney who advises AC, explained that the EO serves at the pleasure of AC and that no reason was needed for terminating her. AC briefly discussed the situation, with the new members expressing a desire for a new staff, a fresh start, and concern that Morris would be unable to work effectively after the past events. Finally, new member Jane Emerson moved to terminate Morris effective at 5:00 p.m. that day, and to begin a nationwide search to hire a new EO. Dr. Marguerite Mei-Yu Hung seconded the motion. All members voted to terminate Morris with the exception of public members Kathie Klass and Michael Brown, who voted against termination. Jeanne Tumanjan abstained from voting. Amid angry shouting by many supporters in the audience, Morris gathered her belongings and left.

AC then delegated authority to Chair David Chen to appoint an interim Executive Officer. Curt Augustine, Deputy Chief of DCA's Bureau of Electronic and Appliance Repair, was appointed as interim EO on April 22, and will serve until a new EO is hired.

AC also formed an Executive Officer Search Subcommittee consisting of Kathie Klass, Angela Tu, Jeanne Tumanjan, and Jane Barnett. This subcommittee will advertise, conduct an initial screening, and then forward the top 8–10 candidates for full Committee consideration.

The political overtones involved in the firing of Lynn Morris run in both directions. A longtime state government bureaucrat, Morris enjoys support from numerous Democratic members of the legislature, several of whom allegedly pressured the four AC members who ultimately resigned in December. Immediately after her termination, Morris was hired by the Assembly Office of Research (AOR), controlled by the Speaker of the Assembly, Democrat Willie Brown. Democratic Assemblymember Delaine Eastin asked Morris to perform one of her first research tasks at AOR: a legislative proposal to completely restructure the Department of Consumer Affairs, including severe curtailment of the powers and authorities of the DCA director (*see supra* agency report on DCA for related discussion). At this writing, that proposal is expected to be amended into AB 118 later this summer.

Examination on Schedule After Contractor Controversy. The written portion of AC's 1992 acupuncture licensing examination was administered on May 15. Approximately 475 applicants took the examination, given in five different language groups. The day-long test was administered without any problems. The clinical portion of the licensing exam was scheduled for July 18–19.

DAHP Sends OMD Issue Back to AC. The unmodified use of the acronym OMD (Oriental Medical Doctor) by acupuncturists has created tension between acupuncturists and the medical profession for several years. Under a 1988 Attorney General's Opinion, acupuncturists are permitted to use the acronym DOM (Doctor of Oriental Medicine), but may not use OMD unless it is accompanied by an explanatory qualifier such as "OMD, Licensed Acupuncturist" or "OMD, Lic. Ac." Recently, the Medical Board's Division of Allied Health Professions demanded compliance with the AG's Opinion, and threatened legislative action unless AC required compliance by its licensees. *[12:1 CRLR 77]*

At AC's February 13 meeting, DAHP Program Manager Tony Arjil spoke briefly on this topic, noting that it had basically been resolved. AC staff agreed to send a newsletter to its licensees discussing the requirement that acupuncturists qualify OMD with an explanatory phrase or abbreviation.

However, DAHP public member

Alfred Song raised the issue again at the Division's May 8 meeting. Song opined that acupuncturists should only use the OMD acronym *after* an appropriate term indicating acupuncturist licensure (such as "Licensed Acupuncturist, OMD" or "Lic. Ac., OMD"); otherwise, acupuncturists should not be permitted to use the term OMD. Song, a former state senator, stated that consumers should not be confused into thinking an acupuncturist is a medical doctor, and directed Interim Executive Officer Curt Augustine to take this issue back to AC for discussion and resolution.

AC Rulemaking. At this writing, three AC regulatory packages are pending in the rulemaking process:

–AC's fall 1991 rulemaking action which amended ten sections and added three new sections to the Committee's regulations in Division 13.7, Title 16 of the CCR, is awaiting approval by DCA at this writing; thereafter, it must be approved by the Office of Administrative Law. *[12:1 CRLR 77]*

–AC's fall 1991 adoption of rules to implement SB 633 (Rosenthal) (Chapter 103, Statutes of 1990) is also pending at DCA at this writing. SB 633 requires all acupuncturists licensed prior to 1988 to complete 40 hours of continuing education (CE) in six specified subject matter areas prior to January 1, 1993. The proposed regulations establish the curriculum in the six areas and require CE providers to submit specified course information to AC. *[12:1 CRLR 77]*

–AC scheduled an April 23 hearing on a proposed amendment to section 1399.439. The amendment would require AC-approved acupuncture schools to submit to AC on or before a date specified by the Committee a course catalog for that year with a letter outlining the following: (1) any courses added/deleted or significantly changed from the previous year's curriculum; (2) any changes in faculty, administration, or governing body; (3) any major changes in the school's facility; and (4) a statement regarding the school's financial condition which enables the Committee to evaluate whether the school has sufficient resources to ensure the capability of the program for enrolled students. The amendment would also provide that if an onsite visit is necessary, the school is required to reimburse the Committee for the costs incurred in conducting such a review; and require a school to notify AC within 30 days of any substantial changes to its facility, clinics, or curriculum. Due to the firing of its Executive Officer, AC cancelled the April 23 hearing and rescheduled it for July 22 in Los Angeles.

LEGISLATION:

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including the Acupuncture Committee, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. *[A. CPGE&ED]*

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify the Medical Board of California (MBC) and the Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including the Acupuncture Committee, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

SB 1813 (Russell), as amended April 2, is a follow-up bill to SB 1070 (Thompson) (Chapter 1180, Statutes of 1991). SB 1070 requires the Department of Health Services (DHS) to promulgate guidelines and regulations to minimize the risk of transmission of bloodborne infectious diseases in the health care setting by January 1993. It requires AC and other health profession regulatory agencies to ensure that their licentiates are informed of their responsibility to minimize the risk of transmission of bloodborne infectious diseases in the health care setting, and makes it unprofessional conduct for a licentiate to knowingly fail to protect patients by failing to follow DHS' infection control guidelines.

SB 1813 would provide that, in investigating and disciplining acupuncturists for knowing failure to protect patients from transmission of bloodborne infectious diseases in the health care setting, AC shall consider referencing DHS' guidelines; it would also require AC to consult with the Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, the Board of Vocational Nurse and Psychiatric Technician Examiners, and other agencies to encourage consistency in the implementation of this provision. *[A. Health]*

SB 664 (Calderon). Existing law prohibits acupuncturists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, or customer 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, unless the patient, client, or customer is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any acupuncturist to assess additional charges for any clinical laboratory service that is not actually rendered by the acupuncturist to the patient and itemized in the charge, bill, or other solicitation of payment. This bill has passed both the Senate and Assembly and is currently pending Senate concurrence in Assembly amendments.

The following bills died in committee: ***SB 1647 (Hart)***, which would have required the state Department of Alcohol and Drug Programs to conduct a study on the use of acupuncture as a method of drug rehabilitation and report to the legislature on or before January 1, 1994, concerning the results of the study; and ***SB 417 (Royce)***, which would have (among other things) revised 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.

RECENT MEETINGS:

At AC's February 13 meeting, public member Kathie Klass was elected Committee Vice-Chair. Traditionally, AC has two vice-chairs. The term of Vice-Chair Leona Yeh expired in February, leaving the second position vacant.

Also in February, Committee Chair David Chen presented several awards of recognition to AC members, staff, and members of the public for their assistance

and support during the exam contractor controversy during the past few months. Chen also stated that he purchased the awards with his own funds, such that there was no misuse of public money.

During the Chair's report, Chen discussed scope of practice issues, noting the continuation and expansion of AC's Blue Ribbon Panel of experts to work with its Scope of Practice Subcommittee. Members of the audience expressed concern about losing the work performed by the former Blue Ribbon Panel. Chen stated that the previous work would not be lost or ignored and that the reason for adding members is to ensure an open public process which includes all viewpoints. Additionally, Chen expressed the need for a special Blue Ribbon Panel to address issues concerning herbal medicine and possibly restrictive regulatory action by the federal Food and Drug Administration (FDA). Although acupuncturists are authorized to prescribe drugless herbal substances under Business and Professions Code section 4937, action by the FDA could preempt state law and affect the practice of California acupuncturists.

At its February meeting, at the request of public member Kathie Klass, AC also discussed the possibility of seeking new legislation which would require acupuncturists to use disposable needles to reduce the possibility of disease transmission. This suggestion was met with opposition by members of the profession, who argued that other health care providers are not required to use "disposable sharps." In addition, acupuncturists stated that such fears are unjustified, inasmuch as there have been no reports of transmission of infectious diseases through acupuncture. After discussing possible legislation which would apply to all health care providers, AC decided that the issue should first be taken up by the Blue Ribbon Panel of the Scope of Practice Subcommittee.

Also in February, AC decided to revise its distribution process for meeting minutes. AC will now distribute full Committee minutes only after they have been approved by the Committee at a subsequent meeting. Subcommittee meeting minutes will no longer be mailed out; however, these will be available at subsequent subcommittee meetings. Subcommittee recommendations are discussed by the full Committee and are a part of its minutes. All meeting notices will continue to be distributed to individuals on AC's general mailing list.

At its May 7 meeting, AC discussed the fact that the Food and Drug Branch of the state Department of Health Services (DHS) held a February press conference to announce that twenty Asian patent medicines contain toxic herbs and dangerous substances, and must be removed from store shelves. DHS plans an extensive consumer education program, and will first target patent medicines which pose an immediate health risk; the second part of the campaign will focus on improperly labeled patent medicines with unproven claims. AC decided to refer this issue to its Blue Ribbon Panel of experts.

AC also heard a presentation by a DHS representative on the Department's directive on the illegal use of certain new devices used by acupuncturists. DHS has currently outlawed the use of cold lasers, electrocutaneous point measurement devices, ion pumping cords, and magnets by acupuncturists, and the status of other "grey area" Class III devices is unclear. AC referred this issue to its Planning and Development Subcommittee to determine whether there is a need for an institutional review process for new devices.

Also in May, AC Chair David Chen announced that the job description for the Committee's Executive Officer had been completed. The Executive Officer Search Subcommittee was scheduled to meet on May 19, June 19, and July 1 to discuss the hiring procedure and review applications; final interviews were scheduled to take place at AC's July 21–22 meeting.

FUTURE MEETINGS:

To be announced.

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.

On March 26, Governor Wilson appointed two new hearing aid dispensers to the Committee: Deborah R. Kelly is a dispensing audiologist, and Keld T. Helmuth is a dispenser. These appointments give HADEC its full complement of seven members for the first time in several years. However, the term of hearing aid dispenser Byron Burton expired last December; Burton continues to serve on HADEC during a temporary grace period.

MAJOR PROJECTS:

Call for Contracts. During the fall of 1991, HADEC issued a "call for contracts," requesting licensed hearing aid dispensers to voluntarily submit forms of various purchase agreements, written receipts, and other contract documents issued by dispensers to purchasers of hearing aids. The Committee sought to review the forms for compliance with consumer protection laws and advise dispensers of common errors and problems, in hopes that the review program would improve consumer protection and reduce contract-related disputes and complaints.

