California, and one member must be a resident of and practice landscape architecture in northern California. Three members of the Board must be licensed to practice landscape architecture in the state of California. The other four members are public members and must not be licentiates of the Board. Board members are appointed to four-year terms. BLA's regulations are codified in Division 26, Title 16 of the California Code of Regulations (CCR).

MAJOR PROJECTS:

Update on Proposed Regulatory Changes. BLA's rulemaking package which proposes to repeal existing section 2620, adopt new sections 2620 and 2620.5, and amend section 2649, Division 26, Title 16 of the CCR, has not yet been sent to the Office of Administrative Law (OAL) at this writing. The proposed changes would clarify educational and work requirements necessary to sit for BLA's licensing exam and increase selected fees. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 79; Vol. 11, No. 1 (Winter 1991) pp. 65-66; and Vol. 10, No. 4 (Fall 1990) p. 78 for background information.)

LEGISLATION:

AB 1996 (Campbell). Under existing law, in any action for indemnity or damages arising out of the professional negligence of a person licensed as a professional architect, engineer, or land surveyor, the plaintiff's attorney is required to attempt to obtain consultation with at least one professional architect, engineer, or land surveyor who is not a party to the action. The attorney is then required to file a certificate which declares why the consultation was not obtained or that, on the basis of the consultation, the attorney believes there is reasonable and meritorious cause for filing an action. As introduced March 8, this bill would specify that these provisions also apply to actions arising out of the professional negligence of landscape architects. This bill is pending in the Assembly Judiciary Committee.

SB 173 (Bergeson). Under existing law, state and local agency heads may contract for specified services based on demonstrated competence and professional qualifications rather than competitive bidding. As introduced January 14, this bill would add landscape architectural services to the list of specified services. This bill is pending in the Senate Transportation Committee.

AB 1893 (Lancaster), as amended May 24, would authorize BLA to adopt guidelines for the delegation of its authority to grade the examinations of licensure applicants to any vendor under contract to the Board. This bill is pending in the Assembly Ways and Means Committee.

FUTURE MEETINGS:

August 2 in Irvine.

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 licenses and certificates under the Board's jurisdiction; administering the Board's continuing medical education program; suspending, revoking, or limiting licenses upon order of the Division of Medical Quality; approving undergraduate and graduate medical education programs for physicians; and developing and administering physician and surgeon examinations.

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. 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 investigate 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 non-physician certificate holders under the jurisdiction of the Board. The following allied health professions are subject to the jurisdiction 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:

Senate Committee Reviews Auditor General's Report on MBC's Discipline System, Board's Implementation of SB 2375. On May 23, the Senate Business and Professions Committee held an oversight hearing on the progress of the Medical Board in implementing SB 2375 (Presley), a 37-part physician discipline system reform bill enacted by the legislature in 1990. (See CRLR Vol. 11, No. 1 (Spring 1991) pp. 81-82; Vol. 11, No. 1 (Winter 1991) pp. 66-67; and Vol. 10, No. 4 (Fall 1990) pp. 79-80 for extensive background information on DMQ's preliminary implementation of SB 2375.) According to a May report issued by Public Citizen, a Washington D.C.-based consumer advocacy group, California ranks 38th in physician discipline.

The Committee first received a report from Tom Britting of the Office of the Auditor General (OAG); OAG had recently completed an in-depth analysis of MBC's complaint processing system and released a critical report. (*See supra* agency report on OAG for more detailed summary of the report.) Specifically,

OAG noted that SB 2375 requires the Board to set a goal that by January 1, 1992, it will complete investigations within an average of six months from receipt of the complaint. After reviewing a selected sample of MBC enforcement cases resolved between December 1, 1989 through November 30, 1990, OAG concluded that the Board will not be able to meet this goal. DMQ investigations last approximately 14 months—eight months beyond SB 2375's six-month goal. The fact that it takes an average of 117 days for DMQ to simply assign a case to a field investigator contributes substantially to this problem. Of the 312 cases reviewed by OAG, 22% were unassigned for six months (180 days) or longer.

After DMQ completes its investigation and decides to file an accusation against a physician, the case is referred to the Attorney General's Office, which has set a deadline of completing accusations within 60 days of receipt. However, OAG found that it presently takes the AG's Office over 200 days to prepare an accusation.

Once the accusation is prepared, it is filed in the Office of Administrative Hearings (OAH), whose administrative law judges (ALJs) preside over the disciplinary hearing and make a recommended disciplinary decision to DMQ. Although the functioning of OAH was beyond the scope of its audit, OAG noted that it usually takes OAH an average of 264 days (from the filing of the accusation) to complete a disciplinary hearing. Once the hearing is completed, the ALJ has 30 days in which to prepare a proposed decision and forward it to DMQ, which then has 100 days in which to act on the proposed decision.

Thus, the Auditor General found that DMQ, the AG's Office, and OAH take an average of 2.8 years to process a discipline case, from DMQ's receipt of the complaint to its final disciplinary decision. Even if DMQ were to meet the SB 2375- imposed six-month investigation goal and the AG's Office were to meet its self-imposed 60-day goal for the preparation of an accusation, the physician discipline process would still take 1.7 years. Judicial review of an agency disciplinary ruling—which does not commence until the agency has made its final decision—can last from two to five years if contested.

OAG made other findings as well, including the following:

-Of 180 cases closed by DMQ as without merit, 17% were closed for reasons that were not sufficient for concluding that the cases lacked merit.

-OAG found no evidence of supervisory approval for 15% of the 150 cases closed without merit involving allegations of physician negligence, incompetence, or drugs.

-DMQ does not maintain its central file of all licensee names and complaint history as required by law, and is not always able to obtain complete case file documentation from its central file.

-MBC's toll-free complaint telephone number (1-800-MED-BD- CA) is not easily available to the public in some areas of the state.

However, MBC witnesses—including Executive Director Ken Wagstaff, Board President Dr. John Tsao, DMQ President Frank Albino, and DMQ Enforcement Chief Vern Leeper—disputed the findings of the Auditor General, and contended that they are unrepresentative because the Board has made so many changes in its discipline system since it processed the cases reviewed by OAG. At the hearing, MBC representatives stated that DMQ has made numerous improvements to its discipline system since it has come under close scrutiny due to the pendency of SB 2375 and the notorious *Klvana* case, in which both the prosecutor and the judge harshly criticized the Board's discipline system (see CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 21 and 97-98 for background information on the *Klvana* case). Specifically, the MBC witnesses testified to the following reforms implemented since mid-1990:

-it has reduced its backlog of 900 unassigned consumer complaint cases by assigning them to its investigators;

-over the past few years, it has doubled the number of regional field offices and increased the number of DMQ investigators from 40 to 70. Further, it recently succeeded in reclassifying its investigator positions and securing a salary increase for each investigator classification, which will hopefully lead to the Board's retention of trained medical investigators;

-it has established a toll-free consumer complaint number (1-800-MED-BD-CA) and created a centralized and computerized complaint intake and routing system;

-pursuant to the terms of SB 2375 (Presley), it has established a new "partnership" with the Health Quality Enforcement Section (HQES), the new unit of attorneys in the AG's Office which specializes in prosecuting medical discipline cases. This improved working relationship should enhance the quality of the investigations performed by Medical Board investigators, and enable the attorneys who will eventually try the discipline case to guide the investigation from the outset. The AG's office is also participating in the development of the Medical Board's training program for its investigators;

-the Medical Board is becoming more aware of its responsibility to promptly refer cases which should be criminally prosecuted to the appropriate law enforcement agency prior to the running of the statute of limitations; and

-so far during calendar year 1991, DMQ has increased the number of completed investigations which it has referred to the AG's office for prosecution; estimates of the increase proffered by Board witnesses ranged from a 25-50% increase over 1990.

Although DMQ appears to have achieved some success in its preliminary implementation of SB 2375, the AG's Office and OAH have not. Al Korobkin, a veteran AG from San Diego and the new HQES Chief, testified that the new unit is burdened by a huge backlog of investigated cases which must be processed and tried. HQES has been in existence for only five months; during those five months, however, the legislative and public pressure on the Medical Board to improve its disciplinary output has finally succeeded—DMQ has added 18 investigator positions over the past two years, and the Board is rapidly forwarding long-delayed cases for prosecution. As noted above, the 22 attorneys assigned to HQES commonly take over seven months just to prepare the accusation, due to the transition and the case backlog. Korobkin promised to seek additional attorney positions if the unit is unable to keep up with the Board—especially if MBC succeeds in convincing the legislature to add 23 new investigator positions to DMQ during fiscal year 1991-92.

On the positive side, Korobkin noted that his attorneys are frequently available at DMQ regional offices for consultation with investigators and medical consultants. He stated that, as of July 1, HQES will implement a new system of monitoring DMQ investigators. All cases forwarded to HQES for prosecution will be immediately reviewed by a Supervising Deputy Attorney General for completeness of the investigation; if additional investigation is needed, the Supervising DAG will take the file personally to the relevant regional office and discuss the case with the investigator. Korobkin believes this approach will expedite the comprehensive investigation of cases, provide ongoing training of investigative staff, and create a consistent working relationship between top-level attorneys and DMQ

investigators. Also, during the month of July, Korobkin will personally supervise the Board's Central Complaint Investigation Control Unit (CCICU) in Sacramento, DMQ's new centralized complaint intake unit. He will focus on reviewing cases which have been recommended for closure.