Under section 3365 of the Business and Professions Code, section 1793.02 of the Civil Code (the Song-Beverly Consumer Warranty Act), and section 701.3 of the Federal Trade Commission's disclosure regulations, hearing aid dispensers must, upon the consummation of a sale of a hearing aid, deliver to the purchaser a written receipt signed by or on behalf of the licensee and containing several disclosures and items of information, including the date of consummation of the sale; specifications as to the make, serial number, and model number of the aid(s) sold; the address of the licensee's principal place of business and office hours at which the licensee shall be available for fitting or postfitting adjustments and servicing of the aid(s) sold; a disclosure that the aid(s) sold are reconditioned, if that is the fact; the licensee's license number; the terms of any guarantee or written warranty made to the purchaser with respect to the hearing aid(s); a statement that any examination or representation made by a hearing aid dispenser is not an examination, diagnosis, or prescription by a person licensed to prac-

tice medicine or audiology, and therefore must not be regarded as medical opinion or professional advice; a disclosure that the hearing aid is warranted to be specifically fit for the particular needs of the purchaser and that, if it does not serve those needs, it may be returned to the seller within 30 days (or longer) of the date of actual receipt by the purchaser or completion of fitting by the seller, whichever is later.

HADEC publicized its "call for contracts" in the November 1991 and February 1992 issues of its *HADEC News Bulletin* newsletter for licensees, and reported a 14% response rate. Executive Officer Elizabeth Ware and HADEC staff reviewed each contract form using a checklist outlining the legal requirements for receipts and warranties. The results were used to develop a fact sheet with guidelines for hearing aid receipts, and each dispenser who submitted a contract for review was mailed a copy of the contract accompanied by the checklist evaluating it and the fact sheet.

In March, staff noted that it is tabulating the results of the experiment by hand, and that final statistics would be available at HADEC's June meeting. However, preliminary results indicate that some legislative changes may be in order. For example, HADEC's enabling act currently requires these contracts or receipts to include a statement that any examination or representation made by a hearing aid dispenser is not an examination, diagnosis, or prescription by a person licensed to practice medicine or audiology, and therefore must not be regarded as medical opinion or professional advice. Some dispensers who are audiologists or physicians have altered this required language, which is technically against the law. HADEC will consider whether to seek legislation repealing the provision requiring the statement under these circumstances, or tailoring it to the various types of professionals who may dispense hearing aids.

HADEC discovered other common errors and problems in its review of the contract forms submitted. For example, many dispensers have improperly altered the 30-day warranty language required by the Song-Beverly Consumer Warranty Act, and/or printed it in other than 10-point bold type as required by the statute. HADEC also reminded licensees that it licenses "dispensers," and that the use of other terms such as "specialist" or "consultant" may be misleading or confusing to the consumer. Finally, the Committee noted that, in 1988, the authority to license hearing aid dispensers passed from the Medical Board to HADEC, and that dispensers should discontinue the use of statements advising consumers that they are licensed by the Medical Board.

In the meantime, HADEC has sent the fact sheet to all dispensers who did not respond to its call for contracts. The fact sheet sets forth the current contract content requirements and describes common errors and problems detected in the contracts submitted. HADEC has also begun the enforcement process to sanction those hearing aid dispensers who have not changed their contracts as suggested through the call for contracts. When a non-complying contract is reported to HADEC, the dispenser will be warned and given ten days to change the contract. If a second complaint is received, HADEC will assess a fine for noncompliance.

OAL "Underground Rulemaking" Ruling Issued. On April 6, the Office of Administrative Law (OAL) finally released a long-pending determination on the validity of several policies and actions of both HADEC and the Speech-Language Pathology and Audiology Examining Committee (SPAEC), which were challenged by dispensers Robert and Mary Hughes as "underground regulations." *[11:4 CRLR 94; 11:3 CRLR 91–92]* The Administrative Procedure Act, Government Code section 11340 *et seq.*, requires administrative agencies to formally adopt all "regulations" (defined as "every rule, regulation, order, or standard of general application...adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure...") through the formal rulemaking process defined therein; the APA also empowers OAL to decide whether rules or policies sought to be enforced by agencies but not adopted pursuant to the APA are "regulations" within the meaning of the Act, and invalid until properly adopted.

In Determination No. 5, OAL considered the Hugheses' challenge to several HADEC and SPAEC actions concerning the use of hearing tests and examination procedures for hearing aid dispensers. OAL first reviewed a number of actions taken by HADEC through the Medical Board's Division of Allied Health Professions. Most of these actions relate to the interpretation and enforcement of existing HADEC regulations regarding the supervision of hearing aid dispenser trainees by licensed hearing aid dispensers, specifically Hughes and his wife. OAL found that the Division was merely applying the provisions of existing law to the Hugheses. OAL acknowledged that whether the Division applied the law correctly is not for OAL to decide; only a court may decide that issue (*see infra* LITIGATION).

The petitioners also challenged the validity of a joint HADEC/SPAEC statement regarding acoustic immittance testing ("tympanometry statement"), a legal opinion regarding the authority of the Division over HADEC and SPAEC, and a legal opinion regarding the advertising of hearing tests, all of which were published in the minutes of HADEC's January 27, 1990 meeting. *[10:2/3 CRLR 111]* OAL rejected the challenge, finding that all three statements are merely restatements of existing law.

Next, petitioners challenged practically every provision contained in HADEC's examination information material, which describes the two parts of the current licensing exam (a written portion and a practical skills portion), specifies that a minimum of 70% must be scored in each part in order to pass, and lists and describes the various sections of the exam. OAL found that HADEC's instructions for its written examination are regulations in that they establish the amount of time given to take the test, the number and type of questions which make up the test, and the minimum score a candidate must get in each section of the written test in order to pass. With regard to HADEC's instructions for its practical skills portion, OAL found that they exceed existing law by requiring that an applicant receive an overall score of 70% and demonstrate competence on several "critical skills areas" which have been designated by HADEC; thus, they are regulations and must be adopted pursuant to the APA.

Finally, OAL also found the following examination rules or policies to be regulations within the meaning of the APA: (1) a rule requiring licensure applicants to bring with them to the examination an audiogram from a test performed on the applicant with specified threshold readings of specified frequencies; (2) a rule requiring applicants to bring their own audiometer which meets ANSI 1969 standards and a written certification that the audiometer has been calibrated within the past twelve months; (3) a rule prohibiting an applicant from using another applicant's audiometer at the examination; (4) a rule requiring applicants to bring a hearing aid which meets listed specifications to the examination; and (5) a rule requiring fingerprint verification and payment of a $19.50 fee for such verification.

HADEC was expected to discuss the ramifications of OAL's ruling at its June meeting.

New Licensing Exam. For over one

year, HADEC has been engaged in the process of revising its licensing exam. *[11:4 CRLR 94; 11:3 CRLR 92]* At the Committee's March meeting, staff announced that the new examination, which should be ready by the end of 1992, differs from the description of the exam in the Committee's enabling act; thus, legislative changes will be necessary in order to administer the new test. Some of the necessary changes may also rectify the problems posed by OAL's ruling on the Hughes request for determination (*see supra*). For example, the new test is not divided into subject matter sections as currently defined in existing section 3353 of the Business and Professions Code; therefore, that section must be amended to delete the description of the various test sections and to permit the Committee to define the "critical tasks involved in the fitting and selling of hearing aids" which may be tested on the exam. Also, the questions on the new test will vary from administration to administration, as will the passing score. Thus, section 3361—which currently states that applicants must obtain an average of 70% in every subject—must be amended to provide for the varying passing score. HADEC plans to ask the Department of Consumer Affairs (DCA) to add these changes to its pending omnibus bill, AB 2743 (Lancaster).

Fee Increases Imminent. At its January and March meetings, HADEC discussed the need to increase several of its licensing fees to accommodate increased enforcement costs and shared-services costs imposed by the Medical Board. In March, staff reported that AB 2743 (Lancaster) had been amended to include various fee increases requested by HADEC (*see infra* LEGISLATION).

HADEC/SPAEC Joint Task Force. Now that the Committee's member vacancies have been filled, HADEC and SPAEC plan to establish a standing task force composed of members from both boards to address ongoing issues of mutual interest. *[11:4 CRLR 101]* One topic of discussion is SPAEC's contention that hearing aid dispensers are engaging in deceptive advertising. SPAEC and its licensees allege that many hearing aid dispenser advertisements are misleading in that they imply that the dispenser is offering or qualified to offer audiological services. Both SPAEC and HADEC hope to create a fact sheet with advertising guidelines for hearing aid dispensers, and plan to use their citation and fine authority to sanction violations.

LEGISLATION:

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, or other prosecuting agencies to notify the Medical Board of California (MBC) and the Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including HADEC, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including HADEC, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. SB 2044 would also provide that if, upon investigation, HADEC has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by the Committee to offer or perform those services, the Committee may issue a citation containing an order of correction which requires the violator to cease the unlawful advertising and notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising. *[A. CPGE&ED]*

AB 2743 (Lancaster), as amended April 9, would provide that branch licenses for hearing aid dispensers shall expire on the same date as the permanent license, and would increase the following HADEC fees: temporary trainee renewal fee (from $75 to $100); biennial permanent renewal fee (from $200 to $280); initial permanent license fee (from $150 to $280); branch license fee (from $15 to $25); and duplicate license fee (from $15 to $25). Additionally, AB 2743 would institute new fees for the following services: temporary license fee ($100); branch license renewal fee ($25); continuing education (CE) approval application ($50); CE course monitoring ($100); CE transcript ($10); license confirmation letter ($10); and official license certification ($15). At this writing, HADEC is drafting proposed legislative changes to the Business and Professions Code sections describing its licensing exam, which it anticipates will be amended into AB 2743 later this summer (*see supra* MAJOR PROJECTS). *[A. Floor]*

SB 1549 (Rogers), as amended March 23, would expand the definition of the practice of fitting or selling hearing aids to include the screening of persons at a health fair or similar event in a prescribed manner. *[A. Health]*

AB 3160 (Conroy), as amended April 29, would include the conduct of hearing screening within the definition of the practice of speech-language pathology. *[S. B&P]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any hearing aid dispenser to assess additional charges for any clinical laboratory service that is not actually rendered by that person to the patient and itemized in the charge, bill, or other solicitation of payment. This bill has passed both the Senate and Assembly, and is currently awaiting Senate concurrence in Assembly amendments.

LITIGATION:

Hughes v. State of California, No. B060940, is still pending in the Second District Court of Appeal. In this case, Robert and Mary Hughes appeal the dismissal of their action against HADEC. Both are hearing aid dispensers who 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. Specifically, plaintiffs allege that HADEC applied underground rules to "unfairly, arbitrarily, and without cause"

revoke its approval of plaintiffs to supervise hearing aid dispenser trainees, revoke the temporary licenses of plaintiffs' trainees, and withhold permanent licensure from plaintiffs' trainees, thus making it "impossible for plaintiffs to induce would-be trainees into their employ." The trial court dismissed plaintiffs' action for lack of standing to sue, defendants' immunity from liability for failure to issue a license, and failure to exhaust administrative remedies. This last ground for dismissal refers to the Hugheses' inability to secure a ruling from the Office of Administrative Law (OAL) on the "underground rulemaking" status of the disputed policies. Robert Hughes requested an OAL determination in 1990, but OAL failed to issue it until April 1992 due to budget cuts (*see supra* MAJOR PROJECTS).

On appeal, HADEC argues that plaintiffs lack standing because they are attempting to assert the claims of third parties (the trainees); plaintiffs respond that HADEC's application of underground rules has caused them injury as dispensers and trainers. Just because regulations have an impact on third parties, argues Hughes, does not negate the standing of one affected by the regulations. Plaintiffs also argue that they have exhausted all available administrative remedies; any requirement that they wait to file suit until OAL released its decision would expose them to the statute of limitations, and is thus unreasonable. Finally, plaintiffs argue that HADEC's immunity applies only to discretionary licensing decisions and not to the exercise of mandatory duties; they contend that HADEC's constitutional obligations to afford them due process and equal protection are mandatory duties which have been breached.