Under SB 2375, OAH is to designate a "Medical Quality List" of ALJs who have experience and relevant education/training in handling the complex medical discipline cases. The intent of Senator Presley and SB 2375's sponsor, the Center for Public Interest Law (CPIL), in drafting this section of the bill was to replicate the recent reforms made to the State Bar's discipline system—that is, to create a relatively small panel of ALJs (6-8 judges) who would exclusively hear and specialize in medical discipline cases. Use of a small panel of judges for a particular type of case usually results in judicial expertise and familiarity with the subject matter, and consistency and predictability in decisionmaking (which leads to more settlements and fewer hearings). However, Karl Engeman, the current director of OAH, testified at the May 23 hearing that he has assigned 27 ALJs to the Medical Quality List; that is, he has essentially refused to allow his ALJs to become "specialists."

In response to the testimony, CPIL Director Robert C. Fellmeth acknowledged that the Medical Board has made some progress in improving its discipline system, but expressed concern over what he characterized as the Board's continuing "shell game," alluding to DMQ's admission that it has cleared away its backlog of 900 unassigned cases simply by assigning them to investigators. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 82 and Vol. 11, No. 1 (Winter 1991) p. 67 for background information.) He stressed his belief that physicians should not be involved in the disciplinary review of their fellow physicians, and called for the removal of the Division of Medical Quality and DMQ's Medical Quality Review Committees from the physician discipline process entirely. He expressed his approval of HQES' supervisory role over DMQ's CCICU and investigative staff, and called for even more control by the AG's office of physician discipline cases from the day they are filed. Fellmeth also expressed extreme disappointment with the failure of OAH's Karl Engeman to implement the intent behind SB 2375 by creating a small panel of ALJs to specialize in medical discipline cases, and stated he would discuss this matter with Engeman and pursue other remedies as appropriate.

Finally, Professor Fellmeth called for the creation of a Medical Discipline Monitor position, similar to the State Bar Discipline Monitor position created by the legislature in 1986 (Business and Professions Code section 6086.9). Fellmeth, who has served as State Bar Discipline Monitor since January 1987, clarified that he is not looking for a job, but noted that the creation of an independent monitor position with the investigative powers of the Attorney General and the responsibility to investigate the discipline system from top to bottom, make recommendations for legislative and administrative changes, and publish periodic reports on the system over a three- to four-year term is the best way to provide continuous monitoring and pressure on the system. He noted that during his tenure as State Bar Discipline Monitor, the Bar has hidden its complaint backlog at five or six different locations; only an independent monitor with the responsibility to investigate continuously could detect that kind of manipulation.

Fellmeth also noted that the cost of a discipline monitor is relatively small —only $2 per licensee in the Bar's case—but that investment has paid off. Since the implementation of radical changes in the Bar's discipline system prompted by SB 1498 (Presley) (Chapter 1159, Statutes of 1988), the total output of the system has increased steadily and substantially. Public discipline increased markedly in 1988 over the base level of 1982-87; in 1989, the Bar's public discipline output increased 32% over 1988; and in 1990, public discipline increased almost 50% over 1989 levels. Informal discipline during 1990 was ten times what it was during 1981-86 (from 46-60 cases per year then, to 662 in 1990).

MBC to Raise Licensing Fees to Finance Enhanced Discipline System. Pursuant to decisions made at its February meeting (see CRLR Vol. 11, No. 2 (Spring 1991) pp. 81-82 for background information), DOL held a regulatory hearing at its May meeting on proposed amendments to sections 1351.5 and 1352, Division 13, Title 16 of the CCR. These amendments would increase both the initial license fee and the biennial renewal fee to $400, the statutory maximum. The Board needs the additional revenue to help finance the enhanced discipline system required by SB 2375 (Presley). Following minimal public comments, DOL adopted the proposed changes and has forwarded the rulemaking package to the Department of Consumer Affairs (DCA) for approval.

The Board is also seeking a legislative change authorizing it to raise licensing fees up to $500 every two years (*see infra* LEGISLATION for description of AB 1553 (Filante)).

Other Discipline System Issues. In its written response to the Auditor General's report and at the May 23 hearing before the Senate Business and Professions Committee, DMQ disputed the meaning of Business and Professions Code section 2319(a), which requires it to "set as a goal the improvement of its disciplinary system by January 1, 1992, so that an average of no more than six months will elapse from the receipt of a complaint to the completion of an investigation." As noted above, OAG found that a 14-month time period generally elapses between DMQ's receipt of a complaint and the completion of the investigation.

At its May meeting, DMQ decided to seek legislative "clarification" of this six-month goal, such that the six-month period would begin not with the receipt of the complaint, but with DMQ's decision that it warrants investigation. According to DMQ Enforcement Chief Vern Leeper, the time spent obtaining records and evaluating the merits of the complaint should not be counted in the six-month period. At the May 23 hearing before the Business and Professions Committee, this suggestion was not warmly received; Senator Presley stated that the language of section 2319(a) is relatively clear and exactly what he intended. At this writing, no legislator is carrying legislation to implement DMQ's desire.

Also in May, DMQ rejected, by a 4-3 vote, the imposition of fines for minor infractions as one way to keep licensure fees down and increase the deterrent effect of the Medical Board's licensing law and DMQ's discipline system. The Division had previously rejected DMQ President Frank Albino's suggestion to create a "cost recovery" system, whereby DMQ's investigation costs are passed on to a disciplined licensee. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 82 and Vol. 11, No. 1 (Winter 1991) p. 67 for background information.) In its May decision, the slim DMQ majority reasoned that discipline should not be monetarily controlled, a cost recovery system would require legislation, and the use of fines would create an increase in administrative paperwork.

MBC Abandons Proposal to Leave DCA. After months of discussion regarding its dissatisfaction with and desire to leave the Department of Consumer Affairs (DCA), MBC shelved the proposal at its May meeting. (See CRLR

Vol. 11, No. 2 (Spring 1991) pp. 80-81; Vol. 11, No. 1 (Winter 1991) p. 68; and Vol. 10, No. 4 (Fall 1990) pp. 81-82 for background information.) Whether the decision to cease its efforts was based on a belated appreciation of the logistics involved in such an endeavor, or simply upon the realization that leaving the Department is not politically feasible, is not clear; both problems have been discussed at Board meetings. However, at least unofficially, some Board members have not entirely abandoned the idea, and have stated their intention to "wait and see how new DCA Director Jim Conran interacts with the Board." For his part, Mr. Conran, when questioned regarding the Board's proposal to leave DCA, simply stated, "They're going nowhere." He elaborated that he believes the Board has more important issues to face at the present time, such as increased consumer protection.

DOL's CME Program. At DOL's May meeting, Division staff presented a report on the Division's Continuing Medical Education (CME) Program and the courses that are acceptable for Category I credit. The primary responsibility of the CME program is to ensure that each physician completes an average of at least 25 hours of approved CME each year, with a minimum of 100 hours every four years. Each year, a random audit on a sample of licensed physicians is conducted to determine CME compliance. In addition to the audit, in order for a physician to renew his/her California license, he/she must certify on the renewal application to having completed 100 CME hours over the last four years.

Section 1337, Chapter 13, Title 16 of the CCR, allows DOL to accept any courses or programs that have been approved for Category 1 credit by the American Medical Association (AMA), the California Medical Association (CMA), the American Academy of Family Practice (AAFP), and any other organization or institution that is acceptable to DOL. In addition, credits are awarded by CMA (and accepted by DOL) for additional educational learning activities which have been determined by DOL to meet the criteria for acceptable CME.

Other credits are also acceptable. A maximum of one-third of the required annual hours of CME (*i.e.*, eight hours per year) may be satisfied by teaching or otherwise presenting a course or program that is directly related to patient care, community health, or public health. Furthermore, any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board will be granted credit for four consecutive years (100 hours) of CME credit for relicensure purposes. Such credit may be applied retroactively or prospectively.

DOL staff also reported that in 1990, the CME program staff audited 775 physicians, 60 of whom have not yet complied with the audit, and "cleaned up" approximately 5,000 old audit files of noncompliant physicians. The CME staff asserts that all physicians who are in noncompliance with the CME requirement are carefully tracked by computer, closely supervised to ensure proper license renewal and, after being given the appropriate time allowed by law to make up any deficiencies, are denied renewal until documentation is submitted to verify CME compliance.

Criteria for Satisfactory Completion of PGT Requirements. Next year, DOL plans to sponsor legislation to increase the postgraduate training (PGT) necessary for licensure from the existing one year to two years. Until then, AB 3272 (Filante) (Chapter 1629, Statutes of 1990) requires the Board to conduct studies on the possible impacts of increasing the required number of PGT years. At its February meeting, DOL members agreed to revise several vague terms in the PGT completion form and clearly redefine the responsibilities of an institution's Director of Medical Education in signing the form and certifying that an applicant has satisfactorily completed a PGT program. (See CRLR Vol. 11, No. 2 (Spring 1991) pp. 82-83; Vol. 10, No. 4 (Fall 1990) pp. 82-83; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) for background information.)

At its May meeting, DOL members discussed the following proposed definitions:

(1) "Satisfactorily" shall be defined as meaning that the physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth, including demonstrated ability to assume graded and increasing responsibility for patient care.

(2) "Responsibilities of the Director of Medical Education" shall be defined as meaning that the individual signing the PGT completion form is formally certifying and documenting, under penalty of perjury, that the physician received quality instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed the training program in accordance with accepted standards and the criteria defined as equating to "satisfactory" performance as described above. In cases where the Director is certifying the completion of the minimum one year of training required for licensure, he/she will be personally attesting to the fact that the physician has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

DOL approved the proposed language, and plans to formally adopt the proposal at its next meeting.