RECENT MEETINGS:

At its March meeting, HADEC decided to start asking for two fingerprint cards from each applicant for licensure with the initial application. Currently, the Committee asks for one fingerprint card (which is submitted to the Department of Justice so that HADEC is notified of subsequent arrests of licensees). If the applicant is from out of state, out of the country, or has a conviction, HADEC must request an additional fingerprint card for submission to the FBI. The additional time for the request, receipt, and FBI processing of the second card sometimes results in a two- to three-month delay in licensure following passage of the examination. To eliminate this delay and the additional staff work inherent in the current procedure, HADEC agreed to ask all license applicants to submit two fingerprint cards with the initial application. HADEC also decided that this change falls within the "internal management" exception to the Administrative Procedure Act, and does not require OAL approval.

FUTURE MEETINGS:

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). The Committee functions under the general oversight of the Medical Board's Division of Allied Health Professions.

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:

Diversion Program. SB 2512 (McCorquodale) (Chapter 1087, Statutes of 1990) authorizes PTEC to establish a diversion program for substance-abusing licensees. During 1991, the Committee contracted with Occupational Health Services, Inc. (OHS) to administer the program; OHS also administers the diversion programs of other Department of Consumer Affairs agencies.

OHS representatives attended PTEC's January 24 meeting to discuss various aspects of the diversion program, which will hopefully become operational by May. Impaired licensees may voluntarily join the program, or PTEC may order participation in the program as an alternative to or in conjunction with discipline. The program utilizes a 12-step philosophy similar to Alcoholics Anonymous, and provides a treatment plan and constant monitoring of the licensee. The OHS representatives opined that a diversion program is more cost-effective than the disciplinary process, and hopefully yields a rehabilitated licensee capable of performing competently.

As to cost, OHS stated that it would charge PTEC a fixed rate of $2,100 per month for ten participants; the rate will increase if more than ten PTEC licensees participate in the program. Part of this cost will be passed on to participating licensees.

Education and Examination Subcommittee Activities. In a closed session at its January 24 meeting, PTEC discussed the recent efforts of its Education and Examination Subcommittee to develop examinations for PTs who wish to be certified in electroneuromyography (EEMG) and kinesiological electromyography (KEMG). Neither of these exams has been administered for the past three years. The exams previously consisted of a written portion and a practical application where PTs penetrate the skin to demonstrate skill. At the January 24 closed session, the Committee decided to administer the exams but to exclude the practical portion, as it raises medical necessity questions; PTEC will revisit this issue in two years.

PTEC's ad hoc committee on education, consisting of Committee member Lida Mooradian and nine outside PTs and PTAs, recently established procedures for exam proctors to follow in handling instances of suspected exam cheating. The procedures, which address incidents of candidates cheating from another person and/or using notes, require a proctor to warn the candidate to stop the behavior, move the candidate to another seat, and/or ask the candidate to leave the exam room. These procedures will be put into practice immediately.

Clinical Service Requirement for Foreign-Trained PTs. At its January 24 meeting, PTEC held a public hearing on its proposed addition of section 1398.26(e) to its regulations in Division 13.2, Title 16 of the CCR. *[12:1 CRLR 79]* 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. New subsection 1398.26(e) would permit the Committee to waive all or part of the clinical service requirement if it finds the applicant has completed a period of clinical education or internship equivalent to that required by section 2650 of the Business and Professions Code for licensure. This proposed regulatory change was initiated to enable foreign-trained PTs who have already demonstrated their clinical competence to emigrate to the United States. When fully implemented, new federal immigration laws will preclude an H-I work visa from being issued unless a foreign-trained PT has a full and unrestricted license to practice in the United States; until the clinical service requirement is either met or waived, a foreign-trained PT would not qualify for licensure or the visa.

Public comments received at the January hearing were mixed; among others, the California Chapter of the American Physical Therapy Association (CCAPTA) opposed the proposal. CCAPTA stated that its understanding of the clinical service requirement is "to ensure that a foreign-trained physical therapist has the ability to function within the contemporary American health care system," and argued that "completion of a period of clinical education or internship in another country...does not necessarily indicate how a foreign-trained physical therapist will function in the United States. Furthermore, the CCAPTA is uncertain what criteria the PTEC will use in determining whether or not to waive all or part of the required clinical service."

Other speakers expressed concern that the existence of the regulatory proposal is not well-known to many PTs. Although PTEC followed the Administrative Procedure Act in noticing its proposal, Executive Officer Steve Hartzell agreed to include an announcement of the proposal in PTEC's upcoming newsletter. The Committee ultimately referred the matter back to its ad hoc committee on education, which reported at PTEC's March meeting that it was still reviewing the comments and drafting revisions to the proposal. After clearing the proposed language with legal counsel, the ad hoc committee hopes to make a final recommendation to PTEC this summer.

Other PTEC Rulemaking. Also in January, PTEC held a public hearing on its proposal to amend section 1398.4, 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. *[12:1 CRLR 79]* At the January hearing, the Committee slightly modified the proposal to additionally delegate these functions to the Committee vice-chair in the absence of the chair and the executive officer. Subject to this modification, PTEC approved the regulatory change; at this writing, staff is preparing the rulemaking file for submission to the Department of Consumer Affairs and the Office of Administrative Law (OAL).

Fee Increases Approved; More on the Way? On January 6, OAL approved PTEC's regulatory amendments to section 1399.52, Title 16 of the CCR, which increase the PTA biennial license renewal fee from $40 to $50, and raise the PTA delinquency fee from $20 to $25. Last December, OAL approved PTEC's amendments to section 1399.50, which increase fees for initial licensing and biennial license renewal (from $40 to $50) and delinquency (from $20 to $25) for physical therapists. *[12:1 CRLR 79]*

At its January meeting, PTEC carried a motion authorizing Executive Officer Steve Hartzell to approach the legislature with a proposal to raise PTEC's statutory fee ceiling to $100 every other year. Currently, the Committee is authorized to raise licensure fees up to $80 biennially, and plans a fee increase to $80 effective July 1, 1993, in order to keep up with increasing costs.

Supervision Requirements. At PTEC's January and March meetings, the Committee continued a discussion commenced at its November 1991 meeting—that is, whether regulatory changes are needed to refine the amount and type of PT supervision over PTAs and physical therapy aides. *[12:1 CRLR 80]*

Regarding PTAs, existing 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 has been deluged with a huge increase in the number of waivers requested, and attempts to handle them on a case-by-case basis.

At the January meeting, the Committee discussed a draft of proposed revisions to section 1398.44 which would eliminate the waiver requests and clarify the definition of "adequate supervision." The draft establishes two supervision standards: one for inpatient/outpatient facilities, and another for the home care setting. In the inpatient/outpatient facility setting, the supervising physical therapist (SPT) must be present in the same facility with the PTA at least 50% of any work week or portion thereof the PTA is on duty, and shall be readily available to the assistant at all other times for advice, assistance, and instruction. Additionally, the SPT is required to initially evaluate each patient prior to the provision of physical therapy treatment by a PTA, document the evaluation in writing, formulate and record a treatment program based upon the evaluation, indicate which elements of the treatment program have been delegated to the PTA, and identify that PTA. The SPT must reevaluate the patient at least bimonthly and modify the treatment and the delegation of authority as needed.

In the home care setting, the SPT and the PTA shall make a joint visit and provide treatment jointly prior to the PTA providing care without the SPT present. Additionally, the SPT and the PTA shall make a joint visit every other week to every patient being seen by the PTA for the purpose of reevaluating the patient's progression and the treatment plan.

Regarding physical therapy aides, the Committee also discussed revisions to section 1399; the amendments would establish similar requirements on the SPT as to the evaluation of a patient, the establishment of a treatment plan, and the specific delegation of patient-related tasks to an aide. However, the SPT must provide continuous and immediate supervision of the aide; the SPT must be in the same facility and in immediate proximity to the location where the aide is performing patient-related tasks, and must (at some point in the treatment day) provide direct service to the patient. The addition of section 1399.1 would preclude a SPT from supervising more than one aide at any time.

At both the January and March meetings, members of the audience expressed general agreement with most of the proposed revisions, except the portion of the supervision proposal requiring the SPT to specifically identify the PTA to whom an element of the treatment plan has been delegated. Although Steve Hartzell argued that this information is necessary for enforcement reasons, the witnesses argued that this requirement would be cumbersome and confusing as more than one PTA may work with a patient during any given time, especially in hospital settings. Other witnesses suggested language changes that would facilitate insurance plan reimbursement for physical therapy ser-

vices, and objected to categorizing home health as a unique setting. Executive Officer Steve Hartzell stated that PTEC would receive additional comments on the draft at the Committee's May 29 meeting, and commence a formal rulemaking proceeding over the summer.

PTA Licensure Standards. 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.

At its November and January meetings, the Committee discussed draft revisions to section 1398.47; the amendments would refine the existing regulation to require a significant portion of any qualifying experience to have been performed under the direct and immediate supervision of a physical therapist in an acute care inpatient facility. *[12:1 CRLR 79]* PTEC plans to move forward with the rulemaking process once it is able to document necessity for the specific number of months outlined in the regulation which qualify for equivalency.

Revised License Applications. At its March meeting, PTEC introduced a draft of a revised license application package which the Committee hopes to be using by June, pending final approval by the Department of Consumer Affairs (DCA). Previously, PTEC utilized different applications for foreign-trained PTs, domestic-trained PTs, and PTAs. The new application package combines all the old applications into one universal package, and eliminates outmoded language and questions.

LEGISLATION:

SB 1813 (Russell), as amended April 2, is a follow-up bill to SB 1070 (Thompson) (Chapter 1180, Statutes of 1991). SB 1070 requires the Department of Health Services (DHS) to promulgate guidelines and regulations to minimize the risk of transmission of bloodborne infectious diseases in the health care setting by January 1993. It requires PTEC and other health profession regulatory agencies to ensure that their licentiates are informed of their responsibility to minimize the risk of transmission of bloodborne infectious diseases in the health care setting, and makes it unprofessional conduct for a licentiate to knowingly fail to protect patients by failing to follow DHS' infection control guidelines.

SB 1813 would provide that, in investigating and disciplining physical therapists for knowing failure to protect patients from transmission of bloodborne infectious diseases in the health care setting, PTEC shall consider referencing DHS' guidelines; it would also require PTEC to consult with the Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, the Board of Vocational Nurse and Psychiatric Technician Examiners, and other agencies to encourage consistency in the implementation of this provision. *[A. Health]*

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including PTEC, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. *[A. CPGE&ED]*

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify the Medical Board of California (MBC) and the Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including PTEC, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

AB 3286 (Tucker). Existing law prohibits a person from furnishing any dangerous drug or device, except upon the prescription of a physician, dentist, podiatrist, or veterinarian. AB 3286, as amended May 13, would provide that the prohibition does not apply to the furnishing of any dangerous device by a manufacturer, wholesaler, or pharmacy to a physical therapist acting within the scope of his/her license.

Existing law authorizes a medical device retailer to dispense, furnish, transfer, or sell a dangerous device only to another medical device retailer, a pharmacy, a licensed physician, a licensed health care facility, or a patient or his/her personal representative. AB 3286 would additionally authorize a medical device retailer to dispense, furnish, transfer, or sell a dangerous device to a licensed physical therapist.