Probationary Medical Licenses. In April 1990, DOL adopted guidelines which provide the parameters within which licensure applicants with a history of chemical dependency or mental disorder may be considered for a physician's license. Section 2221 of the Business and Professions Code authorizes the Division to consider for medical licensure applicants who present evidence of substance abuse or mental disorders. At its February 1991 meeting, DOL members asked staff to review the guidelines and research the costs associated with out-of-state doctors participating in the Board's Diversion Program. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 81 for background information on DMQ's Diversion Program.)

Following the February meeting, Licensing and Diversion Program staff reviewed and evaluated the effectiveness of the guidelines based on the number of applicants who presented a history of chemical dependency or mental disorder and who have successfully progressed through the licensing process to obtain a probationary license. DOL staff stated that "the guidelines have been very useful and have interjected an element of consistency when considering the wide variety of sensitive and complex applications that warrant consideration of a probationary license."

Under the guidelines, a physician with a past substance abuse problem may be considered for an unrestricted license if he/she has demonstrated three years' abstinence (five years for anesthesiologists) which is documented by a program or therapist experienced in recovery; is currently involved in a strong personal recovery program (such as Alcoholics or Narcotics Anonymous); and has a clear and unrestricted license in any other states where licensed. Physicians with past mental disorders may be considered for an unrestricted license if a program or therapist experienced in recovery documents that over five years have passed without a problem with depressive and/or manic episodes; the physician has an understanding of the disease and a support system to help monitor changing moods; and the physician has a clear and unrestricted license in any other states where licensed.

The guidelines also provide that a physician with a past substance abuse problem may be considered for a probationary or conditional license if he/she has demonstrated more than one year of abstinence; has documented evidence of successful completion or current participation in a rehabilitation program; and has a clear and unrestricted license in other states where licensed. A physician with a past mental disorder may be considered for a probationary license if he/she can demonstrate that one year has passed without a problem; has documented evidence of successful completion or current participation in a rehabilitation program with strong evidence of ongoing treatment with positive results; and has a clear and unrestricted license in other states where licensed. The applications of applicants for a physician's license who do not meet the guidelines for a probationary license will be denied.

The results of staff's research indicate that DOL's concern about costs associated with use of the Diversion Program by out-of-state doctors is misplaced. Staff indicated that there is no distinction between in-state and out-of-state physicians participating in the Program. The Diversion Program, like other functions of MBC, is funded by revenues from physician initial license and renewal fees. A physician applying for California medical licensure, whether from in or out of state, and whether or not they may be a probationary licensure candidate, is required to pay the same fee. Furthermore, if a physician becomes a candidate for the Diversion Program, he/she is personally responsible for paying all fees associated with his/her participation, including urine screens for substance abuse, any mandated treatment, and monitoring at group meetings. Thus, the minimal number of out-of-state physicians applying for California licensure present no additional costs to the Diversion Program or MBC.

Second, DOL staff's findings are also contrary to the common belief that recovering physicians represent a greater risk to public safety. The volume of complaints filed against physicians who successfully complete the Diversion Program is comparatively less than the volume of complaints lodged against the remaining licensed physician population. Diversion Program statistics indicate that complaints were filed against 4.2% of the 257 physicians who successfully completed the Diversion Program between January 1980 and June 1990. For the same period, complaints were filed against 6.7% of the remaining licensed physician population.

Third, DOL reported that the Diversion Program's average success rate is 73% of the total number of physicians who have participated in the program.

Based on the above information, DOL members reaffirmed the Diversion guidelines at the May meeting.

DOL Rulemaking. On April 5, the Office of Administrative Law (OAL) approved DOL's amendments to regulatory section 1351, which increase fees for the FLEX and SPEX licensing examinations. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 70 and Vol. 10, No. 4 (Fall 1990) p. 83 for background information.)

On June 5, OAL approved DOL's amendments to section 1328, which specify that DOL's "written examination" requirement for foreign medical graduates (FMGs) may be satisfied by either (1) Components I and II of the FLEX, or (2) Parts I and II of the National Board exam, plus Component II of the FLEX. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 83; Vol. 11, No. 1 (Winter 1991) p. 70; and Vol. 10, No. 4 (Fall 1990) p. 83 for background information.)

At this writing, DOL staff is in the final stages of completing the rulemaking file on the Division's controversial amendments to section 1324, which would revise the standards for DOL-approved clinical training programs for FMGs. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 69; Vol. 10, No. 4 (Fall 1990) p. 83; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 100 for detailed background information.)

Implementation of SB 2036. For the past several months, DOL members and staff have been engaged in preliminary implementation of SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990). Effective January 1, 1993, that bill amends Business and Professions Code section 651 relating to specialty advertising by physicians. The bill provides that a physician licensed by MBC may include a statement in his/her advertising that he/she limits his/her practice to specific fields, but may only include a statement that he/she is certified or eligible for certification by a private or public board or parent association if that board or association is a member board of the American Board of Medical Specialties (ABMS), a board or association with equivalent requirements approved by MBC, or a board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training program that provides complete training in that specialty or subspecialty.

At its May meeting, DOL reviewed draft regulations to guide its approval of specialty/subspecialty boards for purposes of physician advertising. Under the proposed rules, specialty boards or associations which are not member boards of the ABMS and/or which do not have a PGT program approved by the ACGME must meet the following requirements to be approved by DOL:

-the primary purpose of the specialty board shall be certification and education in a medical specialty or subspecialty;

-the specialty board shall be a nonprofit corporation or association and shall have a minimum of 100 members located in at least one-third of the states;

-the specialty board shall have articles of incorporation, a constitution, or a charter and bylaws which contain specified components, including a requirement that the specialty board conducts comprehensive evaluations of the knowledge and experience of certification applicants;

-the specialty board shall have standards for determining that those who are certified possess the knowledge and skills essential to provide competent care in the designated specialty or subspecialty area;

-more than 80% of the specialty board's revenue comes from certification and examination fees, membership fees, income from continuing education, and interest and investment income;

-physicians certified shall possess a clear and unrestricted license to practice medicine from a jurisdiction of the United States;

-the specialty board shall require all applicants seeking certification to have satisfactorily completed a minimum of three years of PGT approved by the ACGME in a specialty or subspecialty area of medicine which is directly related to the area of medicine in which the physician is seeking certification; in addition, certification applicants shall have satisfactorily completed a minimum of two years of PGT training in the specialty or subspecialty area in which they are being certified in a program affiliated with an approved medical school (one year of which may be obtained in the initial three-year ACGME PGT program);

-the specialty board shall require documentation from applicants which verifies that they meet the board's requirements for certification; and

-the specialty board shall required certification applicants to successfully pass a written and an oral examination which test the applicants' knowledge and skills in the specialty or subspecialty

area of medicine; the examinations shall be a minimum of 16 hours in length.

DOL was scheduled to hold preliminary public hearings on these draft regulations on July 12 in Los Angeles and August 16 in South San Francisco.

DAHP Regulatory Action. At its May 10 meeting, DAHP held a public hearing on its proposed medical assistant (MA) scope of practice regulations. The proposed regulations—which define the technical supportive services which may be performed by an MA, set forth the training which must be provided to the MA by the supervising physician/podiatrist or in an approved community college/postsecondary institution, and set forth recordkeeping requirements regarding services provided by MAs—are now on their second circuit through the system, having been rejected by both OAL and DCA the first time around. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 69; Vol. 10, No. 4 (Fall 1990) p. 82; and Vol. 10, No. 1 (Winter 1990) pp. 76-77 for extensive background information.) The hearing drew a relatively large audience, with extensive comment from the California Nurses Association (CNA), which believes the proposed regulations grant too much authority and discretion to MAs. However, the Division disagreed, and refused to make any of the changes recommended by CNA. Some minor changes were made, and following an additional 15-day notice and comment period, the Division will forward the regulatory package to DCA and then OAL.

On April 10, the Division was notified that OAL again disapproved the physician assistant scope of practice regulations for noncompliance with the Administrative Procedure Act (APA) standards of clarity, nonduplication, and necessity, and for failure to summarize and respond to some of the public comments. The package was originally submitted to OAL in October 1990 and disapproved in November 1990. (*See infra* agency report on PHYSICIAN ASSISTANT EXAMINING COMMITTEE for related discussion.)

LEGISLATION:

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

AB 1084 would create the Committee of Health Care Technology within the Medical Board, composed of 11 members (including one public member). The Committee would be responsible for adopting regulations specifying a "procedurally fair and objective process" which CMA (and other professional associations "that are devoted to the promotion of patient health, safety, and welfare") will use in adopting medical practice opinions (MPOs), which shall include an opportunity for comment by interested persons or entities. The Committee would publish CMA's MPOs in the *California Regulatory Notice Register* within two months of receipt of the MPO; prior to publishing the MPO, the Committee is not charged with reviewing it or evaluating it in any way. The published MPO must carry with it a notice that any interested party may protest an MPO; the protest must be in writing and filed with the Committee within 30 days after publication. Within 15 days of receiving a timely notice of protest, the Committee must set a hearing on the protest, which shall take place within 90 days following receipt of the protest. At the hearing, the Committee will hear and consider oral and documentary evidence provided by the parties; certain provisions of the Administrative Procedure Act regarding discovery, subpoenas, depositions, rules of evidence, evidence by affidavit, and official notice are applicable to the conduct of the hearing. The protestor has the burden of proof to establish that the MPO at issue was made without good cause.

Following the hearing, the Committee must issue a written decision containing findings of fact and a determination of the issues presented. The decision shall sustain, conditionally sustain, overrule, or conditionally overrule the protest. The decision must be published in the *Notice Register*. Any interested party may seek judicial review of final decisions of the Committee by way of a petition for writ of mandate under section 1094.5 of the Code of Civil Procedure.

Under AB 1084, no action in tort or to challenge an MPO may be filed against CMA unless or until the Committee determines (or, if the decision of the Committee is challenged, the court determines) that the determination was not made in compliance with the Committee's regulations. CMA also believes AB 1084 would insulate it from antitrust scrutiny under the "state action exemption" to the antitrust laws. In order to qualify for this exemption, the challenged action must be clearly articulated and affirmatively expressed as state policy, and actively supervised by the state; whether the actions of the Committee in publishing an MPO without review and conducting quasi-adjudicative hearings on MPOs only if they are protested will satisfy the "state action" test is unclear. Further, the adoption and publication by a state agency of standards of practice is arguably rulemaking subject to the entirety of the Administrative Procedure Act; AB 1084's process excludes several APA requirements, most notably review by OAL.

AB 1691 (Filante), as amended May 8, would require, on or after July 1, 1993, every health facility operating a PGT program to develop and adopt written policies governing the working conditions of resident physicians. AB 1691 is pending on the Assembly floor.

AB 1199 (Speier), as amended May 30, would prohibit, on or after January 1, 1992, a health facility operating a PGT program from allowing any resident physician in that training program to work, either in clinical or didactic duty, in excess of certain prescribed hour limits. The bill would authorize a resident physician to work in excess of any specified hour limit whenever he/she is completing a surgical procedure or treating an acutely ill patient whose care may be compromised by the transfer of care to another physician. This bill would also prohibit a health facility from permitting any resident physician to participate in a PGT program if that resident physician provides medical care in a setting outside the health facility and the provision of that care results in any hour limit being exceeded. This bill is pending in the Assembly Ways and Means Committee.

AB 2180 (Felando). Commencing January 1, 1993, SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) permits a physician to advertise that he/she is certified or eligible for certification by a private or public board or parent association if that board or association is a member board of the ABMS, a board or association with equivalent requirements approved by MBC, or a board or association with an ACGME-approved PGT program. (*See supra* MAJOR PROJECTS.) As amended May 30, this bill would prohibit a person certified by an organization other than a board from using the term "board certified" in reference to that certification. This bill is pending on the Assembly floor.

SB 1195 (Boatwright). Existing law requires an applicant for a physician's certificate to take an examination administered by DOL; requires the examination to be practical in character and to be

kept on file for one year; and authorizes DOL to conduct the examination under a uniform examination system. As amended April 17, this bill would no longer require the examination to be practical in character; would require that the examinations be kept on file for at least two years; and would additionally authorize DOL to designate other equivalent written examinations.

Existing law requires a passing score of 75% on the examination and requires applicants to pass an examination in certain enumerated subjects. This bill would instead require DOL to determine the passing score and would require applicants to pass an examination in basic sciences and clinical sciences, as determined by DOL.

Existing law requires MBC, DMQ, DOL, and DAHP to give notice of their meetings in one daily paper published in Los Angeles, Sacramento, and San Francisco. The Bagley-Keene Open Meeting Act requires MBC to provide prescribed notice of its meetings to any person who requests the notice in writing. This bill would delete the former requirement and require only that MBC and its divisions give notice of their meetings in accordance with the Open Meeting Act.

Existing law permits DOL to deny a physician's certificate for unprofessional conduct; permits DOL to issue a probationary certificate subject to terms and conditions; and permits DMQ to initiate disciplinary proceedings to revoke or suspend the probationary license for any violation of probation. This bill would permit DOL to modify or terminate these terms and conditions upon petition from the physician, and would permit DMQ to initiate disciplinary proceedings to revoke or suspend the probationary license for any cause that would subject a licensee to license revocation or suspension. This bill passed the Senate on May 30 and is pending in the Assembly Health Committee.

SB 664 (Calderon), as introduced March 5, would prohibit physicians, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

SB 1258 (Torres). Section 1795.12 of the Health and Safety Code provides for the inspection of patient records, and requires any patient or patient's representative to be entitled to copies of the patient records which he/she has a right to inspect, upon presenting a written request to the health care provider and a fee. As amended May 30, this bill would prohibit health care providers from withholding patient records or summaries of patient records because of an unpaid bill for health care services. A health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services shall be subject to specified sanctions. This bill is pending in the Senate Appropriations Committee.

AB 992 (Brulte), as introduced March 4, would require medical experts testifying in medical malpractice actions against a physician to have substantial professional experience in the same medical specialty as the defendant. Under the bill, "substantial professional experience" would be determined by the custom and practice of the same or similar localities where the alleged negligence occurred. This bill is pending in the Assembly Judiciary Committee.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at pages 83-85:

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

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

AB 190 (Bronzan), as amended April 4, would require a physician to inform a patient by means of a specified standardized written summary of the advantages, disadvantages, risks, and possible side effects of, and whether the federal government has approved silicone implants and injections and collagen injections used in cosmetic, plastic, reconstructive, or similar surgery, before the physician performs the surgery. This bill passed the Assembly on April 11 and is pending in the Senate Business and Professions Committee.

AB 196 (Filante) amends the Budget Act of 1990 to increase funding for the support of MBC from $14,253,000 to $19,004,000 during fiscal year 1990-91. The legislature withheld one-quarter of the Board's budget last year, in an effort to encourage DMQ to eliminate its backlog of 900 unassigned cases. (*See supra* MAJOR PROJECTS.) This urgency bill was signed by the Governor on April 1 (Chapter 20, Statutes of 1991).

AB 465 (Floyd). Existing law provides general civil immunity to persons who provide information to MBC or the Department of Justice indicating that an MBC licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to certain activities of specified health care organizations. As introduced February 8, this bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This bill passed the Assembly on May 30 and is pending in the Senate Judiciary Committee.

AB 112 (Kelley), as introduced December 4, would exempt a physician from liability for any negligent injury or death caused by an act or omission of the physician in rendering medical assistance, when the physician in good faith and without compensation or consideration renders voluntary medical assistance at a clinic or long-term health care facility. AB 112 is pending in the Assembly Judiciary Committee.

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

AB 1496 (Murray), as amended May 30, would specify a procedure by which a coroner could enforce a subpoena duces tecum for records of confidential communications of a decedent subject to the physician-patient privilege, when the records are sought by the coroner for specified purposes. This bill is pending on the Assembly floor.

AB 566 (Hunter), as amended May 14, would prohibit any person from practicing or offering to practice perfusion for compensation received or expected to be received, or from holding himself/herself out as a perfusionist, unless at the time of doing so the person holds a valid, unexpired, unrevoked perfusionist license. This bill is pending in the Assembly Ways and Means Committee.

AB 569 (Hunter), as introduced February 15, would permit MBC to take action to implement SB 2036 (McCorquodale) (Chapter 1660, Statutes of 1990) on or after January 1, 1992. (*See supra* MAJOR PROJECTS.) This bill passed the Assembly on May 29 and is pending in the Senate Business and Professions Committee.

AB 704 (Speier), as amended April 23, would require DMQ, when undertaking a review of a physician's practice during any investigation pursuant to the Medical Practice Act, to ensure that the review is accomplished by peers of the subject physician. This bill passed the Assembly on May 16 and is pending in the Senate Business and Professions Committee.

AB 1183 (Speier), as introduced March 6, would require MBC to develop a California Indigent Obstetric Care Indemnification Program, requiring the program to provide prescribed state indemnification for malpractice claims against a physician who provides obstetric or gynecological care to patients at least 10% of whom are enrolled in Medi-Cal or other indigent care programs, and who has at least $100,000 in malpractice coverage. This bill is pending in the Assembly Judiciary Committee.

AB 1553 (Filante), as introduced March 7, would require MBC's initial license fee and biennial renewal fee to be fixed at an amount not to exceed $500, and reduce MBC's required Contingent Fund reserve to approximately two months' operating expenses. This bill passed the Assembly on May 20 and is pending in the Senate Business and Professions Committee.

AB 2222 (Roybal-Allard), as introduced March 12, would provide that the reviewing of X-rays for the purpose of identifying breast cancer or related medical disorders without being certified as a radiologist qualified to identify breast cancer or related medical disorders by a member board or association of the American Board of Medical Specialties, or a board or association with equivalent requirements approved by MBC, constitutes unprofessional conduct. This bill is pending in the Assembly Health Committee.

SB 1190 (Killea), as amended May 2, would enact the Licensed Midwifery Practice Act of 1991, establishing within DAHP a five-member Licensed Midwifery Examining Committee, which would be required to adopt reasonable rules and regulations to carry out the Act. This bill, which would also provide that a physician shall not be liable for independent acts of negligence by a licensed midwife, was rejected by the Senate Business and Professions Committee on May 13, but has been granted reconsideration.

AB 819 (Speier). Existing law provides that it is not unlawful for a prescribed licensed health care professional (including a physician) to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or coownership in the facility. As introduced February 27, this bill would, effective July 1, 1992, instead provide that, subject to specified exceptions, it is unlawful for these licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure of the ownership or proprietary interest would not exempt the licensee from the prohibition. This bill is pending in the Assembly Health Committee.

LITIGATION:

On April 30, San Francisco Superior Court Judge Stuart Pollak awarded the Center for Public Interest Law (CPIL) another $20,000 in attorneys' fees for its successful representation of 32 Vietnamese refugee physicians in *Le Bup Thi Dao v. Board of Medical Quality Assurance*, a civil rights action against DOL for its refusal to license the Vietnamese physicians without hearing or explanation for a two-year period. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 70; Vol. 10, No. 4 (Fall 1990) p. 86; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 102-03 for background information on this case.) CPIL has now been awarded a total of $96,300 from the Board for its work on this case. The Board has appealed the attorneys' fees awards.