This bill, which contains an urgency clause, was introduced to clarify Business and Professions Code section 4227, which does not expressly permit physical therapists to dispense dangerous medical devices to patients without a dispensing license. Physical therapists currently dispense and administer treatments through transcutaneous electrical nerve stimulation ("TENS") units, which are considered dangerous devices under the medical device retailer statutes. TENS units are used in physical therapy and by physicians to control pain. *[S. B&P]* As introduced, ***AB 2379 (Baker)*** and ***AB 2638 (Boland)*** would have made the same changes. AB 2379 was dropped by its author; AB 2638 was amended on May 13, and now pertains to chiropractors instead of physical therapists.

AB 2743 (Lancaster), as amended April 9, would add section 2660.1 to the Business and Professions Code to provide that a patient, client, or customer of a physical therapist is conclusively presumed to be incapable of giving free, full, and informed consent to any sexual activity which is a violation of Business and Professions Code section 726. It would also authorize PTEC to establish a "cost recovery" system, under which it could request an administrative law judge presiding over a disciplinary hearing to order a disciplined licensee to reimburse the Committee for its costs of investigating the case. *[A. Floor]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for

any physical therapist to assess additional charges for any clinical laboratory service that is not actually rendered by that person to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and the Assembly and is currently awaiting Senate concurrence in Assembly amendments.

AB 819 (Speier). Existing law generally provides it is not unlawful for prescribed health care professionals to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or co-ownership in the facility. As amended January 29, this bill would instead provide that it shall be unlawful for these licensed health professionals to refer a person to any diagnostic imaging center, clinical laboratory, physical therapy or rehabilitation facility, or psychometric testing facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest, and would provide that disclosure of the ownership or proprietary interest does not exempt the licensee from the prohibition. It would, however, permit specified licensed health professionals to refer a person to such a facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest if the person referred is the licensee's patient of record, there is no alternative provider or facility available, and to delay or forego the needed health care would pose an immediate health risk to the patient. *[S. B&P]*

RECENT MEETINGS:

Over the past few months, PTEC has been drafting a manual which will outline its procedures for implementing its citation and fine program. *[12:1 CRLR 79]* Under the program, PTEC may issue citations and/or fines to licensees who commit relatively minor violations of the Committee's statute or regulations; it also intends to issues citations to physicians who illegally supervise physical therapy assistants, physical therapy, or other unlicensed individuals performing physical therapy. Although the Medical Board opposes PTEC's proposed issuance of citations to physicians, the Committee contends that a physician's scope of practice does not include the supervision of physical therapy or the performance of duties which only a physical therapist is authorized to perform; therefore, a physician is considered to be an unlicensed person under the Physical Therapy Practice Act. At PTEC's January meeting, staff reported that a draft of the manual has been forwarded to the Attorney General's Office for comment.

At PTEC's March 27 meeting, Executive Officer Steve Hartzell discussed his reply to a questionnaire concerning annual planning distributed by DCA Director Jim Conran. The questionnaire asked executive officers of DCA boards and committees to discuss their relations with DCA, the quality of DCA support services, long-range planning goals, government streamlining, enforcement, and 1992–93 planning goals. In his response for PTEC, Executive Officer Hartzell praised certain DCA personnel but criticized the unavailability of disbursement journals, which would enable individual boards and committees to determine whether charges assessed to them are accurate. His report also stated that PTEC currently operates on an annual plan, but various goals and objectives adopted in August of each year serve as a two- to five-year plan. Regarding enforcement, Executive Officer Hartzell stressed that PTEC investigates all complaints that appear to have merit, and that the Committee has identified areas where consumer education is needed. PTEC's major goals for 1992–93 include the sponsorship of legislation to update educational requirements in the Physical Therapy Practice Act; the revision of education and supervision regulations; the improvement of regulation of the practice of physical therapy; and the development of public information brochures.

Executive Officer Hartzell also discussed his participation in a March 23 public forum held in San Diego to analyze the structure and future of DCA. The Department sponsored the hearing, partly in response to a February recommendation by the Legislative Analyst's Office (LAO) that all independent boards and committees within DCA, including PTEC, be abolished and replaced with, at most, advisory boards. The licensing and enforcement functions of all existing boards and committees would be transferred to DCA on a consolidated basis. (*See supra* agency reports on DCA and LAO for related discussion.) Hartzell's suggestions for changing the Department included:

–Centralization of disciplinary investigations within DCA's Division of Investigations and elimination of individual boards' authority to conduct investigations of their licensees; currently, PTEC's investigations are handled primarily by Medical Board investigators—a situation with which PTEC is largely dissatisfied.

–The creation of an Office of Ombudsman within DCA's Division of Consumer Services to review complaints and investigative files when a citizen notifies the ombudsman that he/she disagrees with the conclusion of an investigator or a board.

–One board should not be under the authority of another board; overlapping authority between boards should be eliminated. Currently, PTEC operates under the aegis of the Medical Board.

–The complaint intake structure should be changed so that each board receives and routes complaints about its own licensees. Presently, complaints about PTEC licensees are received by the Central Complaint and Investigative Control Unit of the Medical Board.

–Creation of a mandatory 90-day suspension period when a license is revoked to eliminate a licensee's ability to avoid any penalty due to a decision to stay the revocation.

FUTURE MEETINGS:

August 14 in San Diego.
October 22 in Sacramento.

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 Califor-

nia (MBC), a physician representative of a California medical school, an educator participating in an approved program for the training of PAs, one physician who is an approved supervising physician of PAs and who is not a member of any division of MBC, three PAs, and two public members. PAEC functions under the jurisdiction and supervision of MBC's Division of Allied Health Professions (DAHP).

MAJOR PROJECTS:

Nurses Take Aim at New PA Scope of Practice Regulations. On January 28, the Office of Administrative Law (OAL) finally approved PAEC's regulatory changes defining the physician assistant's scope of practice. The Committee's changes amend sections 1399.541, 1399.543, and 1399.545, Division 3.8, Title 16 of the CCR. Under the new regulations, a PA's supervising physician (SP) is permitted to specify the type and limit of delegated medical services based on the SP's specialty or usual and customary scope of practice. The changes also authorize PAs to initiate (or transmit an order to initiate) certain tests and procedures without patient-specific authorization from the SP, and to provide necessary treatment in emergency or life-threatening situations. *[12:1 CRLR 80]*

Over the past several years, these regulatory changes—drafted in response to a November 1988 Attorney General's Opinion (No. 88-303) which narrowly defined the PA's scope of practice—had been rejected by OAL three times. The version approved on January 28 was forwarded to OAL by the Medical Board's Division of Allied Health Professions (DAHP) over the veto of Department of Consumer Affairs Director Jim Conran, and despite objections by the California Nurses Association (CNA) and other nursing and physician groups. CNA and others object to the fact that these regulations apparently authorize PAs to give orders to nurses, and contend that they are inconsistent with Business and Professions Code section 2725(b), which states that the practice of nursing includes "[d]irect and indirect patient care services...ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist."

At first blush, this contention may appear to be another in a long line of "turf battles" among the health care professions. CNA, however, contends that PAs are not adequately trained to give nurses orders, and that the chain of command should not be further complicated by adding PAs as mid-level managers. PA training programs vary in length from one to two years; most require a minimum of a high school diploma and certain college-level courses for admission. All five PA training programs in California are affiliated with medical schools; one offers a special program in surgery, and another offers a special program in emergency care and neonatology. However, CNA argues that PAs' guaranteed minimum level of education and training is less than that of nurse practitioners, who are educated as registered nurses before being certified as nurse practitioners. CNA also contends that, unlike nurses, PAs have no independent scope of practice; they are limited to assisting a specific physician or groups of physicians approved in advance by DAHP upon the recommendation of PAEC.

PA representatives counter that PAs are acting as an agent of the supervising physician when they "give orders" to nurses or other health care personnel, and that the supervising physician is ultimately responsible for all care ordered for or given to his/her patient by the PA. The PAs also note that the new regulations were technically sponsored by DAHP, an arm of the Medical Board, underwent extensive public comment over the course of a three-year rulemaking process, and were reviewed by OAL for conflict and/or consistency with other laws and regulations. Finding no conflict, OAL finally approved them in January 1992. PA representatives argue that physicians have been allowing and directing their PAs to initiate orders to nurses for nursing services for over 15 years without any documented patient complaints or evidence of patient harm. Finally, the PAs contend that adoption of CNA's position would cause health care in rural and underserved communities to suffer, and increase overall costs of health care because physicians would be required to initiate all orders.

Be it turf battle or legitimate concern for patient protection, this issue will move to the legislative arena this summer. CNA has convinced Assemblymember Tricia Hunter, a registered nurse and former member of the Board of Registered Nursing, to amend AB 569 (Hunter) to override PAEC's new scope of practice regulations. Although the amendments have not been formally incorporated into AB 569 at this writing, the bill is expected to severely restrict the authority of a PA to provide medical services in the physical absence of the supervising physician and to prohibit a PA from initiating diagnoses, treatment plans, or orders, including orders for nursing services, in the absence of patient-specific authorization from the supervising physician. Since it was forced to cancel its April 3 and May 1 meetings, PAEC has not been able to take a formal position on the proposed amendments at this writing. (*See infra* agency report on BOARD OF REGISTERED NURSING for related discussion.)

Federal Regulations Expand PA Role in Nursing Homes. On April 13, PAEC Executive Officer Ray Dale announced that the federal Health Care Financing Administration has approved new regulations (42 C.F.R. Parts 442, 447, 483, 488, 489, and 498) which permit physicians to delegate more tasks to PAs and nurse practitioners who work in specified types of nursing homes. The regulations affect care provided to Medicare and Medicaid patients while they are in specific long-term care facilities, intermediate care facilities, and nursing facilities. The tasks that may be delegated depend on several factors, including but not limited to the supervising physician's option, the type of facility in which the patient resides, and the absence of prohibiting state law. Reimbursement for PA-delivered services will still be through the supervising physician's provider number.

DAHP Revises Supervising Physician Application Review Procedure. At its January 31 meeting, DAHP considered a proposal to revise the way it reviews applications from MBC-licensed physicians to supervise PAs.

For the past ten years, PAEC staff has reviewed all initial SP applications; if the application form is complete, all information is accurate, the physician's license is free from discipline and probation terms, and the physician is not under investigation by the Medical Board, PAEC staff has issued the SP approval in the name of the Division. If, however, the physician was the subject of a discipline/probation order or under investigation, the PAEC executive officer (EO) would review the file. If the EO found that the order or investigation was not substantially related to the ability and appropriateness of the physician to utilize and supervise the services of a PA, the approval would be granted. If the EO found the application questionable, it would be referred to the PAEC chair. If the PAEC chair found the order or investigation unrelated to supervision of a PA, the approval would be granted. If the chair found the application questionable, the application would be presented to the full Division.

Because PAEC and DAHP staff found that laws and circumstances have changed significantly during the past ten years, they proposed a revised procedure, which was unanimously approved by the Division at its January 31 meeting. Under

the new procedure, if an applicant's license is found to be (1) currently under disciplinary terms and conditions; (2) the subject of a completed investigation which has been transferred to the Attorney General's Office for the filing of an accusation and is significantly related to the authority to supervise a PA; or (3) the subject of an unresolved accusation, the application will be deemed by PAEC's EO to be questionable. The entire SP file and all related materials will be made available for review by a three-person MBC "questionable application" review panel, consisting of one DAHP member, MBC's chief medical consultant, and DAHP's program manager. This panel may call upon legal counsel and investigative staff as it sees fit in reviewing the application, and may ask the applicant to voluntarily answer additional questions in relation to the application. If the panel approves the application, the DAHP program manager will instruct PAEC staff to issue the permit; if not, the DAHP program manager will present the panel's recommendation at the next DAHP meeting. At the public meeting, DAHP will not consider the actual application; it will vote to determine if a statement of issues should be developed by the Attorney General to deny the application request as proposed by staff. The DAHP member who sits on the review panel will be recused from discussing or voting on the matter.