In *Summit Health, Ltd. v. Pinhas*, No. 89-1679 (May 28, 1991), the U.S. Supreme Court affirmed the Ninth Circuit Court of Appeals' reinstatement of Dr. Simon Pinhas' antitrust claim against Summit Health, Ltd., Midway Hospital Medical Center in Los Angeles, and several physicians on the hospital's peer review committee. After a 1987 peer review proceeding, Midway conditioned Dr. Pinhas' staff privileges on his agreement to several requirements relating to his conduct of ophthalmological operations; Dr. Pinhas challenged the decision in both state and federal court. In July 1989, the Ninth Circuit reversed the district court's dismissal of the claim, finding that the "state action" exemption to antitrust scrutiny is inapplicable to California peer review proceedings; and found that Dr. Pinhas had alleged a sufficient nexus between the alleged anticompetitive conduct and interstate commerce. (See CRLR Vol. 9, No. 4 (Fall 1989) p. 65 for background information.) Noting that Midway is unquestionably engaged in interstate commerce, that Dr. Pinhas' ophthalmological services were regularly performed for out-of-state patients, and that "the competitive significance of respondent's exclusion from the market must be measured, not just by a particularized evaluation of his own practice, but rather, by a general evaluation of the impact of the restraint on other participants and potential participants in the market from which he has been excluded," the Supreme Court held that respondent's claim...has sufficient nexus to support federal jurisdiction." All defendants are now potentially subject to treble damages and attorneys' fees.

RECENT MEETINGS:

At its May 10 meeting, DAHP discussed the status of the existing diversion programs within various allied health licensing programs (AHLPs), and the possibility of including AHLP licensees within MBC's diversion program. Several AHLPs—including the Board of Podiatric Medicine, the Physical Therapy Examining Committee, and the Board of Psychology—have diversion programs; all of these programs are independent of MBC and each other. MBC Diversion Program Manager Chet Pelton reminded the Division that it would be practical to include all AHLP licensees in MBC's diversion program, but that the Board has rejected this idea in the past as unacceptable, arguing that inclusion of AHLP licensees would "dilute" MBC's program. (See CRLR Vol. 8, No. 1 (Winter 1988) pp. 59 and 63 for background information.) Pelton stated the long-range options of the AHLPs as: (1) complete integration of all AHLP diversion activities into MBC's program; (2) a combined program including all AHLPs but separate from MBC; or (3) a continuation of the policy of separate programs for each AHLP. Pelton urged DAHP to approach the Division of Medical Quality (DMQ), to again broach the subject of combining one or more AHLP diversion programs with that of MBC. DAHP agreed to inquire, but only regarding the Board of Podiatric Medicine; further discussion of this issue is slated for the Division's September meeting. (*See infra* agency report on BPM for related discussion.)

FUTURE MEETINGS:

September 12-13 in San Francisco.
November 21-22 in San Diego.

ACUPUNCTURE COMMITTEE

Executive Officer: Lynn Morris
(916) 924-2642

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

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

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

MAJOR PROJECTS:

Proposed Regulatory Changes. On May 31, AC published notice of its intent to adopt numerous changes to its regulations. The following changes were scheduled for a July 18 public hearing in San Diego:

-Section 1399.401 would be amended to correct AC's name and address.

-Section 1399.403 would be amended to correct the names of AC and the Medical Board.

-Section 1399.414(a) would be amended to reduce the period of time in which an applicant for registration as an acupuncturist has to request AC reconsideration of a rejected application from 60 days to 15 days from the date of the rejection.

-Section 1399.418 would be amended to clarify that an applicant who fails to appear for a scheduled examination must state his/her reason for failing to appear in writing, or his/her application will be deemed withdrawn.

-New section 1399.419 would specify AC's examination application processing time periods, in compliance with the Permit Reform Act of 1981.

-Section 1399.436, regarding criteria used by AC in approving acupuncture training programs, would be amended to clarify that "four academic years" means eight semesters, twelve quarters, nine trimesters, or 36 months, and to specify that such schools must be approved by the Council for Private Postsecondary and Vocational Education (CPPVE) under Education Code section 94310.

-Section 1399.439 would be amended to require each approved school of acupuncture to submit an annual report to AC containing specified information; and to specify that, if an onsite visit by AC is necessary, the school must reimburse AC for the costs incurred in conducting such a review. It would also require a school to notify AC within 30 days of any changes to its facility or clinics, curriculum, instructors, course schedules, policies, or programs.

-Section 1399.443 would be amended to require licensure applicants to pass the written examination before they are eligible to sit for the oral and practical examination.

-New section 1399.445 would set forth the method by which an applicant who has received a failing score on the practical examination may appeal to AC for a review of the exam results.

-Section 1399.422, regarding tutorials, would be amended to correct a grammatical error.

-Existing section 1399.424(c) provides that the theoretical and clinical training components of a tutorial program may be reduced based upon a trainee's training and experience obtained prior to January 1, 1980. This regulatory proposal would delete the requirement that the training and experience must have occurred prior to January 1, 1980.

-Section 1399.425, which specifies AC's criteria for approving tutorial programs, would be amended to require a tutorial trainee to complete a course in Western medicine in a school approved under Education Code section 94310, an institution of public higher education as defined in Education Code section 66010, or in an out-of-state institution approved by the appropriate governmental educational authority using standards equivalent to those required in California. This regulatory proposal would also increase the amount of theoretical and didactic training to 1,548 hours; such training would consist of 990 hours in oriental medicine and 558 hours in Western medicine. It would provide that a tutorial program could not provide more than 1,500 hours of training per year; and specify that a tutorial trainee is required to possess either an associate degree from a community college or have completed at least 60 college credits of general education at a college with a four-year curriculum.

-Section 1399.427, regarding the duties of a trainee in a tutorial program, would be amended to clarify that the trainee must meet the objectives of the program submitted to AC; require the trainee to maintain a written log, with specified information, of the patients whom he/she has seen during the clinical training; and specify that such a log must be available for inspection by AC.

-Section 1399.430(d), regarding denial, suspension, or revocation of a supervisor's registration, would be amended to replace a reference to DAHP with a reference to AC.

-New section 1399.433 would specify AC's processing time periods for tutorial applications, in compliance with the Permit Reform Act of 1981.

Implementation of SB 633. On May 31, AC published notice of its intent to adopt regulations to implement SB 633 (Rosenthal) (Chapter 103, Statutes of 1990), which requires all acupuncturists licensed prior to January 1, 1988, to complete 40 hours of continuing education (CE) in six specified subject areas by January 1, 1993. (See CRLR Vol. 11, No. 2 (Spring 199) p. 86 and Vol. 11, No. 1 (Winter 1991) pp. 71-72 for background information.) Specifically, AC seeks to adopt the following regulatory proposals:

-Section 1399.481 would be amended to clarify that CE providers must submit specified course information and a curriculum vitae to AC at least 30 days before the first day of the scheduled course. It would also specify that one hour of CE credit would equate to 50 minutes of classroom instruction.

-New section 1399.486 would specify the curriculum which is to be covered in each of the specified subject areas, and state that at least 4 CE hours must be taken in each of the specified subject areas; the remaining 16 hours of required CE may be obtained in any of the areas.

AC was scheduled to hold a July 18 public hearing on these regulatory changes.

LEGISLATION:

SB 1195 (Boatwright). The Acupuncture Act requires that on or before September 1, 1990, or within five years of initial approval by the Committee, whichever is later, each acupuncture

education/training program must be approved by the CPPVE under Education Code section 94310. As amended April 17, this bill would instead require that each program receive full institutional approval within three years of initial approval; require, until January 1, 1996, each acupuncturist to complete fifteen hours of CE every year; and require, until January 1, 1996, acupuncturist certificates to expire annually on the last day of the birth month of the licensee. This bill passed the Senate on May 30 and is pending in the Assembly Health Committee.

SB 664 (Calderon), as introduced March 5, would prohibit acupuncturists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

SB 417 (Royce), as amended April 15, would (among other things) revise existing law regarding the licensure and regulation of acupuncturists to require a person to complete an education and training program approved by the appropriate governmental educational authority to award a professional degree in the field of traditional oriental medicine approved by the Committee. In the case of an applicant who has completed education and training in schools and colleges other than those approved by the Committee, this bill would require the applicant's educational training and clinical experience to be approved by the Committee as equivalent to the standards established pursuant to prescribed provisions through an examination administered by one or more qualified, independent consultants with expertise in the professional licensure field, which is based on educational program learning outcomes comparable to those of institutions approved under a certain provision. The bill would also add section 4938.2 to the Business and Professions Code, to require AC to contract with an independent consultant for the purposes of determining the equivalency of educational training and clinical experience. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 86 for background information.) This bill is pending in the Senate Business and Professions Committee.

RECENT MEETINGS:

At AC's March 21 meeting, Executive Officer Lynn Morris introduced Frank Garcia, who was hired to develop the Request for Proposals (RFP) for the tutorial and foreign school equivalency studies mandated by SB 633, and to monitor the schools program. AC scheduled a special April 11 meeting for the sole purpose of approving one of the proposals, but cancelled it because none of the proposals submitted was awarded the required points necessary for adoption. Therefore, the RFP will be republished for further bids.

Tom Heerhartz, Assistant Executive Director of the Medical Board of California, Tony Arjil, Program Manager of DAHP, and DAHP President Bruce Hasenkamp attended the March 21 meeting, and explained to the Committee that DAHP is available to assist AC in any way possible. Heerhartz informed the Committee that he plans to attend AC meetings in the future; Hasenkamp encouraged all AC members to attend DAHP meetings when possible.

With regard to public outreach, AC has allocated a budget of $2,000 to be used for the production of an AC video. At its March meeting, AC established a task force to further research the development of the video. AC also passed a motion allowing Executive Officer Morris to carry out the processing of a quarterly newsletter, upon the conditions that AC Chair Lam Kong will be kept informed of its progress and that it will be reviewed by the Committee prior to final publishing and distribution. The first issue is expected in July.

FUTURE MEETINGS:

October 17 in Los Angeles.
December 12 in Sacramento.

HEARING AID DISPENSERS EXAMINING COMMITTEE

Interim 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 are licensed hearing aid dispensers.

MAJOR PROJECTS:

Citation and Fine Regulations Approved. On May 20, the Office of Administrative Law (OAL) approved HADEC's adoption of new regulatory sections 1399.135-.139, which establish a system for issuing citations and fines. (See CRLR Vol. 10, No. 4 (Fall 1990) pp. 87-88 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 105 for background information.) Pursuant to Business and Professions Code section 125.9, these rules authorize HADEC's Executive Officer to issue citations containing orders of abatement and fines for violations of specified provisions of law.

Enforcement of SB 1916. Effective January 1, 1991, SB 1916 (Rosenthal) (Chapter 514, Statutes of 1990) added section 3351.5 to the Business and Professions Code, which provides, among other things, that hearing aids may be sold by catalog or direct mail to California residents only if the seller is licensed as a hearing aid dispenser in California. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 88 for background information.) Since January, HADEC Executive Officer Elizabeth Ware has sent numerous cease and desist letters to organizations (both within and outside California) offering to sell hearing aids to California residents, requesting that they stop offering hearing aids for sale until and unless they are licensed in California and comply with the other requirements of section 3351.5. Numerous licensed hearing aid dispensers are forwarding "tips" to Ware to alert HADEC to unlicensed practice.

Regulatory Determination Delayed. On January 11 in the *California Regulatory Notice Register*, OAL published notice that Robert Hughes of Long Beach has requested a determination as to the "underground rulemaking" status of several of policies and procedures of HADEC and the Speech Pathology and Audiology Examining Committee.

Among other things, Hughes challenges several aspects of HADEC's examinations and its policies regarding temporary licenses and evaluating the competency of a hearing aid dispenser to supervise a trainee. Although OAL's determination was scheduled to be issued on March 27, at this writing it has not yet been published.

Occupational Analysis Survey. HADEC is in the process of conducting a validation study of its licensing examination in order to assess its effectiveness and to facilitate the possible creation of a new exam. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 87 for background information.) As a part of this study, HADEC is currently preparing an occupational survey to be sent to all dispensers. This survey is being conducted in coordination with the Department of Consumer Affairs' Central Testing Unit, and will evaluate the tasks performed by hearing aid dispensers, from which the knowledge, skills, and abilities necessary to perform those tasks will be determined.

Consumer Pamphlet. At its meeting on March 2, HADEC approved the revised version of its consumer information brochure, *Everything You Always Wanted to Know About Hearing Aids!* (See CRLR Vol. 11, No. 2 (Spring 1991) p. 87; Vol. 11, No. 1 (Winter 1991) p. 73; and Vol. 10, No. 4 (Fall 1990) p. 88 for background information.) The pamphlet has been sent to the printing office, and actual printing will begin when sufficient funds become available. At this writing, details of the distribution of the brochures are still being worked out, but it is believed that all dispensers will receive a number of copies free of charge, and larger quantities may be purchased.

Committee Vacancies. Boyce Calkins, a licensed hearing aid dispenser member of the Committee, died on May 14. This leaves HADEC with three vacant seats—two dispenser positions and one physician member, and leaves HADEC dangerously close to losing its ability to meet. For the purposes of quorum, all four of the remaining members must be present at future meetings. At this writing, no replacements have been suggested by the appointing authorities.

This possible crisis heightens the controversy over whether a dispenser who is also an audiologist may sit on the Committee in a dispenser capacity. In recent years there has been an ongoing, yet informal, discussion over that possibility. Historically, those appointed to the dispenser seats have not been audiologists. One "public" member of the Committee must be a licensed audiologist. A HADEC subcommittee has voted to send a letter to the Governor, who makes this appointment, stating the Committee's lack of opposition to the appointment of an audiologist-dispenser. The letter has not been approved by the Committee as a whole, and is expected to come up for further discussion at HADEC's June meeting.

Appointment of Permanent Executive Officer. In May, a special subcommittee on staffing issues was formed to evaluate options regarding the position of Executive Officer. Elizabeth Ware, HADEC's current EO, was originally appointed as an interim EO during the leave of absence taken by Peggy McNally last July. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 88 for background information.) The EO serves at the pleasure of the Committee. HADEC was expected to decide on the status of the EO position at its June meeting.

LEGISLATION:

SB 664 (Calderon), as introduced March 5, would prohibit hearing aid dispensers, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

FUTURE MEETINGS:

September 14 in San Francisco.
November 16 in Los Angeles.

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 11,400 physical therapists. The committee is comprised of three public and three physical therapist members. PTEC is authorized under Business and Professions Code section 2600 *et seq.*; the Committee's regulations are codified in Division 13.2, Title 16 of the California Code of Regulations (CCR).

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

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

On May 21, Assembly Speaker Willie Brown reappointed George Suey to another four-year term on PTEC.

MAJOR PROJECTS:

Fee Increases. At its April 5 meeting, PTEC adopted proposed changes to regulatory sections 1399.52(c) and (d). These changes would raise the biennial renewal fee for a PTA from $40 to $50, and raise the delinquency fee for a PTA from $20 to $25, respectively. At this writing, PTEC staff is preparing the rulemaking file for submission to the Department of Consumer Affairs (DCA) and the Office of Administrative Law (OAL). PTEC's changes to section 1399.50, which would increase the initial license fee and the biennial renewal fee for PTs from $40 to $50 and increase the delinquency fee from $20 to $25, are on file with DCA, but have not been submitted to OAL. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 88 for background information.)

Other Regulatory Changes. On May 15, OAL approved PTEC's revisions to section 1398.20 (date for submitting applications for examination), 1398.47(a)(1) and (a)(2) (to require PTA candidates to achieve a grade of "C" or better in all coursework), and 1399.50, 1399.52, and 1399.54 (all regarding fee changes). These changes were adopted at PTEC's August 1990 meeting. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 88 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 106 for background information.)

PTEC Newsletter. At the Committee's April 5 meeting, Executive Officer Steve Hartzell announced that the first issue of PTEC's newsletter is expected in September. The Committee will begin with a short publication to encourage thorough reading. The newsletter will serve as a forum for articles about the Committee's planned diversion program, licensure information, complaints, enforcement, and other items of interest to licentiates, including the practice of physical therapy by general law corporations. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 89 and Vol. 11, No. 1 (Winter 1991) pp. 74-75 for background information.) The Committee decided on a May 24 deadline for submission of material

for the newsletter, allowing PTEC time to review the material before its June 7 meeting.

Looking Toward Better Cooperation with DAHP. Bruce Hasenkamp, President of the Medical Board's Division of Allied Health Professions (DAHP), addressed PTEC at its April 5 meeting in Long Beach. Hasenkamp explained DAHP's goal to establish a more cooperative relationship with its member boards and committees. DAHP plans to send a liaison to at least one meeting per year of each of its boards and committees, and intends to institute a quarterly forum for these constituents. The Division also wants to assist and coordinate the efforts of its boards and committees in approaching the legislature in support of or opposition to health care legislation. DAHP will also strive to work out the existing schedule conflict between its meetings and the meetings of the Medical Board's Division of Medical Quality (DMQ).

LEGISLATION:

SB 664 (Calderon), as introduced March 5, would prohibit physical therapists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at page 88:

SB 483 (Green), as amended April 30, would authorize PTEC to create a cost recovery system; that is, in any order issued in resolution of a disciplinary proceeding before the Committee, PTEC may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay to PTEC a sum not to exceed the actual and reasonable costs of the investigation and prosecution. This bill, which would also increase fees applicable to the practice of physical therapy, passed the Senate on May 16 and is pending in the Assembly Health Committee.

AB 819 (Speier). Existing law provides that it is not unlawful for prescribed health professionals to refer a person to a laboratory, pharmacy, clinic, or health care facility solely because the licensee has a proprietary interest or coownership in the facility. As introduced February 27, this bill would, effective July 1, 1992, provide that, subject to specified exceptions, it is unlawful for these licensed health professionals to refer a person to any laboratory, pharmacy, clinic, or health care facility which is owned in whole or in part by the licensee or in which the licensee has a proprietary interest; the bill would also provide that disclosure of the ownership or proprietary interest would not exempt the licensee from the prohibition. This bill is pending in the Assembly Health Committee.

LITIGATION:

All parties have finally reached a settlement of *California Chapter of the American Physical Therapy Ass'n, et al. v. California State Board of Chiropractic Examiners, et al.*, Nos. 35-44-85 and 35-24-14 (Sacramento County Superior Court). The parties were litigating the validity of the Board of Chiropractic Examiners' (BCE) adoption and OAL's approval of section 302 of BCE's regulations, which defines the scope of chiropractic practice. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 106; Vol. 9, No. 4 (Fall 1989) p. 127; and Vol. 9, No. 3 (Summer 1989) p. 118 for background information on this case.)