Revised Supervisor Applications. On March 20, PAEC Program Analyst Jennifer Barnhart announced the development of a revised application form for physicians who wish to supervise a PA. The new packet includes more information about the legal requirements of supervising PAs and makes the application process more understandable to applicants.

LEGISLATION:

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify the Medical Board of California (MBC) and the Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including PAEC, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including PAEC, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. *[A. CPGE&ED]*

AB 569 (Hunter) as amended February 10, pertains to the use of the term "board certified" in physician advertising. Over the summer, AB 569 will be amended to override PAEC's new scope of practice regulations, and to restrict the authority of PAs to give orders to nurses unless they are patient-specific orders delegated by the PA's supervising physician (*see supra* MAJOR PROJECTS). *[S. B&P]*

SB 664 (Calderon). Existing law prohibits PAs, 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any PA to assess additional charges for any clinical laboratory service that is not actually rendered by the PA to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and Assembly, and is currently awaiting Senate concurrence in Assembly amendments.

AB 706 (Jones). Under the Song-Brown Family Physician Training Act, the Director of the Office of Statewide Health Planning and Development is required to select and contract with programs that train primary care PAs, among others, for the purpose of training undergraduate medical students in the specialty of family practice. This bill would declare the intent of the legislature that stable funding to increase the training provided by the Act be sought. *[S. Inactive File]*

SB 1813 (Russell), as amended April 2, is a follow-up bill to SB 1070 (Thompson) (Chapter 1180, Statutes of 1991). SB 1070 requires the Department of Health Services (DHS) to promulgate guidelines and regulations to minimize the risk of transmission of bloodborne infectious diseases in the health care setting by January 1993. It requires PAEC and other health profession regulatory agencies to ensure that their licentiates are informed of their responsibility to minimize the risk of transmission of bloodborne infectious diseases in the health care setting, and makes it unprofessional conduct for a licentiate to knowingly fail to protect patients by failing to follow DHS' infection control guidelines.

SB 1813 would provide that, in investigating and disciplining PAs for knowing failure to protect patients from transmission of bloodborne infectious diseases in the health care setting, PAEC shall consider referencing DHS' guidelines; it would also require PAEC to consult with the Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, the Board of Vocational Nurse and Psychiatric Technician Examiners, and other agencies to encourage consistency in the implementation of this provision. *[A. Health]*

RECENT MEETINGS:

The Committee was unable to take any formal action at its January 10 meeting due to lack of a quorum; therefore, the following issues were discussed, but no decisions were made.

DAHP Program Manager Tony Arjil was on hand to request PAEC's support for legislative changes to Business and Professions Code section 2069, which defines the services which may be performed by medical assistants; the modifications would allow PAs and registered nurses to supervise medical assistants in rural areas. The California Medical Association is opposed to these changes; at this writing, no legislation has been introduced to accomplish them.

Representatives from the California Academy of Physician Assistants (CAPA) requested PAEC's support for draft legislative amendments to the Emergency Services Act, Government Code section 8550 *et seq.*, and the Committee's enabling act to permit PAs to use their health care skills in the absence of a supervising physician in times of emergency. CAPA's proposed changes would also confer "Good

Samaritan" immunity from liability on PAs for emergency health care acts (excluding acts of gross negligence) in the event of a disaster; registered nurses and licensed vocational nurses currently enjoy such immunity, but PAs do not.

In January, PAEC Executive Officer Ray Dale noted that, as of December 31, 1991, 17 completed investigations against PAs were pending at the Attorney General's Office, 14 of which were awaiting the drafting of formal charges; and an additional six California-licensed PAs are the subject of a filed accusation. Thus far in fiscal year 1991–92, a total of 2 PAs had been disciplined.

Staff member Jennifer Barnhart presented a status report on current licensing statistics. As of November 15, there were a total of 5,131 approved supervising physicians and 2,054 PAs. SPs are changing to a staggered renewal system for dues collection instead of May 31 of every even-numbered year.

Occupational Health Services, which administers PAEC's diversion program for substance-abusing PAs, reported two active participants during fiscal year 1991–92.

PAEC cancelled both its April 3 and May 1 meetings, and rescheduled them to June 12.

FUTURE MEETINGS:

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:

Use of the Term "Podiatric Physician and Surgeon." In mid-March, Dr. Robert del Junco, MD, a member of MBC's Division of Licensing, requested an opinion from the Department of Consumer Affairs' (DCA) legal unit on the legality of the use of the term "podiatric physician and surgeon." Apparently disturbed by the California Podiatric Medical Association's (CPMA) use of the term "Podiatric Physician" as the title of its newsletter, and by a school of podiatry's use of the term in academic catalogs, Dr. del Junco challenged the propriety of the term under section 2054 of the Business and Professions Code. That section makes it a misdemeanor for a person not licensed as a physician and surgeon to use the term "doctor," "physician," or any other term indicating or implying that he/she is a physician. Dr. del Junco contended that since podiatrists do not graduate with a doctor of medicine from a school of medicine and do not obtain a physician and surgeon's license from the Medical Board, they are violating section 2054 when they refer to themselves as "podiatric physicians."

In a March 24 letter, BPM Executive Officer Jim Rathlesberger responded that BPM has instructed the Medical Board's Central Complaint and Investigation Control Unit to send a cease and desist letter whenever a complaint is received about a DPM using the term. He maintained that "such usage is not widespread, we receive few complaints about it, and the advisory letters quickly resolve the matter when we do." Additionally, Rathlesberger confirmed that in 1990, the California Medical Association (CMA) challenged BPM's 1984 policy statement permitting the use of the term as "underground rulemaking" under the Administrative Procedure Act (APA), Government Code section 11340 *et seq.* In 1991, the Office of Administrative Law concluded that BPM's policy statement was a regulation which must be adopted pursuant to the APA, but made no comment on whether the use of the terms "podiatric physician," "podiatric surgeon," or "podiatric physician and surgeon" by DPMs is authorized by law. *[11:2 CRLR 42–43, 90]*

With regard to the use of the term "podiatric physician" by CPMA, BPM has no jurisdiction over a trade association. Rathlesberger stated that the issue raised by Dr. del Junco is a professional association issue best left to CMA, CPMA, and the California Orthopaedic Association. Rathlesberger acknowledged that economic competition is heating up between the licensed professions, but noted that issue is outside BPM's charter, which is to ensure protection of consumers.

On May 5, DCA Supervising Staff Counsel Dan Buntjer replied to Dr. del Junco's question about the use of the term "podiatric physician" by CPMA and schools of podiatry. Buntjer opined that such use does not violate section 2054, as the thrust of that provision is aimed at individuals who represent themselves as physicians and surgeons; the section does not cover professional associations or schools.

BPM/MBC Joint Task Force on Podiatric Residencies. Over the past few months, BPM has engaged in a review of the various types of podiatric residency programs, which include the rotating podiatry residency (RPR), the podiatric orthopedic residency (POR), the podiatric surgical residency (12 months), and the podiatric surgical residency (24 months). *[12:1 CRLR 83]* Section 2484 of the Business and Professions Code requires that prior to regular licensure by BPM, each applicant must complete an approved one-year hospital residency. The national Council on Podiatric Medical Education (CPME) evaluates and approves podiatric residency programs, and any program approved by CPME is deemed acceptable by BPM. Section 2475 expressly authorizes a podiatric resident "in an approved...residency...[to] engage *in the practice of medicine* for a period not to exceed two years wherever and whenever required as a part of the training program..." (emphasis added). Under this provision, the podiatry resident is allowed to practice medicine beyond the scope of podiatric medicine during the residency (not to exceed two years), so they might gain sufficient overall medical training to perform podiatric medicine.

Within the context of a proposed legislative amendment to extend the two-year period in section 2475 to four years, Dr. Robert del Junco of the Medical Board expressed concern about the practice of medicine by podiatric residents. Specifically, Dr. del Junco noted two issues: (1) whether it is appropriate to allow podiatry residents to practice beyond podiatric medicine in hospitals without completing the medical education and training that MDs receive in medical school to prepare them for advanced residency training; and (2) whether the podiatry resident is receiving the same supervision and training in the hospital as physicians receive in postgraduate training programs approved by the American Medical Association's Accreditation Council of Graduate Medical Education (ACGME). Dr. del Junco was particularly concerned about whether medical care is compromised when podiatry residents are allowed to train in the various specialty areas in hospitals, especially in areas which are arguably ir-

relevant to the practice of podiatric medicine (*e.g.*, obstetrics/gynecology).

While maintaining that existing section 2475 accurately expresses the intent of the legislature to provide podiatric residents with the greatest possible opportunity for training, BPM Executive Officer Jim Rathlesberger and member Dr. Steve DeValentine invited Dr. del Junco and other interested members of the Medical Board to participate in a joint task force to explore these and other issues of mutual interest and concern. BPM welcomes the opportunity to discuss the following issues:

–BPM's concern about the quality of some residency programs, the degree of hospital and surgical experience, and the adequacy of national review-approval-evaluation standards and procedures;

–concerns shared by BPM and others, such as Dr. del Junco, that podiatric residents have not gained the same access as MD residents to programs in teaching hospitals; and

–questions raised by MBC members and MD professional associations as to whether some hospitals are allowing DPM residents to participate in rotations that are unnecessary for their training and in such a way that a danger is posed to patients.

The joint task force tentatively consists of MBC members Dr. del Junco and Dr. Michael Weisman, BPM members Dr. DeValentine and Dr. Joanne Watson, and Karen McGagin, Special Assistant to the Director of Consumer Affairs. DOL Program Manager Terri Ciau, DCA legal counsel Greg Gorges, DAHP Program Manager Tony Arjil, and BPM's Jim Rathlesberger will provide staff support to the task force, whose first meeting is scheduled for July 16 in San Diego. Because each board is contributing only two members to the task force, the task force meetings are deemed exempt from the public notice and agenda requirements of the Bagley-Keene Open Meeting Act.

BPM Participates in Public Forum on the Future of DCA. On March 23, BPM President Karen McElliott presented testimony at the first in a series of statewide public hearings on the structure and future of the Department of Consumer Affairs. DCA sponsored the hearings, partly in response to a February recommendation by the Legislative Analyst's Office that all independent boards and commissions within DCA be abolished and replaced with, at most, advisory boards. The licensing and enforcement functions of existing DCA boards and commissions would be transferred to DCA on a consolidated basis. (*See supra* agency reports on DCA and LAO for related discussion.)

McElliott first commented on BPM's view of the best administrative structure for enforcement. Under the current structure, BPM essentially acts as accuser, police, judge, and jury. McElliott acknowledged that these conflicting roles sometimes cause problems at other boards, and "in reorganizing the current structure, you have to design the system to improve poor performers." She stated that BPM could support a transfer of investigative responsibility from MBC to DCA only if BPM's executive officer continues to be responsible for managing BPM enforcement, accountable to the Board for the success of BPM enforcement, and able to work with investigators and the Attorney General's Office to expedite case processing. McElliott expressed support for the idea of a single complaint unit at DCA with a single toll-free number, providing consumers of services of all DCA licensees with "one-stop" enforcement access; and the concept of a single DCA special fund (rather than 37 special funds, one for each DCA agency), with monies allocated to the various boards by the DCA Director based on need.

Finally, McElliott noted that executive officers must be accountable to their boards and the public. Boards must take an active role in evaluating the executive officer's performance, and the DCA Director should be involved in this function as well. Boards should carefully scrutinize the information given them by their executive officers and staff, and hold staff accountable and responsible for overall agency performance.

Enforcement Matrix. At BPM's March 3 meeting, Executive Officer (EO) Jim Rathlesberger reported on the slow progress of the Medical Board in implementing its "enforcement matrix"—a computer printout display of key enforcement statistics of the Medical Board's Division of Medical Quality, BPM, and the allied health licensing programs under the jurisdiction of the Medical Board's Division of Allied Health Professions (DAHP); all DMQ, BPM, and allied health program complaints are routed and tracked through DMQ's Central Complaint and Investigation Control Unit (CCICU).

SB 2375 (Presley) (Chapter 1597, Statutes of 1990) requires the Medical Board to track and regularly publish numerous statistics of its enforcement program for medical doctors; during the summer of 1991, Rathlesberger suggested that similar statistics of BPM and DAHP's allied health licensing programs be tracked and published as well. Rathlesberger noted that the matrix would enable MBC, BPM, and allied health program EOs to better evaluate the services they are receiving from CCICU, MBC investigators, and the Attorney General's Office; identify growing backlogs at an early stage, and request additional staffing or resources to alleviate them; and evaluate the performance of staff. Although several allied health program EOs initially opposed having their enforcement statistics publicly displayed in a matrix format and argued that the allied health programs are not "legally accountable" to DAHP, they agreed to the publication of the matrix in September 1991.

SB 2375 (Presley) also directs DMQ to investigate and dispose of complaints about physicians within six months of receipt—either by dismissal, warning, or forwarding to the AG's Office for preparation of an accusation. At DAHP's September 1991 meeting, several DAHP members noted that the version of the matrix then compiled simply counted the number of cases pending at each stage, and provided no "aging data" to enable a determination of compliance or noncompliance with the six-month goal of SB 2375. DAHP instructed MBC staff to include "aging data" in future versions of the enforcement matrix.

The "aging data" finally appeared in the version of the matrix presented to DAHP at its January 31 meeting. However, the matrix listed only the average number of days a complaint stays at the CCICU stage, in investigations, and at the Attorney General's Office after the investigation is completed. Conspicuously absent from the "aging data" was the average number of days complaints spend on the desk of the executive officer of each agency. At DAHP's January 31 meeting, the inclusion of this information was addressed; many of the EOs present expressed concern over publication of the figures for fear they would be used as a micro-management tool to judge the enforcement performance of the agency. The EOs also disputed the accuracy of the figures generally and the inability of the Medical Board's computer system to account for the flow of complaints from one stage to another just prior to the printing of the matrix.

BPM President Karen McElliott was present at DAHP's January meeting, and expressed BPM's view that aging data for executive officers should be separately delineated on the matrix. In response to the complaints of the allied health program EOs, McElliott stated that aging data do not constitute an evaluation; they are simply data which may or may not form

part of the basis for an evaluation—and which no EO should in any event fear, so long as the data are accurate. According to McElliott, "State government needs managers who welcome accountability, realizing that it strengthens effectiveness. Reluctance to release public information is a danger sign, a red flag for something wrong, even if it is just an unwarranted fear of having others look over one's shoulder....We urge that the full report, without deletions, be provided at every [DAHP] meeting."

At DAHP's May 8 meeting, MBC staff presented the latest version of the matrix, which included the average time complaints stay on the desk of the EO. However, MBC warned that the aging data are still inaccurate. The data reflect current time in process for *open* cases only; MBC has yet to establish a relevant time period for the matrix or to factor in cases closed during that period. (*See supra* agency report on MBC for related discussion.) Thus, the inability of MBC's computer system to accurately track time spent in investigation makes verification of its compliance with the directive of SB 2375 problematical.

BPM Responds to Legislative Request for Enforcement Data. On April 10, Senate Business and Professions Committee Chair Dan Boatwright ordered MBC, BPM, and all the allied health licensing programs to produce—within five working days—detailed enforcement data on disciplinary complaints received, investigated, and forwarded for enforcement action within the past 36 months. Specifically, Senator Boatwright requested, for each case forwarded to the Attorney General's Office or a local district attorney, the following information:

–the date the initial complaint was received by BPM;

–the date the case was sent to investigation;

–the date the investigation was completed and the report received by BPM;

–the date the case was forwarded to the Attorney General's Office or a local prosecutor;

–the date of the filing of an accusation by the AG, if any, or other action taken by the AG or a local prosecutor;

–the name of the respondent licensee and information regarding the nature of the charges against him/her; and

–the current status of the case, including the specific nature of any discipline or penalty that has been imposed on, or agreed to by, the respondent.

In an April 15 letter to Senator Boatwright, MBC Executive Director Ken Wagstaff requested an extension of time in which to gather the information, promising to make it available by May 1. However, BPM responded fully to Senator Boatwright's request on April 16, noting that the statistics provided derived from a manual log initiated by BPM in 1990 "because of the inability of the Medical Board's data processing unit to produce accurate data for management or public information purposes." BPM's statistics reflect an increase in the number of complaints received and an increase in overall disciplinary activity. Only four cases were referred to the AG or the DA in 1988–89, whereas 17 cases have already been so referred during the first nine months of 1991–92. Other areas in which 1991–92 statistics exceed those of prior years include probations (nine thus far in 1991–92, two in 1988–89) and suspensions (three thus far in 1991–92, zero in 1988–89).

Name Change for DAHP? At BPM's March meeting, EO Jim Rathlesberger updated the Board on his and Karen McElliott's January 31 presentation to DAHP regarding the possibility of a name change for the Division. Although BPM is structurally placed under the jurisdiction of DAHP, podiatrists are physicians and not "allied health professionals." McElliott and Rathlesberger explained that BPM licensees feel strongly about transferring the Board from DAHP's oversight or at least changing the name of the Division to reflect the proper status of podiatrists. Rathlesberger suggested the "Division of Health Professions," and noted that the California Podiatric Medicine Association (CPMA) had endorsed the proposal.

However, DAHP's consensus was that a name change must be considered in light of public safety and any new name must not be misleading. Division public member Alfred Song pointed out that "Division of Health Professions" would be inaccurate because the Division does not include physicians—one of the primary health professions. California Medical Association (CMA) representatives present also opposed the suggested name on these grounds. Song advised Rathlesberger that the best approach to this problem might be for BPM to seek legislation to remove itself from DAHP. After discussion, the Division directed DAHP Program Manager Tony Arjil to meet with Rathlesberger and representatives of CPMA and CMA to develop alternate names.

At its March meeting, BPM members reiterated their preference to be removed from the jurisdiction of DAHP. Nurses, optometrists, chiropractors, osteopaths, and other health professions are regulated by boards outside the jurisdiction of DAHP, and BPM believes the public and the podiatry profession would be better served by an independent regulatory agency.

BPM Budget. At its March meeting, BPM members complained about the provision in the 1991–92 state budget bill which strips most state occupational licensing agencies, including BPM, of "excess monies" in their reserve funds. As of June 30, the state Department of Finance will transfer all funds in excess of three months' operating expenses to the general fund to assist in reducing the state's huge budget deficit. BPM stands to lose $625,000 in licensing fees collected from podiatrists; these funds are the sole source of BPM's financial support. Board members are particularly upset because BPM charges one of the highest licensing fees in DCA—$400 per year; in contrast, the Medical Board only recently raised its fees to $240 per year. BPM's high fee is earmarked to provide additional enforcement resources for the agency.

At the March meeting, Board President Karen McElliott characterized the forced budget transfer as unjust "double taxation" of podiatry licensees, and noted that at the same time the state is instructing occupational licensing agencies to increase enforcement activity and output, it is taking money collected for that very purpose.

As a result of this transfer and projected future transfers, BPM believes that, by fiscal year 1993–94, its reserve fund will be effectively eliminated. In the absence of a fee increase, the Board's budget will show a negative reserve of $326,000 by 1994–95.

In a related state budgetary matter, Governor Wilson proposed the elimination of podiatry coverage under the Medi-Cal program in his 1992–93 budget. This suggestion drew strong criticism from BPM members, who feel it is unjust to delete such an essential service as podiatry. If approved by the legislature, this action will force Medi-Cal consumers to seek treatment from more expensive sources—medical doctors.

LEGISLATION:

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including BPM, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission.

SB 2044 would also provide that if, upon investigation, BPM has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by the Board to offer or perform those services, the Board may issue a citation containing an order of correction which requires the violator to cease the unlawful advertising and notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising. *[A. CPGE&ED]*

AB 2743 (Lancaster), as amended April 9, would revise licensing and examination requirements relative to the practice of podiatric medicine. Specifically, the bill would require the Medical Board's Division of Licensing to issue, upon the recommendation of BPM, a certificate to practice podiatric medicine if the applicant meets all of the following requirements: the applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Business and Professions Code section 2483; the applicant has passed, after June 30, 1958, the examination administered by the National Board of Podiatric Medical Examiners or a written examination which is recognized by the Board to be equivalent in content to that administered in this state; the applicant has satisfactorily completed the postgraduate training required by Business and Professions Code section 2484; the applicant takes and passes an oral and practical examination administered by the Board to ascertain clinical competence; the applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 of the Business and Professions Code; and, if the applicant is licensed is another state, territory, or province, the Board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine which constitutes evidence of a pattern of negligence or incompetence. *[A. Floor]*

SB 1813 (Russell), as amended April 2, is a follow-up bill to SB 1070 (Thompson) (Chapter 1180, Statutes of 1991). SB 1070 requires the Department of Health Services (DHS) to promulgate guidelines and regulations to minimize the risk of transmission of bloodborne infectious diseases in the health care setting by January 1993. It requires BPM and other health profession regulatory agencies to ensure that their licentiates are informed of their responsibility to minimize the risk of transmission of bloodborne infectious diseases in the health care setting, and makes it unprofessional conduct for a licentiate to knowingly fail to protect patients by failing to follow DHS' infection control guidelines.

SB 1813 would provide that, in investigating and disciplining podiatrists for knowing failure to protect patients from transmission of bloodborne infectious diseases in the health care setting, BPM shall consider referencing DHS' guidelines; it would also require BPM to consult with the Medical Board, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nurse and Psychiatric Technician Examiners, and other agencies to encourage consistency in the implementation of this provision. *[A. Health]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any podiatrists to assess additional charges for any clinical laboratory service that is not actually rendered by that person to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and Assembly and is awaiting Senate concurrence in Assembly amendments.

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify MBC and BPM of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

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 certain peer review 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. *[S. Jud]*

SB 1004 (McCorquodale) would have prohibited 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 have defined "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 bill died in committee.

FUTURE MEETINGS:

September 25 in Los Angeles.
December 11 in San Diego.

BOARD OF PSYCHOLOGY

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

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

posed of eight members, three of whom are public members.