On February 1, the court approved a settlement between BCE and the California Medical Association (CMA), which required BCE to adopt new section 302 on an emergency basis; OAL approved the emergency rule on April 4. Other parties and intervenors— including the California chapter of the American Physical Therapy Association, the Medical Board of California, and PTEC—initially objected to the settlement agreement and the proposed regulation, because it included the practice of physical therapy within the scope of practice of a chiropractor. However, BCE later agreed to amend the proposed regulation to include a definition of the "physical therapy" which may be practiced by a chiropractor, which was acceptable to all parties. BCE was scheduled to hold a regulatory hearing on the proposed adoption of revised section 302 on June 20. (*See infra* agency report on BCE for related discussion.)

RECENT MEETINGS:

At its April 5 meeting, PTEC released the results of its latest license survey. The survey listed the number of active licenses in each of the Committee's four categories, as well as the number of inactive and delinquent licenses. The Committee plans to use its upcoming newsletter to disseminate information about delinquent licensees (and perhaps publish their names) in an effort to minimize their number. Mr. Hartzell noted that the licenses in the delinquent classification may be due to retirement, relocation, or death without notice to PTEC, and are not solely attributable to nonrenewal.

At its April 5 meeting, PTEC discussed the recent decision by the Federation of State Boards of Physical Therapy which would prohibit a state from using the Federation's standardized licensing examination if the state is not an active member of the Federation. PTEC is opposed to this practice, stating that the examination should not be withheld from any state regardless of that state's membership in the Federation.

FUTURE MEETINGS:

August 23 in Sacramento.
October 17 in Los Angeles.

PHYSICIAN ASSISTANT EXAMINING COMMITTEE

Executive Officer: Ray Dale
(916) 924-2626

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

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

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

any division of MBC, three PAs, and two public members.

MAJOR PROJECTS:

Scope of Practice Regulations Rejected Again. On April 10, the Office of Administrative Law (OAL) rejected for a second time PAEC's new regulations defining the permissible scope of practice of a physician assistant, in response to Attorney General's Opinion 88-303 (Nov. 3, 1988). Specifically, PAEC is attempting to amend sections 1399.541, 1399.543, and 1399.545, Division 13.8, Title 16 of the CCR. The proposed regulatory changes would permit a PA's supervising physician (SP) to specify the type and limit of delegated medical services based on the SP's specialty or usual and customary scope of practice. They would also authorize PAs to initiate (or transmit an order to initiate) certain tests and procedures, and to provide necessary treatment in emergency or life-threatening situations. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 75; Vol. 10, No. 4 (Fall 1990) p. 90; and Vol. 10, No. 1 (Winter 1990) pp. 81-82 for background information.)

Once again, OAL found that the regulatory package failed to meet the clarity, nonduplication, and necessity standards of Government Code section 11349.1; and that the Committee failed to summarize and respond to one of the comments submitted during the public comment period, and inadequately responded to two other comments. PAEC plans to remedy these deficiencies and resubmit the rulemaking file to OAL for a third time.

Fee Increases Still Pending. At its January meeting, PAEC approved proposed changes to regulatory section 1399.553, which increase the approval fee for SPs from $50 to $100, and increase the biennial approval fee for SPs from $100 to $150. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 89 and Vol. 11, No. 1 (Winter 1991) pp. 75-76 for background information.) On April 10, Committee staff submitted the rulemaking file to the Director of the Department of Consumer Affairs (DCA), who has sixty days to review the file before it is submitted to OAL.

LEGISLATION:

SB 664 (Calderon), as introduced March 5, would prohibit physician assistants, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at page 90:

AB 535 (Clute), as introduced February 14, would permit a PA acting under the patient-specific authority of his/her physician supervisor to administer a controlled substance to treat an addict for an addiction. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 76 for background information.) This bill passed the Assembly on April 4 and is pending in the Senate Business and Professions Committee.

SB 1077 (Killea), as amended May 16, would raise the limit of the initial license fee for PAs from $100 to $250 and the biennial renewal fee from $150 to $300; raise the limit of the approval fee for SPs from $100 to $250 and the biennial renewal fee from $150 to $300; establish a fee for letters of endorsement, good standing, or verification of licensure or approval; require that all Committee approvals for SPs expire at midnight on the last day of the birth month of the physician; and require MBC to establish a cyclical renewal program for approvals. This bill would also require PAEC to submit a report to the legislature identifying the percentage of funds derived from any increase in fees permitted under this bill that are to be used for investigations or enforcement activities by PAEC and MBC. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 76 for background information.) This bill is pending on the Senate floor.

RECENT MEETINGS:

At its March 15 meeting, PAEC adopted conflict of interest guidelines, which are intended to assist PAEC members in recognizing official decisionmaking from which they should disqualify themselves, and refrain from participating in the discussion and influencing or attempting to influence the outcome. PAEC's guidelines are based on MBC'S conflict of interest guidelines.

In his enforcement report, Executive Officer Ray Dale noted that the Attorney General's Office is currently working on five serious cases. PAEC has spent 100% of the investigation expense budget allocated for the year, so it will divert funds from other line items to compensate for this deficiency. However, MBC will continue to perform investigations even if PAEC runs out of funds.

Staff member Jennifer Barnhart presented a status report on PAEC's Diversion Program. The purpose of the program is to identify and rehabilitate PAs whose competency may be impaired due to substance abuse. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 90 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 107 for background information.) As of March 15, there was one person in the evaluation phase of the program.

PAEC member Nancy Kluth reported on the upcoming issue of the Committee's newsletter. The articles have been reviewed and will be submitted to printing. The Spanish translation of PAEC's *What is a Physician Assistant?* consumer education brochure has been completed and hopefully will be included in the newsletter.

The Committee decided to cancel its May 17 meeting to allow PAEC members to attend meetings of the American Academy of Physician Assistants, to be held May 26-30, and the National Committee on Certification of Physician Assistants, to be held May 23-24.

FUTURE MEETINGS:

October 11 in Monterey.
January 10 in San Diego.
March 13 in San Francisco.
May 8 in Palm Springs.

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; at this writing, one of the public member seats is vacant.

MAJOR PROJECTS:

Diversion Program. Contrary to its past position, the Medical Board has recently indicated interest in discussing a combined diversion program for MBC and allied health licensing program (AHLP) licensees. The purpose of a

diversion program is to identify and rehabilitate licensees whose competency is impaired due to drug or alcohol abuse. (*See supra* agency report on MBC; *see also* CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 108; Vol. 10, No. 1 (Winter 1990) p. 84; and Vol. 7, No. 4 (Fall 1987) p. 58 for background information.) Like several other AHLPs, BPM has a diversion program, which it contracts with Occupational Health Services (OHS) to run; currently, eight podiatrists are in the program.

Recently, MBC Diversion Program Manager Chet Pelton analyzed and compared the costs and services of MBC's program versus BPM's program. BPM's program is run by OHS; BPM pays OHS $64,800 for a three-year contract, and OHS collects an additional $75 per month from each podiatrist in the program. The participating podiatrists pay for treatment programs, urine testing, and attendance at diversion meetings.

MBC's program is administered by Medical Board staff. The total program costs were $625,000 in fiscal year 1989-90. As of June 1990, 253 physicians were in the diversion program. MBC's program collects no fees from participants; thus, all California-licensed physicians cross-subsidize the diversion program through their licensing fees. Participating physicians pay for treatment costs, urine testing, and attendance at group meetings.

MBC claims that its success rate is 73%; success is achieved when a physician has over two years' sobriety and has demonstrated to the Diversion Evaluation Committee a lifestyle which would support sobriety the rest of his/her life. The average time in the program is between three and four years. Pelton noted that five years ago, 60% of the referrals to the program came from the Medical Board; now, 60% of the participants are self-referred. Once a physician is admitted to the program, he/she is closely tracked by program staff, but will not be disciplined by the Medical Board.

On several occasions, AHLPs have asked to participate in the Medical Board's diversion program, but on each such occasion the answer was no. Thus, the AHLPs' only recourse has been to seek legislation authorizing them to establish their own program. In the past six months, however, the Medical Board (and particularly its Division of Allied Health Professions) has adopted a new spirit of cooperation and communication with its AHLPs, and discussion of a joint diversion program reflects that spirit. This matter will be on the agenda of future BPM and DAHP meetings.

LEGISLATION:

SB 1195 (Boatwright). Existing law prescribes fees that apply to the issuance of certificates to practice podiatric medicine, including the initial license fee. Existing law also provides that if the license will expire less than one year after its issuance, then the initial license fee is an amount equal to 50% of the initial license fees fixed by MBC, and permits MBC to waive or refund the initial license fee where the license will expires within 45 days after it is issued. As amended April 17, this bill would delete the provisions relations to the reduction, waiver, and refund of the initial license fee, and instead would permit MBC to reduce the initial license fee by up to 50% of the amount of the fee for any applicant enrolled in an MBC-approved postgraduate training program or who has completed an MBC-approved postgraduate training program within six months prior to the payment of the initial license fee. This bill passed the Senate on May 30 and is pending in the Assembly Health Committee.

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

SB 664 (Calderon), as introduced March 5, would prohibit podiatrists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at page 91:

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

AB 1568 (Klehs), as amended May 15, proposes to make numerous changes to the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, relating to podiatry. For example, this bill would prohibit a hospital which contracts with an insurer, nonprofit hospital service plan, or health care service plan from determining or conditioning medical staff membership or clinical privileges upon the basis of a podiatrist's participation or nonparticipation in the contract. This bill is pending in the Assembly Ways and Means Committee.