MAJOR PROJECTS:

Fictitious Name Permit Rulemaking in Limbo. On January 10, BOP held a public hearing on its proposed adoption of new sections 1397.50–.53, Division 13.1, Title 16 of the CCR. *[12:1 CRLR 84]* These regulations would implement Business and Professions Code section 2930.5, added by AB 4016 (Filante) (Chapter 800, Statutes of 1988), which prohibits psychologists from practicing under a fictitious name unless that name meets specified criteria and is approved by BOP. Among other things, the statute requires that any fictitious name used must contain either the term "Psychology Group" or "Psychology Clinic."

The Board received several comments at the hearing and through letters during the public comment period. Sole practitioners expressed concern about the required use of the terms "Psychology Group" or "Psychology Clinic," as those terms would appear to be somewhat misleading for a sole practitioner. Some witnesses questioned the applicability of the new regulations to professional corporations, as Business and Professions Code section 2998 already specifies acceptable names for psychological corporations. Others asked whether any existing fictitious names will be "grandparented in," and questioned which words denote a specialty (which requires a fictitious name permit) and which denote an affiliation with a professional association (which does not require a fictitious name permit).

As a result of these and other comments, BOP approached Assemblymember Filante with a request that the language of section 2930.5 be amended to allow BOP to adopt regulations more appropriate to the psychological profession. The legislator's staff stated that he has no opposition to legislation amending section 2930.5; at this writing, however, no such legislation has been introduced, and BOP's rulemaking is on hold.

Proposed Supervision Regulations. Under Business and Professions Code section 2914, applicants for licensure must have earned a doctoral degree in one of several specified subjects at an accredited or approved institution, and must have engaged for at least two years in "supervised professional experience under the direction of a licensed psychologist, the specific requirements of which shall be defined by the Board in its regulations, or such suitable alternative supervision as determined by the Board in regulations duly adopted under this chapter, at least one year of which shall be after being awarded the doctorate in psychology." At its May 16 meeting, BOP approved draft language of proposed revisions to its "supervised professional experience" (SPE) and "suitable alternative supervision" regulations, to become effective July 1, 1993. *[12:1 CRLR 84–85]*

Specifically, section 1387(b) defines a "qualified primary supervisor" (QPS) as a psychologist who is engaged in rendering professional services a minimum of one-half time in the same work setting in which the person supervised is obtaining SPE. BOP proposes to amend section 1387(b) to require a QPS to have not less than three years of professional post-licensure experience. Section 1387(c) would be amended to specify that a QPS may delegate a portion of the supervision for which he/she is responsible only to another licensed psychologist or to a board-certified psychiatrist. New section 1387(d)(1) would provide that the QPS is responsible for ensuring that any supervision he/she provides is in the same or similar field of psychology as his/her own education and training, and that he/she is able to render competently any psychological services which the supervisee undertakes. Under new section 1387(d)(2), the QPS is responsible for ensuring that the applicant has had adequate coursework for the SPE, and that the SPE is in the same or a similar field of psychology as is the applicant's education and training. Under existing section 1387(e), one year of SPE must consist of not less than 1,500 hours. This section would be amended to specify that no more than 1,500 hours may be accrued under any one supervisor.

Section 1387(o) defines the term "suitable alternative supervision" for persons gaining qualifying experience in a state or territory of the United States other than California. This section would be amended to provide that the alternative supervision must be from a psychologist licensed or certified in the same state or territory where the experience is being gained, and who possesses a doctorate qualifying for licensure in California, and who has three years of post-licensure experience. Section 1387(o)(2) currently allows a maximum of 750 hours of SPE under a primary supervisor who is a licensed professional other than a psychologist, including but not limited to board-eligible or board-certified psychiatrists, educational psychologists, or clinical social workers. This proposal would provide that the primary supervisor referenced in section 1387(o)(2) is limited to a board-certified psychiatrist.

Current regulations do not provide for Board approval of individualized supervision programs in areas where typically there is a lack of training sites or qualified supervisors. Such areas include, but are not limited to, industrial-organizational psychology, applied psychological research, and social-experimental psychology. This proposal would provide for BOP approval of such individualized supervision programs, except for programs involving direct mental health delivery services.

BOP also proposes to add subsection (s) to section 1387, to expressly prohibit a supervisor from supervising a supervisee who is, or ever has been, a client of the supervisor. New section 1387(t) would require supervisees to maintain a written weekly log of all hours of SPE gained toward licensure, containing specified information.

Finally, the Board plans to add new section 1387.3, to set forth the qualifications which must be met by psychologists applying to become supervisors. Also included in this regulatory package is the proposed repeal of section 1386(c), which currently specifies that a doctor of mental health degree earned in a program located in an accredited educational institution shall be deemed an equivalent educational degree for purposes of qualification for licensure.

BOP planned to hold a public hearing on these proposed regulatory changes on July 31 in Sacramento.

Enforcement Report. At BOP's March meeting, staff presented the Board with the latest enforcement statistics. During fiscal year 1990–91, BOP received a total of 483 complaints; from July 1991 through January 1992, the Board has already received 317 complaints. During 1990–91, BOP sent a total of 140 complaints to formal investigation; during the first seven months of 1991–92, the Board has sent 104 complaints to investigation. In 1990–91, BOP forwarded 33 cases to either the Attorney General's Office for disciplinary action or to a local prosecutor for the filing of criminal charges; through January 1992, the Board has forwarded 13 cases for such action. The recent surge in enforcement action has forced the Board to add an Enforcement Coordinator position *[12:1 CRLR 84]*, and to request an increase in the statutory ceiling on its licensing fees (*see supra* LEGISLATION).

LEGISLATION:

SB 1119 (Presley), as amended May 14, would increase the renewal fee for a

psychologist's license from $225 to $400 for biennial renewal periods commencing on or after January 1, 1993, and would authorize BOP to increase the fee to an amount not to exceed $500.

Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify the Medical Board of California (MBC) and the Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. This bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including BOP, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including BOP, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. This bill would also provide that the unlicensed performance of activities for which a BOP license or registration is required may be classified as an infraction punishable by a fine not less than $250 and not more than $1,000. *[A. CPGE&ED]*

AB 2743 (Lancaster), as amended April 9, would revise, effective July 1, 1993, the examination and reexamination fees for written and oral psychologist examinations. This bill would also authorize DCA boards, including BOP, to create a "cost recovery program"—that is, in disciplinary proceedings, BOP could request the administrative law judge to direct the licentiate, under certain circumstances, to pay to the board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. *[A. Floor]*

AB 2416 (Hunter), as amended April 29, would require the Department of Finance, in consultation with the Secretary of the Health and Welfare Agency, to conduct a study and to report to the legislature on or before June 1, 1993, relating to the provision of mental health services by psychologists in state hospitals under the jurisdiction of the state Department of Mental Health. *[A. W&M]*

SB 1773 (Boatwright), as amended March 30, would authorize BOP to refuse to issue a license to an applicant when it appears that the applicant may be unable to practice safely due to mental illness or chemical dependency, and would make specified procedures regarding the examination of licentiates by a Board-designated physician or psychologist also applicable to applicants. The bill would also authorize BOP to deny an application for licensure or registration as a clinical psychologist, or suspend or revoke a license or registration of, and that it constitutes grounds for disciplinary action for unprofessional conduct against, a psychologist if another state revokes or suspends that license, or otherwise disciplines that licensee. This bill would also provide that BOP may deny any application for licensure or registration or suspend or revoke a license or registration to practice psychology if the Board of Behavioral Science Examiners (BBSE) has revoked, suspended, or taken other disciplinary action against that person's license to practice marriage counseling, or marriage, family, and child counseling. *[A. Health]*

AB 3034 (Polanco). Existing law requires a candidate for licensure as a psychologist to meet prescribed requirements, including at least two years of supervised experience under the direction of a licensed psychologist who meets certain requirements, or under the direction of suitable alternative supervision as determined by BOP in regulations. As amended March 26, this bill would provide that a person could meet that experience requirement under other specified conditions that involve Board approval of a plan for supervised experience. This bill would require verification of each supervisor listed in the plan, under penalty of perjury.

The Psychology Licensing Law authorizes the Board to deny an application for a license, issue a license subject to terms and conditions, order the suspension of a license for a period not exceeding one year, or revoke or impose probationary conditions upon a licensee for, among other things, accepting commissions or rebates or other forms of remuneration for referring persons to other professionals. This bill would change that limitation on the issuance or use of a license to practice psychology and would prohibit the payment, acceptance, or solicitation of consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of clients.

This bill would also permit the Board to reinstate a revoked license to practice psychology upon an application made to the Board three years from the date of revocation. *[S. B&P]*

SB 1882 (Bergeson). Existing law provides for the licensure by the state Department of Health Services of clinics, excluding from these licensure requirements a place, establishment, or institution that solely provides advice, counseling, information, or referrals on the maintenance of health or on the means and measures to prevent or avoid illness. As amended April 9, this bill would add psychology services to the list of services such excluded entities may provide. This bill would also eliminate existing law which provides for the licensure of psychology clinics. *[A. Health]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any psychologist to assess additional charges for any clinical laboratory service that is not actually rendered by that person to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and Assembly, and is currently awaiting Senate concurrence in Assembly amendments.

SB 774 (Boatwright) 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. *[S. Conference Committee]*

The following bills died in committee or were dropped by their author: ***SB 1004 (McCorquodale)***, which would have prohibited 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; ***AB 1106 (Felando)***, which would have created the Alcohol and Drug Counselor Examining Committee within BBSE and required the Committee to adopt regulations to establish certification standards and education, training, and experience requirements for persons who practice alcohol and drug counseling; and ***SB 738 (Killea)***, which would have compelled BOP to establish required training or coursework in the area of domestic violence assessment, intervention, and reporting for psychologist licensure and/or renewal.

RECENT MEETINGS:

At its March meeting, BOP reelected Dr. Louis Jenkins as Board Chair, and selected Bruce Ebert as Vice-Chair and Linda Lucks as Secretary.

FUTURE MEETINGS:

September 25–26 in San Diego.
November 6–7 in Sacramento.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards
(916) 920-6388

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

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

SPAEC is authorized by the Speech 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:

Committee Grants Petition for Rulemaking on Exam Waiver Criteria. After discussing the matter at its January 24 and April 2 meetings, SPAEC agreed to reverse an earlier decision and grant a request that it adopt regulations to guide its decisions on requests for exam waivers. *[12:1 CRLR 86]*

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" (EWI). 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. EWIs 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 the Committee's January 24 meeting, the issue again consumed the bulk of the meeting. EWIs were conducted before the entire Committee, in contrast to SPAEC's usual practice of breaking up into two-member subcommittees. SPAEC carried a motion to conduct future EWIs before the entire Committee. Committee members, dissatisfied with the perceived subjectivity of the two-member interviewing subcommittees, believed this step would help make the EWI process more objective.

The Committee discussed various other mechanisms to improve the consistency of exam waiver decisions. In light of the vastly divergent objectives of the Committee members regarding the function of the EWIs, a suggestion was made to clarify the qualifications contained in the interview checksheet and stick to those qualifications as the basis for granting waivers. All members would be expected to contribute in defining those qualifications. Additionally, the information packet sent to applicants could be modified to notify applicants of the qualifications being considered and permit them to prepare appropriately.

Surprisingly, SPAEC passed a second motion to commence rulemaking to repeal section 1399.159(b), the regulation permitting SPAEC to waive its written exam requirement when the exam was taken five years prior to application for licensure. Committee members cited the subjectivity of the exam waiver process and potential liability as the reasons compelling this amendment. Since exam waivers are provided for in the regulations governing SPAEC, the Committee must follow proper rulemaking channels under the Administrative Procedure Act and submit the amendment to the Office of Administrative Law (OAL) for review in order to delete the provision. Consequently, SPAEC must continue to grapple with exam waivers at least until the proposed amendment is approved by OAL. A public hearing regarding the proposed repeal of section 1399.159(b) was tentatively scheduled for SPAEC's July meeting.

Department of Consumer Affairs counsel Greg Gorges, who advises SPAEC on legal issues, warned that the

amendment would make SPAEC one of the few state boards requiring re-examination on entry to California. Such barriers to entry are suspect and may cast the Committee in the role of a guild rather than consumer protector. Gorges stated that the Committee would eventually face pressure to provide EWIs or some form of oral interview to take the place of the written exam requirement.

Finally, a third motion was carried to establish subcommittees for review of exam waiver applications between meetings to determine whether an EWI is necessary. The Committee expects qualified applicants to be waived without resort to an EWI. Only those applicants with borderline qualifications would be required to undergo an EWI. However, this action still fails to address the criteria upon which these borderline decisions will be based.

On February 13, the Center for Public Interest Law (CPIL) formally petitioned SPAEC to adopt regulations establishing the criteria for eligibility for an exam waiver. CPIL's petition requested the Committee to address whether and to what extent any of the following are required or preferred for an exam waiver:

–work experience, including its recency, continuity, length, scope, and nature (*e.g.*, full-time or part-time);

–supervised clinical experience, including its recency, continuity, scope, and nature;

–type(s) of clients treated in previous clinical/work practice (*e.g.*, children, adults, geriatric);

–continuing education (CE), including its amount, recency, scope (*e.g.*, whether CE in a relatively narrow field qualifies), nature (*e.g.*, whether "continuing self-education" qualifies), and continuity;

–score(s) on previous exam(s);

–identity of and/or courses taken during undergraduate program; and

–any other criteria the Committee deems relevant to the issue of an exam waiver.

After discussion at its April 2 meeting, SPAEC decided to rescind its previous decision to repeal section 1399.159(b), and to grant CPIL's petition for rulemaking. The Committee delegated to a subcommittee the task of drafting proposed regulations to clarify and standardize exam waiver criteria for all applicants. In the meantime, SPAEC is taking steps to ensure that all candidates' qualifications are reviewed on an equal basis. SPAEC instructed the subcommittee to present its draft regulations for full Committee review at its July 10 meeting.

Mandatory Continuing Education. For over one year, SPAEC has been discussing the concept of mandatory continuing education (MCE) for its licensees. *[12:1 CRLR 86]* At SPAEC's April 2 meeting, the subcommittee presented its latest MCE draft. The legislative proposal would require each SPAEC licensee to complete a minimum of 30 hours of SPAEC-approved CE during each license renewal period (except upon the first license renewal); licensees who are both speech-language pathologists and audiologists shall only be required to complete a total of 50 CE hours per renewal period. All MCE courses must be pre-approved by SPAEC and must meet specified criteria. Under the proposal, a maximum of one-third of the required CE hours may be satisfied by teaching CE courses; a maximum of 25% of the required CE hours may be in the field of audiology for a speech-language pathologist, and in the field of speech-language pathology for an audiologist; and a maximum of 10% of the required CE hours may be in a subject or area "related to" the licensee's field of practice. Otherwise, acceptable courses "shall relate directly" to either speech-language pathology or audiology.

The draft provides that an unspecified percentage of the required hours may be satisfied by self-study or unsupervised study; another unresolved issue is the length of time for which a SPAEC approval of a CE course will remain effective. The entire concept is being addressed in the context of the Department of Consumer Affairs' (DCA) ongoing study of the CE requirements of various DCA boards and bureaus, and a provision of SB 2044 (Boatwright) (*see infra* LEGISLATION) which would authorize the DCA Director to develop guidelines and prescribe components for MCE programs administered by any agency within the Department. SPAEC was scheduled to address these issues at its July meeting.

Hearing Screening Via Telephone. At SPAEC's January meeting, the Committee continued a discussion commenced at its November meeting about the legality of conducting hearing screenings via telephone. *[12:1 CRLR 87]* Legal counsel Greg Gorges stated that diagnosis or treatment of individuals for speech or hearing disorders is reserved for licensed audiologists; for these individuals, such conduct over the telephone is unprofessional conduct unless the licensee has previously examined the patient. An unlicensed person may "screen" hearing to determine whether an individual needs further audiologic evaluation, but the line between "screening" and "testing" is difficult to draw.

After noting instances of consumer abuse through unlicensed hearing screening, the Committee decided that hearing screening falls within the practice of audiology. Outside audiology, speech-language pathologists are permitted to conduct hearing screening only if it is related to evaluating a speech-language disorder. Hearing aid dispensers are limited to offering hearing testing only for the purpose of fitting or selling hearing aids; screening is not included within this definition.

This problem may be resolved with the passage of AB 3160 (Conroy) (*see infra* LEGISLATION). The Committee agreed to consider various agency and professional association positions and to revisit this issue at a future meeting.

Audiology Aides and Earmold Impressions. In January, SPAEC continued another discussion begun at its November meeting—the issue of unlicensed audiology aides taking earmold impressions while employed in nonprofit settings where licensed audiologists sell hearing aids. *[12:1 CRLR 86–87]* Section 3351 of the Business and Professions Code exempts such aides from licensure requirements so long as the aide does not "engage directly or indirectly in the sale or offering for sale of hearing aids." The Committee expressed concern that unlicensed audiology aides engaged in taking earmolds should be licensed as temporary hearing aid dispensers under the Hearing Aid Dispensers Licensing Law. However, Committee legal counsel Greg Gorges stated that the definition of the practice of audiology permits an audiologist to take earmold impressions when fitting hearing aids; therefore, an audiology aide may make an earmold. Gorges opined that although the making of an earmold is one step in the process of fitting, dispensing, and ultimately selling a hearing aid to a consumer, it is a very indirect step. If all the steps in the process were considered the "indirect" sale of a hearing aid, the exemption in section 3351 would become meaningless. Gorges acknowledged that aides could overstep the exemption with other types of conduct, but the mere taking of an earmold impression or assisting with the hearing test should not require a license as a temporary hearing aid dispenser.

Joint SPAEC/HADEC Task Force. For several years, SPAEC has sought to establish a joint task force with the Hearing Aid Dispensers Examining Committee (HADEC) which, composed of members of both boards, can address issues of mutual interest. *[12:1 CRLR 87]* Although this goal has been thwarted for several

years due to numerous member vacancies on HADEC, that committee recently achieved its full membership and voted to assemble such a task force. One topic of discussion is SPAEC's contention that hearing aid dispensers are engaging in deceptive advertising. SPAEC and its licensees allege that many hearing aid dispenser advertisements are misleading in that they imply that the dispenser is offering or qualified to offer audiological services. Both SPAEC and HADEC hope to create a fact sheet with advertising guidelines for hearing aid dispensers, and plan to use their citation and fine authority to sanction violations.

SPAEC hopes the task force can address other issues outside the advertising problem. At its April meeting, Committee Chair Robert Hall suggested that the task force serve as an ongoing liaison to address issues of common concern. For example, the task force might discuss the appropriate definition of "hearing screening" and the distinction between "screening" and "testing," and determine the scope of practice into which it falls.

LEGISLATION:

SB 1119 (Presley). Existing law requires district attorneys, city attorneys, and other prosecuting agencies to notify the Medical Board of California (MBC) and the California Board of Podiatric Medicine (BPM) of any filings of felony charges against a licensee of either board. Existing law also requires the clerk of the court to transmit a certified copy of the record of conviction of a licensee to MBC or BPM, and to transmit any felony preliminary hearing transcripts to MBC or BPM, as applicable. As amended May 14, this bill would expand these requirements to also require notification to other applicable allied health professional program committees or boards, including SPAEC, of the filing of felony charges against licensees of those agencies, and transmission of records of conviction or felony preliminary hearing transcripts concerning licensees of those agencies. For licensees regulated by an allied health professional program, the record of conviction would be transmitted to both MBC and the appropriate allied health professional regulatory committee or board. *[A. Health]*

SB 2044 (Boatwright), as amended April 2, would declare legislative findings regarding unlicensed activity and authorize all DCA boards, bureaus, and commissions, including SPAEC, to establish by regulation a system for the issuance of an administrative citation to an unlicensed person who is acting in the capacity of a licensee or registrant under the jurisdiction of that board, bureau, or commission. This bill would also authorize the DCA Director to develop guidelines for mandatory continuing education programs administered by any DCA board. *[A. CPGE&ED]*

AB 3160 (Conroy), as amended April 29, would include the conduct of hearing screening within the definition of the practice of speech-language pathology. Previous language placing cerumen management within the practice of audiology was deleted. *[S. B&P]*

AB 2743 (Lancaster), as amended April 9, would rename SPAEC's enabling act as the Speech-Language Pathologists and Audiologists Licensure Act; provide that the fee for a duplicate wall certificate fee is $40 and the duplicate renewal receipt fee is $40; provide that all speech-language pathologist and audiologist licenses issued as of January 1, 1992, shall expire at midnight on the last day of the birth month of the licensee during the second year of a two-year term if not renewed; provide that all initial licenses issued by SPAEC will expire at midnight on the last day of the birth month of the licensee during the second year after it is issued; and provide that, to renew an unexpired license, the licensee must, on or before the date of expiration of the license, apply for renewal on a form provided by SPAEC, accompanied by the prescribed renewal fee. *[A. Floor]*

SB 664 (Calderon). Existing law prohibits 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, unless the patient is apprised at the first solicitation for payment of the name, address, and charges of the clinical laboratory performing the service. As amended March 12, this bill would also make this prohibition applicable to any subsequent charge, bill, or solicitation. This bill would also make it unlawful for any speech-language pathologist or audiologist to charge additional charges for any clinical laboratory service that is not actually rendered by that person to the patient and itemized in the charge, bill, or other solicitation of payment. This bill passed both the Senate and Assembly and is currently awaiting Senate concurrence in Assembly amendments.

RECENT MEETINGS:

At the Committee's January meeting, the subcommittee which is developing SPAEC's Fine/Citation/Enforcement Manual reported that the project is still in progress. *[12:1 CRLR 87]* The manual will be used in implementing SPAEC's citation and fine regulations, adopted pursuant to Business and Professions Code section 125.9. Subcommittee member Gail Hubbard reported that she is working on the definition of the practice of audiology. Draft copies were to be provided to Committee members for review and critique before Hubbard proceeds. Hubbard also noted that she has not yet had an opportunity to begin the speech-language pathology portion.

Also in January, Executive Officer Carol Richards suggested that SPAEC consider modifying the direct supervision requirement for applicants who have completed their supervised professional experience in another state. In 1979, the Committee decided to require eight hours per month direct supervision during a candidate's year of required professional experience. Then, as now, the American Speech-Language-Hearing Association (ASHA) suggested a minimum of two hours per month direct supervision. The majority of the 39 other states requiring licensure follow the lead of ASHA. SPAEC tabled this issue.

At its April 2 meeting, SPAEC reviewed the practice of ear wax removal (cerumen management) by audiologists. At that time, AB 3160 (Conroy) would have expanded the scope of the practice of audiology to include ear wax removal. The Committee expressed its disapproval of such an extension of the audiology scope of practice, noting that no education or training in this area is currently mandated, and that the procedure is a high-risk invasive technique involving entry in a bodily orifice. AB 3160 was amended on April 29 to delete that provision (*see supra* LEGISLATION).

FUTURE MEETINGS:

September 11 in San Francisco.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

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

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