AB 465 (Floyd). Existing law provides general civil immunity to persons who provide information to MBC/BPM or the Department of Justice indicating that a licensee may be guilty of unprofessional conduct or impaired because of drug or alcohol abuse or mental illness. Existing law also sets forth special immunity provisions relating to the certain activities of specified health care organizations. As introduced February 8, this bill would make the general immunity provisions inapplicable to the activities which are subject to the special immunity provisions. This bill passed the Assembly on May 30 and is pending in the Senate Judiciary Committee.

FUTURE MEETINGS:

October 4 in Los Angeles.
December 6 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.* BOP sets standards for education and experience required for licensing, administers licensing examinations, issues licenses, promulgates rules of professional conduct, regulates the use of psychological assistants, investigates consumer complaints, and takes disciplinary action against licensees by suspension or revocation. BOP's regulations are located in Division 13.1, Title 16 of the California Code of Regulations (CCR). BOP is composed of eight members, three of whom are public members.

MAJOR PROJECTS:

Permit Reform Act Regulations Approved. At its May 18 meeting in Los Angeles, BOP announced that the Office of Administrative Law (OAL) had approved its long-awaited regulations to implement the Permit Reform Act of 1981. The regulations, which add section 1381.6 to Chapter 13.1, Title 16 of the CCR, establish a timeline for BOP's processing of license applications. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 92 and Vol. 10, No. 4 (Fall 1990) p. 93 for background information.) The approval clears the way for future submittal of other regulatory packages to OAL, which had occasionally refused to approve new regulation filings if the promulgating agency or board had not yet complied with the Permit Reform Act.

Fee Increases Approved. On May 24, OAL approved BOP's amendments to regulatory sections 1392, 1383, and 1836, which—among other things—increase the biennial license renewal fee for psychologists. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 92 for background information.)

Draft Regulatory Amendments on Supervised Professional Experience. Also at its May meeting, BOP resumed its analysis of draft amendments and additions to regulatory section 1387, discussion of which had been postponed pending OAL approval of BOP's Permit Reform Act regulations. Through the proposed amendments and additions, the Board intends to further define the criteria for and responsibilities of a "qualified primary supervisor"; specify the length and type of required supervised professional experience; define acceptable group supervision; and delineate the responsibilities between supervisors and supervisees regarding the proper logging of supervised experience to ensure accurate verification of supervised professional experience. (See CRLR Vol. 10, No. 4 (Fall 1990) p. 93 and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 110 for background information.) At the May meeting, the Board stated its intention to finalize the proposed language at its July meeting in San Francisco, and to hold a formal public hearing at its September meeting in San Diego.

Fictitious Name Permit Program. BOP has also resumed work on its revision of proposed regulations to establish a procedure for application and issuance of fictitious name permits. The proposal was rejected by OAL in February 1990, and then temporarily shelved pending completion of the Permit Reform Act regulations. The proposal would add sections 1398, 1398.1, and 1398.2 to Title 16 of the CCR, to implement AB 4016 (Chapter 800, Statutes of 1988), which requires psychologists desiring to practice under a fictitious name to obtain a permit from the Board. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 110; Vol. 9, No. 4 (Fall 1989) p. 70; and Vol. 8, No. 4 (Fall 1988) p. 65 for background information.) At its May meeting, the Board authorized legal counsel to make necessary revisions to the proposed regulations for submittal to the Board at the July meeting. The Board intends to hold a public hearing regarding the proposal at its September meeting in San Diego.

Conflict of Interest/Dual Relationship Regulations. BOP Executive Officer Tom O'Connor informed the Board at its May meeting that he is presently attempting to organize a meeting with the Executive Officer of the Board of Behavioral Science Examiners (BBSE) in order to work out mutually acceptable regulatory language defining "conflicts of interest." (*See supra* agency report on BBSE for related discussion.) The proposed regulations would define and prohibit certain relationships between a therapist and a patient outside the primary relationship of providing professional services.

Following a joint BOP/BBSE meeting on the issue in December 1990, O'Connor became dissatisfied with the "dual relationship" terminology, the precursor to the as-yet-unwritten "conflicts of interest" language, and subsequently recommended to the Board that such terminology be abandoned. After his planned conferral with BBSE, O'Connor intends to present proposed "conflict of interest" language to the Board for discussion.

LEGISLATION:

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

AB 1106 (Felando), as introduced March 5, would create the Alcohol and Drug Counselor Examining Committee within BBSE, and would require the Committee to adopt regulations to establish certification standards and requirements relating to education, training, and experience for persons who practice alcohol and drug abuse counseling, and to grant certificates to practice drug and alcohol abuse counseling to applicants who meet the requirements and standards established by BBSE. This bill is pending in the Assembly Health Committee.

SB 664 (Calderon), as introduced March 5, would prohibit psychologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at page 92:

SB 774 (Boatwright), as amended May 7, 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 50 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. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 78 for background information.) This bill passed the Senate on May 30 and is pending in the Assembly Health Committee.

SB 738 (Killea), as introduced March 6, would require BOP to establish required training or coursework in the area of domestic violence assessment, intervention, and reporting for all persons applying for an initial psychologist's license and the renewal of such a license. This bill is pending in the Senate Business and Professions Committee.

AB 1496 (Murray), as amended May 30, would specify a procedure by which a coroner could enforce a subpoena duces tecum for records of confidential communications of a decedent subject to the psychotherapist-patient privilege when sought by the coroner for specified

purposes. This bill is pending on the Assembly floor.

RECENT MEETINGS:

At its May 18 meeting in Los Angeles, the Board decided it will no longer allow offsite licensing examinations for handicapped examinees as part of its Reasonable Accommodations for Psychology Licensing Examinations Policy adopted in May 1990. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.) The Board will continue to make "reasonable accommodations" for handicapped examinees onsite, including special seating arrangements and up to two extra hours to complete the examination.

FUTURE MEETINGS:

September 27-28 in San Diego.
November 1-2 in Sacramento.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY EXAMINING COMMITTEE

Executive Officer: Carol Richards (916) 920-6388

The Medical Board of California's Speech-Language Pathology and Audiology Examining Committee (SPAEC) consists of nine members: three speech pathologists, three audiologists and three public members (one of whom is a physician).

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

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

MAJOR PROJECTS:

Fee Increase Approved. On May 28, the Office of Administrative Law (OAL) approved SPAEC's proposed amendment to section 1399.186(b), Division 13.4, Title 16 of the CCR, which increases license renewal fees to $75, due to a potential budget deficit due to lack of revenue. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 93 for background information.)

Renewal fees are currently collected on a biennial basis, and all renewal fees are due on the same day. Due to cash flow problems resulting from this system, SPAEC, at its April 18 meeting, proposed a cyclical renewal plan which will allow SPAEC to collect renewal fees on a year-round basis. Renewal fees will be collected based on the licensee's birthdate; this will evenly distribute SPAEC's cash flow and workload throughout the year, and Committee members believe it will be easy for licensees to remember when to pay their renewal fees.

Exam Waiver Interviews. At its April 18 meeting, SPAEC split up into subcommittees to conduct interviews of candidates requesting to be licensed without taking the national exam, pursuant to regulatory section 1399.159. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 93; Vol. 11, No. 1 (Winter 1991) p. 79; and Vol. 10, No. 4 (Fall 1990) p. 96 for background information.) Following interviews of the applicants by the subcommittees, the subcommittees reported their recommendations to the full Committee, which then voted whether to grant each candidate's request for waiver.

Following the interviews, the Committee engaged in discussion regarding its procedure, and agreed to the following: (1) staff should not schedule a waiver interview until the applicant has provided SPAEC with all required documents in their official form (*i.e.*, not copies); (2) each subcommittee should be comprised of one speech-language pathologist, one audiologist, and one public member whenever feasible; and (3) an applicant who is denied a waiver by a subcommittee may request to be reinterviewed by the entire Committee.

LEGISLATION:

SB 664 (Calderon), as introduced March 5, would prohibit speech pathologists and audiologists, among others, from charging, billing, or otherwise soliciting payment from any patient, client, customer, or third-party payor for any clinical laboratory test or service if the test or service was not actually rendered by that person or under his/her direct supervision, except as specified. This bill is pending in the Senate Business and Professions Committee.

RECENT MEETINGS:

At SPAEC's April 18 meeting, Executive Officer Carol Richards reported on a "roundtable discussion" held by the Department of Consumer Affairs (DCA) on continuing education (CE). The roundtable was prompted by the pendency of 12 CE bills in the legislature. Richards reported that, of the 43 agencies within DCA, 19 require some form of CE. However, the general consensus of the staff of these agencies is that CE, in most instances, is of questionable value to both participants and consumers. SPAEC currently has no CE requirement, but has seriously considered sponsoring legislation to impose one in the past. (See CRLR Vol. 11, No. 1 (Winter 1991) pp. 79-80; Vol. 10, No. 4 (Fall 1990) p. 96; and Vol. 9, No. 4 (Fall 1989) p. 71 for background information.)

Also in April, SPAEC again discussed speech pathology aides, the limited amount of supervision many of them receive from their supervisors, and the practice of many speech pathologists to charge the same amount for services performed by aides. Staff reminded the Committee that a new brochure designed to inform supervisor-licensees of the duties which aides may and may not perform is on order, and will be included in the aide application packet in the future. (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 111 for background information.) Committee member Gail Hubbard stated that she has no reservation about denying an application for registration of an aide if the supervisor does not intend to properly supervise the aide.

FUTURE MEETINGS:

September 6 in Los Angeles.
November 8 in Sacramento.

BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

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

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